Fifth Progress Report

Abortion

Coiste Uile-Pháirtí an
Oireachtais ar an mBunreacht

The All-Party Oireachtas
Committee on the Constitution

Baile Átha Cliath
Arna Fhoilsiú ag Oifig an tSoláthair

Le ceannach díreach ón
Oifig Dhíolta Foilseachán Rialtais
Teach Sun Alliance
Sráid Theach Laigean, Baile Átha Cliath 2

nó tríd an bpost ó
Foilseacháin Rialtais, An Rannóg Post-Tráchta
4-5 Bóthar Fhearchair, Baile Átha Cliath 2
(Teil: 01 - 661-3111 - fo-líne 4040/4045; Fax: 01 - 475 2760)
nó trí aon díoltóir leabhar.

Dublin
Published by the Stationery Office

To be purchased directly from the
Government Publications Sale Office
Sun Alliance House
Molesworth Street, Dublin 2
or by mail order from
Government Publications, Postal Trade Section
4-5 Harcourt Road, Dublin 2
(Tel: 01 – 661 3111 – ext 4040/4045; Fax: 01 – 475 2760)
or through any bookseller.

£10.00

Pn 6250

ISBN 0-7076-6161-7

Printed by Criterion Press Printers, Dublin

The All-Party Oireachtas Committee was established on 16 October 1997. Its terms of reference are:

> *In order to provide focus to the place and relevance of the Constitution and to establish those areas where Constitutional change may be desirable or necessary, the All-Party Committee will undertake a full review of the Constitution. In undertaking this review, the All-Party Committee will have regard to the following:*
>
> *a* *the Report of the Constitution Review Group*
>
> *b* *participation in the All-Party Committee would involve no obligation to support any recommendations which might be made, even if made unanimously*
>
> *c* *members of the All-Party Committee, either as individuals or as Party representatives, would not be regarded as committed in any way to support such recommendations*
>
> *d* *members of the All-Party Committee shall keep their respective Party Leaders informed from time to time of the progress of the Committee's work*
>
> *e* *none of the parties, in Government or Opposition, would be precluded from dealing with matters within the All-Party Committee's terms of reference while it is sitting, and*
>
> *f* *whether there might be a single draft of non-controversial amendments to the Constitution to deal with technical matters.*

The committee comprises eight TDs and four senators:

Brian Lenihan, TD (FF), *chairman*
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Brendan Daly, TD (FF)
Senator John Dardis (PD)
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The secretariat is provided by the Institute of Public Administration:

Jim O'Donnell, *secretary*
James McDermott, *assistant secretary*.

While no constitutional issue is excluded from consideration by the committee, it is not a body with exclusive concern for constitutional amendments: the Government, as the executive, is free to make constitutional proposals at any time.

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Foreword

The Green Paper on Abortion was referred to the All-Party Oireachtas Committee on the Constitution by the government in September 1999.

This Progress Report is not a comprehensive analysis of the matters discussed in the Green Paper. It is a political assessment of certain questions which arise from it in the context of the submissions we received and the hearings we conducted.

I want to thank the members of the public who made submissions to us, the witnesses who appeared at the oral hearings, the staff of the Houses of the Oireachtas and the Cathaoirleach of Seanad Éireann for their assistance.

The secretariat to the committee rendered us invaluable service at all times.

I want to thank the members of the committee for their dedicated participation in the work of this report and their unfailing courtesy at all times.

Brian Lenihan, TD

ABORTION

Chapter One

Introduction

A referendum to amend the Constitution took place on 7 September 1983 and the people voted to insert the Eighth Amendment. This became Article 40.3.3º and read:

> 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.

In 1992 the Supreme Court gave judgment in the case of the *Attorney General v X and Others*. While diverging judgments were delivered in the *X* decision the judgment of Finlay CJ is often cited:

> … if it can be 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.

A majority in the Supreme Court ruled that a threat of self-destruction can amount to a substantial risk to the life of the mother.

In current Irish law termination of pregnancy is not lawful in the state unless it meets the conditions laid down by the Supreme Court in the *X* case. Information on abortion services abroad can be provided within the terms of the Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995. The protection of the unborn referred to in the Constitution cannot be invoked to ban travel abroad by pregnant women.

A significant body of opinion has expressed dissatisfaction with the current position resulting from the *X* decision.

The numbers travelling abroad for abortion has occasioned considerable comment and concern.

The Taoiseach indicated after the government took office in 1997 that it was intended to issue a Green Paper on the subject of abortion. A cabinet committee was established to supervise the drafting of this Green Paper. The preparatory work was carried out by an Interdepartmental Working Group of officials.

In drawing up the Green Paper, submissions were invited from the public, from professional and voluntary organisations and any other parties who wished to contribute. Over 10,000 such submissions were received, as well as petitions containing 36,500 signatures.

The Green Paper was published in September 1999. It has seven chapters. Chapter one discusses the medical issues which arise in relation to the treatment of pregnant women. Chapter two deals with the legal issues raised by the courts' interpretation of the Constitution and the law in relation to abortion. Chapter three deals with Ireland's obligations under international and European Union law and considers what implications these might have for constitutional or legal change in relation to abortion. Wider grounds for abortion are examined in an international context in chapter four. A summary of the issues raised in the submissions received is contained in chapter five. Chapter six discusses the social context of abortion. Possible constitutional and legislative approaches to addressing the issues identified in the Green Paper are discussed in chapter seven.

Having considered the legal, medical and social issues involved, the Green Paper sets out and discusses seven different options on the substantive issue of abortion:

i) an absolute constitutional ban on abortion

ii) an amendment of the constitutional provisions so as to restrict the application of the *X* case

iii) the retention of the *status quo*

iv) the retention of the constitutional *status quo* with legislative restatement of the prohibition on abortion

v) legislation to regulate abortion in circumstances defined in the *X* case

vi) a reversion to the pre-1983 position

vii) permitting abortion on grounds beyond those specified in the *X* case.

The Green Paper was then referred to the All-Party Oireachtas Committee on the Constitution for its consideration and recommendations.

The committee invited written submissions on the options in the Green Paper through public notices on 20 September 1999. It set a deadline of 30 November 1999 for the receipt of submissions, judging this a sufficient period to allow both individuals and organisations to prepare submissions. The committee received approximately 105,000 communications by the deadline of 30 November 1999. Many of these took the form of a simple request for a referendum but a considerable number were detailed submissions, some of which were supported by printed materials, tapes and videos. Approximately ninety-two percent of these communications took the form of signatures to petitions. Over 80,000 signatures were contained in one petition alone. The balance comprised signatures to circular letters of one form or another (about five percent) and personal letters (3,500 in all or just over three percent. There were about one hundred letters from priests, one hundred and fifty from nuns, ten from religious brothers, sixty-five from medical doctors and twenty from nurses. There were about ten submissions from lawyers.

The vast majority of communications were in favour of option 1.

Over fifty national organisations and groups made submissions, almost equally divided between those that supported option 1 and those that supported other options.

The majority of those individuals who made submissions are totally against abortion and desire a referendum which will give them the opportunity to secure an absolute ban on abortion. The points they most frequently make are:

1. life begins at conception
2. abortion is murder
3. life is sacred; the innocent unborn must always be protected
4. there is no medical reason for abortion – no medical condition which would require abortion to save the mother's life
5. Ireland is the last line of defence
6. to allow abortion under any circumstances would represent the slippery slope and open the floodgates
7. the Supreme Court was wrong in the *X* case
8. we need a referendum – politicians should now end the process of consultation and arrange for a referendum
9. pregnancy is more often a protection against suicide
10. abortion causes enormous physical and psychological damage.

The secretariat prepared a catalogue which indicated the source of the submissions and provided a summary of the content of each. The catalogue was a working document to help the committee to achieve an overview of the submissions.

In view of the great public interest in the submissions the committee issued a press release in April 2000 which indicated that the submissions could be viewed in the committee's offices and that anyone interested should arrange a suitable time with the secretariat. A number of persons availed themselves of this facility.

The submissions constituted a massive volume of ideas, suggestions and sentiments and included matter from theological, philosophical, legal and medical experts. To ensure that there were no important gaps in its information the committee sought submissions from those organisations which had made submissions to the Interdepartmental Working Group but not to the committee.

The Green Paper pointed out that very few medical bodies or organisations made submissions to the Government in the course of the preparation of the document.

A major concern of the committee was to establish in an authoritative manner current medical practice in Irish hospitals relating to medical intervention during pregnancies. The committee decided that it would be essential to hear the views and opinions of experts in the fields of obstetrics, gynaecology and psychiatry. The committee decided to hold hearings in public with the recording facilities of the Houses of the Oireachtas. Accordingly the committee was reconstituted as the

Joint Committee on the Constitution by resolutions of both Houses of the Oireachtas. The requisite resolutions passed in both Houses enabled the committee to sit as a joint committee of the Oireachtas for the month of May. Subsequent resolutions permitted the committee to sit as a joint committee for the month of July. Hearings were conducted with leading medical specialists, the national interest groups on both sides of the abortion issue, individuals and groups who had expressed a special interest in talking to the committee, and with representatives of the major religious bodies in Ireland.

The hearings were not a tribunal of enquiry. The purpose of the hearings was to assist the members of the committee in their consideration of the submissions.

The committee appreciates the generosity and forbearance of the staff of the Houses of the Oireachtas who, at little notice and at a time when all the other committees of the Oireachtas were pressing to complete their work before the summer recess, undertook the extra substantial burden involved in the committee's public hearings – Kieran Coughlan, Clerk of the Dáil, Deirdre Lane, Clerk of the Seanad, Eamon O'Donoghue, the Superintendent of the House, John Kissane, who acted as Clerk of the Joint Committee, Tom Dwan, who directed the filming of the hearings, and Liam FitzGibbon, the Editor of Debates, who managed the production of the transcripts. The committee is most grateful to the Cathaoirleach of Seanad Éireann, Senator Brian Mullooly, who made the Seanad Chamber available to the committee for the medical hearings, 2-9 May 2000.

The schedule for the public hearings was as follows:

Tuesday 2 May 2000

Dr James Clinch, consultant obstetrician and gynaecologist
Professor John Bonnar, Chairman, Institute of Obstetricians and Gynaecologists

Wednesday 3 May 2000

Dr Declan Keane, Master, National Maternity Hospital, Holles Street, Dublin
Dr Peter McKenna, Master, Rotunda Hospital, Dublin
Dr Sean Daly, Master, Coombe Women's Hospital, Dublin

Thursday 4 May 2000

Dr Brian Denham, paediatrician, Mount Carmel Hospital, Dublin
Dr Anthony Clare, Medical Director, St Patrick's Hospital, Dublin
Dr Michael Solomons, obstetrician gynaecologist, retired
Dr PJK Conway, consultant obstetrician gynaecologist, Portlaoise General Hospital, Co Laois
Professor Eamon O'Dwyer, Professor Emeritus, Obstetrics and Gynaecology, NUI Galway

Tuesday 9 May 2000

Professor Walter Prendiville, consultant gynaecologist, Coombe Women's Hospital, Dublin
Fred Lowe, senior clinical psychologist, Baggot Street Hospital, Dublin

Irish Medical Council
Professor Gerard Bury
Dr John Hillery
Dr Helena Stokes
Mr Brendan Healy

Dr Alistair McFarlane, consultant obstetrician gynaecologist
Dr John D Sheehan, consultant psychiatrist, Rotunda Hospital, Dublin
Senator Mary Henry MD

Wednesday 17 May 2000

Dr TK Whitaker, Chairman of the Constitution Review Group (1995-96)

The de Borda Institute
Peter Emerson
Phil Kearney
Dr Sieneke Hakvoort
John Baker

Tuesday 23 May 2000

Breda O'Brien
Professor Patricia Casey

Wednesday 24 May 2000

Irish Family Planning Association
Tony O'Brien
Sherie de Burgh
Catherine Forde
Dr Nial O'Leary

Abortion Reform
Ivana Bacik
Anne Marlborough
Damian Ó Broin
Monica O'Connor

Irish Congress of Trade Unions
Peter Cassells
Inez McCormack
Patricia O'Donovan
Joan Carmichael

Adelaide Hospital Society
Professor Ian Graham
Dr Fergus O'Ferrall
Dr Elaine Kay

Well Woman Centre
Alison Begas
Dr Shirley McQuade

Tuesday 30 May 2000

Psychologists for Freedom of Information
Dr Geraldine Moane
Professor Hannah McGee

Dr Harith Lamki, consultant obstetrician and gynaecologist, Royal Maternity Hospital, Belfast

Public Policy Institute of Ireland
Tom Troy
Dr Gerard Casey

Wednesday 31 May 2000

Family and Life
David Manly
Claire Lahiffe

Christian Solidarity Party
John Wood
Dr Phil Boyle
Donal Corrigan
Enda Dunleavy

Pro-Life Campaign
Professor William Binchy
Dr Berry Kiely
Caroline Simons

Society for the Protection of Unborn Children
Marie Vernon
Cora Sherlock

Youth Defence
Justin Barrett
Niamh Nic Mhathúna
Dr Sean Ó Domhnaill

Muintir na hÉireann Teoranta
Richard Greene
Anne Greene
Donal O'Driscoll
Phil Walshe

Doctors for Life
Dr Miriam Brady
Dr Catherine Bannon
Dr Máire Nesta Nic Ghearailt

Life Pregnancy Care
Dr Kevin Doran
Julia Heffernan
Mary Gallagher
Anne Kennedy

Wednesday 5 July 2000

The Muslim Community in Ireland
Shaheen Ahmed
Arif Fitzsimons
Sheikh Hussein Halawa
Ali Selim

The Church of Ireland
The Right Reverend HC Miller
Dr MRN Darling
Dr PHC Trimble

The Presbyterian Church in Ireland
Rev Dr Trevor Morrow
Rev Norman Cameron

The Methodist Church in Ireland
Robert Cochran
Rev Des Bain

The Jewish Community in Ireland
The Very Rev Chief Rabbi Gavin Broder

The Irish Catholic Bishops' Conference
The Most Rev Desmond Connell
The Most Rev Laurence Ryan
Dr Ciaran Craven
Rev Paul Tighe
Ann Power

Wednesday 12 July 2000

Rosemarie Rowley

The Association of Irish Humanists
Justin Keating
Mary Hardiman
Dick Spicer

A group of barristers
Benedict O Floinn
Shane Murphy

Joseph F Foyle

Cork Women's Right to Choose Group
Orla McDonnell
Sandra McEvoy
Linda Connolly
Orla O'Donovan

The Women's Health Council
Geraldine Luddy
Maureen Gilbert

Máire Kirrane

Catholics for a Free Choice
Frances Kissling
Jon O'Brien
Eileen Moran

Dr Everard Hewson

Lelia O'Flaherty

To assist any citizen seeking information on this subject the committee decided to reproduce as appendices the Green Paper on Abortion, the section from the Report of the Constitution Review Group dealing with rights to life, the transcripts of the oral hearings, and a representative selection of the written submissions made to the committee.

Chapter Two

Legal Aspects

The regulation of abortion is a matter for the law – in Ireland for the Constitution, the fundamental law, and legislation. This chapter deals with the legal issues arising in the submissions: the legal definition of abortion, the consequences of the *X* case, 'the slippery slope', and the need for a referendum.

How do you define abortion?

If abortion is to be banned in the Constitution it is necessary to have a clear definition of it. People must have a clear idea of what is banned: justice demands legal certainty. The committee has been offered a wide range of definitions. One of the most straightforward is that abortion is the killing of innocent babies and killing offends against the commandment 'Thou shalt not kill'. This definition would be morally conclusive if the commandment were itself absolute – if it always applied in its simple, direct sense. However, the commandment has never, throughout history, been applied in that sense. It has been qualified to allow people to kill in 'just' wars, in holy wars such as the crusades, to execute criminals convicted of capital offences in courts, to allow a person to kill in self-defence, to allow the unborn to die to save the life of the mother.

Ms Lelia O'Flaherty, who attended the hearings and asked to be heard, told the committee:

> There has been a lot of discussion at these hearings as to a definition of the word abortion. There may very well be various dictionary definitions of the word but what the vast majority of people in Ireland anyway and worldwide understand when you refer to abortion is the direct and intentional killing, by whatever means, of an unborn child at whatever stage of his or her development from conception up to birth and including birth. At the moment of birth, the killing of the child is called partial birth abortion. After birth the killing of the child is called infanticide. In the UK recently there was discussion on the possible acceptance of fourth trimester abortion, that is, killing a child up to three months after birth.

In his evidence to the committee Dr Declan Keane, Master of the National Maternity Hospital, Holles Street, Dublin, said:

> … it is critical always, whenever anyone is discussing any topic, to define what one means by it. In the medical profession we have always defined – and in the clinical textbooks – an abortion as a pregnancy that is lost in the first

> trimester of pregnancy. It is unfortunate that the term 'abortion', certainly in the lay press, has become synonymous with the termination of pregnancy induced by a variety of means. But, as I say, an abortion is a pregnancy lost in the first trimester of pregnancy, which is up to fourteen weeks.
>
> A miscarriage, technically, was the definition of a loss of a pregnancy between fourteen weeks up to a period of viability of the foetus, which used to be taken as twenty-eight weeks but which is increasingly coming down because we can now keep babies alive from about twenty-four weeks' gestation onwards. However, I think in terms of the debate that we are having here at the moment and your committee, we are talking about abortion in terms of terminating a pregnancy, and that is what I have taken it to mean …

Dr Sean Daly, Master of the Coombe Women's Hospital, Dublin, said:

> The medical term 'abortion' that I understand means the premature ending of a pregnancy before the foetus or baby is viable – that can happen spontaneously and, in general, we refer to that as a 'miscarriage' – but that whenever there is a medical condition that necessitates that the pregnancy needs to be ended before the foetus is viable, that is what I would consider an abortion. Now, certainly, there are different indications for it but, broadly speaking, I think that that is what an abortion refers to.

Professor John Bonnar, Chairman of the Institute of Obstetricians and Gynaecologists, in agreeing that doctors use the term abortion to embrace miscarriages, adverted to the definitional complexities:

> I agree that is one of the definitions. The other one that we usually teach is the expulsion of the foetus-placenta post-conception prior to the age of viability, but the understanding of all that is from a uterus, a pregnancy in the womb. When you get these simple definitions, they are not going into the complexities of pregnancies that end up in the ovary or in the fallopian tube or in the abdomen or in the cervix. They are not talking about a woman with cancer of the neck of the womb. They are talking about a healthy woman with a normal intra-uterine pregnancy, where a pregnancy is developing, a healthy pregnancy in a healthy woman. When we talk about termination or legal abortion, we are talking about intervening in that situation with the direct intention of taking the life of the foetus or unborn. That is what we mean by procured abortion. We do not talk about a doctor dealing with a mother with severe pre-eclampsia as procuring abortion, or dealing with an ectopic pregnancy as procuring abortion, or dealing with cancer of the cervix as procuring abortion.

Professor Eamon O'Dwyer, Professor Emeritus of Obstetrics and Gynaecology at NUI Galway, in referring the committee to the

submission of the Institute of Obstetricians and Gynaecologists, indicated how the definitional complexities were compounded when one sought to connect medical and legal terminology:

> Professor Bonnar's submission from the Institute had a rather tortuous gestation – let us put it that way – and there was more than one draft. I disagreed with him on the use of the word 'termination', which appeared in it at first. He amended that to 'therapeutic termination' – I think that is what the word is.
>
> Chairman: The words are 'therapeutic intervention'.
>
> Professor O'Dwyer: Yes, 'intervention'. I objected to the use of the word 'intervention' because I said: 'Intervention to me will lend itself to all sorts of constructions, legal constructions, and I would be much happier if you would use the word "treatment" '. Then this thing, 'intervention' appeared in the last paragraph too, I think, and he took it out there and he put in the word 'treatment' and I said: 'Now, hold it, John. You should put a comma after that word "treatment" and put in "other than abortion" '. Because, you remember that a judge of the High Court said that abortion was medical treatment by any definition and I said 'we leave ourselves open to being caught there and we have been caught with the other one'. Now, interestingly, therapeutic intervention has been interpreted by at least one University College Dublin graduate in the US, writing recently, who said that the Institute is allowing for termination of pregnancy in certain cases and he said what is therapeutic intervention if it is not termination of pregnancy?

Dr Alistair McFarlane, a consultant obstetrician gynaecologist, in his submission adverted to the transmigratory tendency of words:

> Words also change their usage; we often carelessly say that their 'meanings' have changed. Thus once, if we wrote in a patient's case notes that she had had two abortions, we meant that there had been two miscarriages. The word miscarriage was avoided in notes as being a lay term. Now however it is readily used, because abortion now has come to mean in both medical and lay usage the destruction of an embryo or foetus at a hospital or private clinic (usually in Britain). We do need a term to apply to *the deliberate ending of the life of a little human being by whatever means, the action having been taken before birth and where he or she could have survived with recognised antenatal care***.** So why not use the word 'abortion' – after all that is how we mostly use the word nowadays.

Even the term 'termination of pregnancy' which is often used as a synonym for abortion was exposed to the committee as being ambiguous.

Dr Seán Ó Domhnaill, a representative of Youth Defence at the hearings, said:

> There is a difference between a termination of a pregnancy and a termination of the life of the unborn child.
>
> Deputy J. O'Keeffe: What is the difference?
>
> Dr Ó Domhnaill: The difference is that you can terminate a pregnancy by going into labour. You can terminate the life of a child by killing it. Every pregnancy is eventually terminated.

It is the nature of definitions to cabin and confine the meaning of words. Dr TK Whitaker, the Chairman of the Constitution Review Group, 1995-96, observed in his address to the committee:

> As regards definitions, I expressed great caution about that controversial matter in the submission. Nevertheless, I do believe that the time has come to begin to attempt some definitions and I would favour doing this legislatively. I don't think the Constitution is the place for definitions, particularly definitions that must be tentative and be subject to review in the light of advances in science.
>
> I think perhaps a start could be made with the term 'pregnancy'. That is what we are dealing with – termination of pregnancy. It is clear to everyone when it ends, but when does it begin? When does an unborn come into existence? Should there not logically be some clarity as to what we want to protect?

Rev Paul Tighe, a representative of the Irish Catholic Bishops' Conference, agreed that there was a difficulty in using the term abortion in a referendum proposal:

> I think there is a real difficulty in terms of the first option when it speaks of the ban on abortion because abortion, as the evidence from the previous submission shows, can cover simply spontaneous miscarriage. It can also be used to talk about any death that occurs as a result of medical treatment. Within the Catholic tradition we would always have distinguished between a direct abortion and an indirect abortion – a direct abortion being an abortion which happens where there is a direct and intentional killing of the unborn child. I suppose that distinction is rooted in our general distinctions. It's not confined to the Catholic tradition. You'll find it in medical ethics. You'll find it also in law at times that general distinction between a direct and indirect consequence of one's actions. I think that's where it's rooted.

Professor William Binchy, Legal Adviser to the Pro-Life Campaign, told the committee:

> We are not wedded to any word and we are not specifically wedded to the word 'abortion' appearing in any particular text … it's not so much the language that counts here, it's the activities that are done and the context in which they are done that's important – the principles that underlie the activities in question.

How should we respond to the *X* case?

The defendant in the *X* case was a fourteen-year-old girl who became pregnant after being raped by the father of one of her schoolfriends. The girl and her parents decided that the best course of action was to travel to England to procure an abortion. The parents made known to the Gardaí that they were considering this course of action and suggested that someone in England could carry out a forensic test on the foetus to ascertain the identity of the father. The garda concerned explained that he did not know whether such evidence would be admissible but that he would make inquiries. A legal opinion was sought from the office of the Director of Public Prosecutions (DPP) and the advice obtained was that such evidence would be inadmissible in court.

The DPP informed the Attorney General about the matter. The Attorney General as guardian of the public interest applied for an interim injunction from the High Court restraining the girl and her parents from interfering with the life of the unborn, from leaving the jurisdiction for nine months and from procuring or arranging an abortion within or outside the jurisdiction. On hearing about this order the defendants, who were in England, cancelled the arranged abortion and travelled back to Ireland. They sought to have the interlocutory injunction set aside on the grounds that they had the right to travel from the jurisdiction to do what was lawful elsewhere, that the mother's right to life was in peril and that such injunctions were unprecedented and ought not to have been granted. Their motion was treated by consent as a full trial and the defendants offered oral testimony from a psychologist to the effect that, in view of the girl's threatened intentions, there was a risk that she might commit suicide.

In the High Court Costello J granted the injunctions sought by the Attorney General. The defendants appealed to the Supreme Court. The Supreme Court, in a four to one majority judgment, allowed the appeal.

In the crucial passage in the judgment, Finlay CJ laid down the test to be applied in such cases:

> 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 40.3.3º of the Constitution.

Looking at the psychological evidence in the case the Chief Justice held that the test was satisfied on the facts of the case before the court:

> In my view, it is common sense that a threat of self-destruction such as is outlined 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 the termination of her pregnancy.

The Chief Justice went on to consider the balance between the right to life and the right to travel and concluded:

> Notwithstanding the very fundamental nature of the right to travel and its particular importance in relation to the characteristics of a free society, I would be forced to conclude that if there were a stark conflict between the right of a mother of an unborn child to travel and the right to life of the unborn child, the right to life would necessarily have to take precedence over the right to travel.

In his judgment McCarthy J considered how to balance the right to life of the unborn and the right to life of the mother:

> It is not a question of balancing the life of the unborn against the life of the mother, if it were, the life of the unborn would virtually always have to be preserved, since the termination of pregnancy means the death of the unborn; there is no certainty, however high the probability, that the mother will die if there is not a termination of pregnancy. In my view, the true construction of the Amendment, bearing in mind the other provisions of Article 40 and the fundamental rights of the family guaranteed by Article 41, is that, paying due regard to the equal right to life of the mother, when there is a real and substantial risk attached to her survival not merely at the time of application but in contemplation at least throughout the pregnancy, then it may not be practicable to vindicate the right to life of the unborn.

O'Flaherty J analysed the term 'substantial risk' to the life of the mother:

> 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. The danger has to represent a substantial risk to her life though this does not necessarily have to be an imminent danger of instant death. The law does not require the doctors to wait until the mother is in peril of immediate death.

Egan J focused on the impracticality of imposing a requirement of certainty of death before an abortion could be permitted:

> I would regard it as a denial of the mother's right to life if there was a requirement of certainty of death in her case before a termination of the pregnancy would be permissible. In my opinion the true test should be that a pregnancy may be terminated if its continuance as a matter of probability involves a real and substantial risk to the life of the mother. The risk must be to her life but it is irrelevant, in my view, that it should be a risk of self-destruction rather than a risk to life for any other reason.

Hederman J delivered a dissenting judgment which focused on the inadequacy of the medical evidence before the court:

> The Eighth Amendment does contemplate a situation arising where the protection of the mother's right to life has to be taken into the balance between the competing rights of both lives, namely the mother's and the unborn child's. Abortion as a medical procedure is unique in that it involves three parties. It involves the person carrying out the procedure, the mother and the child. It is inevitable that if the procedure is adopted the child's life is extinguished. Therefore before the decision is taken it is obvious that the evidence required to justify the choice being made must be of such weight and cogency as to leave open no other conclusion but that the consequences of the continuance of the pregnancy will, to an extremely high degree of probability, cost the mother her life and that any such option must be based on the most competent medical opinion available. 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 whatsoever of an obstetrical problem, 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 self-destruction by reason of the fact of being pregnant. This is a very extreme reaction to a pregnancy, even an unwanted pregnancy. But as was pointed out in this Court in *SPUC v Coogan* [1989] IR 734 the fact that a pregnancy is unwanted was no justification for terminating it or attempting to terminate it. 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. I do not think the terms of the Eighth Amendment or indeed the terms of the Constitution before amendment would absolve the State from its obligation to vindicate, and protect, the life of a person who has expressed the intention of self-destruction. This young girl clearly requires loving and sympathetic care and professional counselling and all the protection which the State agencies can provide or furnish. There could be no question whatsoever of permitting another life to be taken to deal with the situation even if the intent to self-destruct could be traced directly to the activities or the existence of another person.

Considering the possibility that the girl might commit suicide he suggested that this threat could be contained:

> Suicide threats can be contained. The duration of the pregnancy is a matter of months and it should not be impossible to guard the girl against self-destruction and preserve the life of the unborn child at the same time. The choice is between the certain death of the unborn life and a feared substantial danger of death but no degree of certainty of the mother by way of self-destruction.

Legal response Following on the *X* decision three amendments were proposed to the Constitution in 1992.

The proposed twelfth amendment provided:

> It shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life, not being a risk of self-destruction.

The amendment was rejected. Contemporary reports suggest that the amendment was opposed by some who objected to the recognition in the Constitution of the principle of termination of the life of the unborn and was opposed by others who objected to the restrictions imposed by the proposal.

The Thirteenth Amendment of the Constitution related to travel. It stated:

> This subsection shall not limit freedom to travel between the State and another state.

This amendment was approved. Accordingly, constitutional provisions relating to the unborn cannot be invoked to restrict travel.

The Fourteenth Amendment of the Constitution, related to the provision of information. It stated:

> This subsection shall not limit freedom to obtain or make available, in the State, subject to such conditions as may be laid down by law, information relating to services lawfully available in another state.

The amendment was approved.

The Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995 was enacted to implement the Fourteenth Amendment. It set out the circumstances when information about services lawfully available in another state might be made available in the state. It provides that a doctor or an appropriate agency can give information about abortion to a pregnant woman in the context of full counselling as to all available options and without any advocacy of abortion. Abortion referral is prohibited under the Act.

In A and B the Eastern Health Board, Mary Fahy, C and the Attorney General (the *C* Case), a thirteen year old girl, who was a member of the travelling community, became pregnant as the result of an alleged rape carried out by an adult male. The Eastern Health Board, which had taken the girl into care, applied to the District Court for orders allowing it to take the girl abroad for an abortion and to make all necessary arrangements for the abortion.

The District Court made an order directing that the child *C* be brought to such place as may be appropriate to terminate her pregnancy, having heard from two psychiatrists that the girl was likely to commit suicide if such a termination was not carried out.

C's parents sought to prevent any such abortion from taking place by challenging the District Court orders in the High Court by way of an action for judicial review. In the course of his judgment delivered on 28 November 1997 Geoghegan J accepted that where evidence had been given to the effect that the pregnant girl might commit suicide unless allowed to terminate her pregnancy, there was a real and substantial risk to her life and such termination was therefore a permissible medical treatment of her condition where abortion was the only means of avoiding such a risk. In its judgment the High Court followed the *X* decision.

Many submissions to the committee criticised the *X* decision.

Dr PJK Conway, a consultant obstetrician gynaecologist, commented as follows:

> They bring no credit on the legal system. If the people involved in that were judged the same way as we are judged as doctors, when things go wrong and we are hauled up before the courts and so on, they would be judged as being highly negligent, highly negligent. Their judgments were

> totally flawed and totally wrong, based on the medical evidence that was presented. In the first case, there was no medical evidence – a psychologist was used. In the second case, one psychiatrist gave his opinion and the other psychiatrist verified that the girl was capable of giving evidence but no other psychiatrist was asked to corroborate or agree with the first psychiatrist.

Dr John Sheehan, a consultant in liaison psychiatry, said:

> … I don't know the details of the case, you know, specific details – but clearly there wasn't a real and substantial risk, you know, and there wasn't a probability that the fourteen year old girl would have gone on to commit suicide, and that's borne out by both international figures and the Finnish study and the British study.

Dr Sean Ó Domhnaill, a psychiatrist representing Youth Defence, told the committee:

> We would certainly feel that the girl in the *X* case was not best served by the court deciding that it would be of greater benefit to her to have an abortion than were she to be disallowed from having an abortion. The court, if it had sought an expert medical opinion on it, would have been told that not only, as you know, does abortion increase the likelihood of suicide, but in a subset of people it increases it even further. The subset, to list the four, would be: previous psychiatric history, in other words, prior to the termination of the life of the unborn – that would include girls who were depressed or suicidal; younger women, which, of course, the girl in the *X* case was; those with poor social support; and those from cultural groups opposed to abortion. Certainly Ireland is a cultural group opposed to abortion. So they were not serving her very well.

John Wood, representing the Christian Solidarity Party, asserted the need for a referendum to restore the level of protection for the unborn:

> … Article 6.1 states that the people, in final appeal, have the right to decide all mattes of national policy. It is our policy that the decision of the people in the 1983 amendment has been interpreted in the *X* case in a way that was not foreseen by the people in the referendum and, as a result, has reduced the level of legal protection to the unborn. It is our policy that the only way to restore that level of protection is to give the people an opportunity to have their say in another referendum.

Professor William Binchy, the Legal Adviser to the Pro-Life Campaign, said:

> Our concern is that the *X* case misunderstood the relevant legal principles; introduced a principle which is at variance with the medical ethics guidelines of the Medical Council, at variance with the Institute of Obstetricians and Gynaecologists, at variance with the recommendation of the IMO and at variance with daily experience in Irish hospitals today. And what we are looking for, legally speaking, is legal support – no more and no less than legal support – for the existing medical practice in Irish hospitals …

Other submissions made the case for legislation to implement the rationale of the *X* decision.

Dr Fergus O'Ferrall, Director of the Adelaide Hospital Society, advanced the need for legislation:

> … the view of the society would be that we need legislation to take into account the circumstances of the *X* and *C* cases because broadly our position is that there should be a legal framework whereby medical indications for termination are clearly secured in a legal framework so that the health care system, and doctors and others who have to care for women, have a very clear situation, which they don't have at the moment. What we have is a constitutional position but we do not have a legal framework.

Anne Marlborough, representing Abortion Reform, supported the view that the *X* case should be
legislated for:

> I would consider it a bit dishonest and dishonourable to have a situation which is running and seems to be working perfectly but, if a problem occurs, it goes to court. We already saw that in the *X* and *C* cases. The threat to life in those cases happened to be from suicide but if there were a different type of a threat to the mother's life and there was a divergence of medical opinion, there would have to be resort to court because there are no legal guidelines for doctors. From the transcripts, doctors did attest that in cases of uncertainty, they would proceed with the termination and then deal with the legal consequences afterwards. They should not have to find themselves in the position of wondering whether they might be breaking the law in a particular case by intervening where there is a threat to the life of the mother.

Dr TK Whitaker, Chairman of the Constitution Review Group, 1995-1996, also supported the need for legislation. In response to the assertion that irrespective of what is done, the courts have the last word on the interpretation of definition he said:

> I fully accept that but, equally, I would maintain that it is up to the legislature to express very clearly and with every due regard to the possibilities of misinterpretation what it wants to be the law of the land. If the courts are in the ultimate

> position of deciding between disputing parties or disputing interpretations … the first requirement is that the law be set out in its original form with the utmost clarity so as to avoid, in so far as possible, recourse to the courts.

The dangers of the 'slippery slope' and 'opening the floodgates'

Many submissions praised the specific recognition of the rights of the unborn in the Constitution. Many pointed out that Ireland's maternity service is among the best in the world and is possibly the best – World Health Organisation figures show, in regard to a major indicator of quality, that Ireland has one of the lowest rates of maternal mortality. Many submissions pointed out that obstetricians and gynaecologists in Ireland treat both the mother and the unborn with a view to bringing the mother to a safe and healthy delivery.

A huge number of the written submissions received by the committee outline religious, philosophical and human rights objections to abortion.

In a submission to the committee a citizen from Cobh, Co Cork, wrote:

> … As a committed Christian, living in a so-called Christian country the only option I can support is option one. *An absolute constitutional ban on abortion*. Options two to seven contain various degrees of abortion.

The following written submission was received from the Presentation Convent, Listowel:

> We the Presentation Sisters urgently request a referendum to ban abortion. A society with a diminished sense of the value of human life at its earliest stages has already opened the door to a culture of death. There is a dulling of conscience regarding the seriousness of the crime of abortion, a crime which cannot be morally justified by any circumstance, purpose or law.
>
> The life of a country is much more than its material development and its power in the world. A nation needs a 'soul'. It needs wisdom and courage to overcome the moral and spiritual temptations in its march through history. It needs to build a society in which the dignity of each person is recognised and the lives of all are defended and enhanced. This is an urgent cry of the heart for a total ban on abortion *now*.

In its submission the Catholic Nurses' Guild of Ireland wrote:

> We recommend that the people of Ireland be given the opportunity to vote on a referendum to prevent abortion being allowed in our country.

The submission of the Pro-Life Campaign presents a rationale for a prohibition on abortion on the basis of the great constitutional values of democracy, justice and equality.

The Pro-Life Campaign believes that 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 equal and inherent dignity and worth of the unborn, treating them unequally before the law. A fully inclusive society committed to treating everyone equally before the law cannot endorse the legalisation of abortion.

It believes that only a constitutional amendment to ban abortion is compatible with an ethos of social inclusiveness and equal respect.

Many submissions drew attention to the widescale extension of abortion in many countries throughout the world. The graphic images of the slippery slope and the opening floodgates were used in many submissions to analyse this development.

Abortion in Britain The extension of abortion in Britain can be traced to an English case, *R v Bourne*, decided in 1939. The decision concerned a fourteen-year-old girl who became pregnant as a result of being raped. The girl's parents, fearing for her mental well-being, arranged for the defendant to carry out an abortion. After the operation the defendant informed the police as to what he had done in order to 'obtain a further definition of the present law'. As a result of his confession the defendant was charged under the Offences Against the Person Act 1861.

In his judgment Macnaghten J looked at the historical background to the Act:

> The defendant is charged with an offence against s.58 of the Offences Against the Person Act, 1861. … The protection which the common law afforded to human life extended to the unborn child in the womb of its mother. But, as in the case of homicide, so also in the case where an unborn child is killed, there may be justification for the act.

In interpreting the Act, Macnaghten J held that although abortion was generally a criminal offence, the Act allowed for the termination of pregnancy for the purpose of preserving the life of the mother. He reached this conclusion by adopting a 'reasonable' approach to the interpretation of the Act:

> As I have said, I think those words ought to be construed in a reasonable sense, and, if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor who, under those circumstances and in that honest belief, operates,

> is operating for the purpose of preserving the life of the mother.

On the basis of this summing up the jury returned a verdict of not guilty.

The decision in *Bourne* was relied on in *R v Newton and Stungo*. This case involved a woman who had threatened suicide. Ashworth J held that abortion is not unlawful where it is done in good faith for the purpose of preserving the life or health of the woman. He defined health as including both physical and mental well-being.

The primary legislation regulating abortion in England, Scotland and Wales is the Abortion Act 1967 as amended by the Human Fertilisation and Embryology Act 1990. The Green Paper describes the position as follows:

> Abortion with the woman's consent is allowed if two doctors certify that a ground for abortion exists. Where the continuance of the pregnancy would involve a risk to the life of the woman, greater than if the pregnancy were terminated, abortion is permitted without any time limit. It is also permitted where the pregnancy has not exceeded twenty-four weeks and the continuance of the pregnancy would involve a risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing child of her family. In assessing the risk to the health of the woman and her existing children, doctors may take into account the woman's 'actual or reasonably foreseeable environment'. Furthermore, if there is a substantial risk that, if the child is born, it will suffer from such physical or mental abnormalities as to be seriously handicapped, abortion is permissible within the first twenty-four weeks.
>
> Except in cases of emergency, an abortion must be obtained in National Health Service hospitals or in approved institutions operating as private abortion clinics.

Northern Ireland It should be noted that the British legislation does not apply to Northern Ireland. The criminal prohibition contained in section 58 of the Offences Against the Person Act still applies there. The interpretation of the 1861 Act has been considered in a number of Northern Ireland judicial decisions.

Practice in Northern Ireland differs from that in Great Britain. Dr Harith Lamki, consultant obstetrician and gynaecologist, Royal Maternity Hospital, Belfast, told the committee:

> Practice in Northern Ireland is … a good practice for women … Termination is not carried out on social grounds. On that side, in the Royal Maternity Hospital we run a very big morning-after pill clinic, which means we have a big reduction in the number of unwanted pregnancies at present. The number of women taking the trip to England, where we

> used to send them for social termination, is a great deal less than what it used to be.

He said:

> In the Royal Maternity Hospital now we would terminate somewhere in the region of around 30 or so women a year … Most of the abortions in Northern Ireland are performed now because of foetal abnormalities … If I am confronted with a woman who wants a termination because of foetal abnormalities which I disagree with, except anencephaly, because to me a Down's syndrome is not a ground for termination, but still I do refer the patient to my colleagues and if the case warrants termination it is carried out. I think it is important to realise that the majority of the people in Northern Ireland – consultant obstetricians and gynaecologists, and there are fifty-five of us – we do not take it lightly. When a patient is referred, she is referred with very good grounds. If a GP sends a patient to us – to me or anybody else – because he or she feels that this woman is going to commit suicide, we do not just accept it. We have to talk to the patient, we have to refer to a psychiatrist or even two psychiatrists and then we take cognisance of what they say and then we decide ourselves whether there is enough grounds or not.

On Tuesday 20 June 2000 the Northern Ireland Assembly debated at length the motion proposing that this Assembly was opposed to the extension of the Abortion Act 1967 to Northern Ireland. An amendment was tabled seeking to refer the question of the extension of the Abortion Act 1967 and related issues to the Health, Social Services and Public Safety Committee and requesting that the Committee report to the Assembly on the matter within six months. The amendment seeking to establish the Committee was rejected by forty-three votes to fifteen. The motion opposing the extension of the Abortion Act 1967 to Northern Ireland was put to the Assembly and agreed to without a division.

Abortion in the United States of America In the United States the nineteen fifties marked the beginning of a period of civil rights reform and the courts became interested in the issue of abortion. In 1973, the Federal Supreme Court legalised abortion throughout the United States in the case of *Roe v Wade.* The court held that, in the first trimester, the woman's decision to have an abortion should be exclusively between herself and her doctor but that in the second trimester, individual states could regulate abortion in order to preserve and protect the woman's health. In the third trimester or after foetal viability, the states could prohibit abortion except where it was necessary to preserve the life or health of the woman. The court held that a foetus was not *per se* a person and was therefore not entitled to protection guaranteed by the United States constitution until it reached the point of viability.

In recent years, both the US Supreme Court and the Congress have begun to allow greater restrictions on abortion. Abortion restrictions now vary from state to state. Many states have laws that prevent a minor from obtaining an abortion without parental consent or notice. States have also introduced abortion-specific 'informed' consent laws requiring the pregnant woman seeking an abortion to receive information on foetal development, pre-natal care and adoption. Some states have introduced mandatory waiting periods.

Many submissions argued that the lesson that can be drawn from the experience of abortion abroad is that a change in the law to deal on compassionate grounds with a small number of exceptional cases can be quickly exploited to allow widescale application. The committee heard from Dr Michael RN Darling, a representative of the Church of Ireland:

> … looking back to the UK experience, when in 1966 David Steele introduced his Private Members' Bill, which became law in 1967. The motivation behind that appears to have been intended to prevent death and misery from back street abortions and also to enable doctors to carry out abortions in hard cases without fear of prosecution. It came at a time when thalidomide was in the news and there were a large number of concerns.
>
> David Steele has stated that it was not the intention of the promoters of the Bill to leave a wide open door for abortion on request, but if we move on thirty years later, he is quoted as saying he did not think anyone foresaw what the numbers would be.

Ms Lelia O'Flaherty told the committee:

> When the *Bourne* case in the UK led to the Abortion Act of 1967, it was no doubt sincerely thought that abortion would be legalised only in limited circumstances. We now know that the case on which the *Bourne* judgment was made was based on a false claim and that it has resulted in the killing by abortion of five million unborn children since that time. We also know that Dr Bourne was so horrified at what resulted from his no doubt well-meaning intervention that he became one of the founder members of the Society for the Protection of the Unborn Child in the UK.
>
> Similarly, the *Roe v Wade* case in the US opened the way for the deaths of millions of unborn children by abortion there. And again we know now that Jane Roe has since revealed that she was used as a pawn in the push to legalise abortion in the US.

Inevitability Many submissions argued that any widening of the grounds for abortion, however narrow, represents the slippery slope that leads to abortion on demand; the slightest loosening of a strict line on abortion quickly leads to a flood of abortions. On the basis

that people are much the same everywhere it is reasonable to apply the two metaphors in a cautionary way to Ireland, which maintains strong legal barriers against abortion. However the metaphors tend to focus attention on a supposedly immense, unsatisfied demand for abortion in Ireland.

The ready availability of abortion facilities abroad and their use by large numbers of Irish women reduce the pressure in Ireland to provide abortion facilities. The secrecy available in British clinics will always be more attractive than the controversy and publicity that would attend any such facilities provided in Ireland.

Moreover the submissions received by the committee and the oral hearings it conducted revealed few organisations or individuals seeking extension of abortion to Ireland. Many such submissions proposed very restricted extensions.

The reality the committee encountered was that there was great concern among many about the need for a referendum to meet a legal danger and regret on all sides that constitutional and legislative changes in Ireland, however laudable, would have no impact on the reality of Irish abortion: the flood of Irish women seeking abortions in England.

'We need a referendum'

The vast majority of the submissions received by, and the petitions made to, the committee were for a referendum proposing an absolute constitutional ban on abortion.

Apart from numerous individuals, a considerable number of organisations indicated their support for this option. Among these were the Pro-Life Campaign, the Society for the Protection of Unborn Children, Youth Defence, the Public Policy Institute of Ireland, Doctors for Life, Thomas More Medical Association, Family and Life, the Vincentian Partnership for Life and the Knights of Columbanus.

The Society for the Protection of Unborn Children (SPUC) in its submission stated 'There is a democratic demand for a referendum which would give the people an opportunity to restore a total ban on direct abortion'.

Youth Defence proposed that a new Article be inserted into the Constitution:

> Article 40.3.4º No law shall be enacted, nor any provision of the Constitution be interpreted to render induced abortion, or the procurement of induced abortion, lawful in the State.

The Public Policy Institute of Ireland in its submission said, '… as a minimum, the people should be given the option of voting for/against the maintenance of a principled moral position in relation to the right to life such as existed (or was thought to exist) before the *X* case'.

The Irish Bishops' Conference in its submission stated: 'We reaffirm our conviction that the Irish people should be offered the opportunity to restore by referendum the constitutional guarantee of the right to life of the unborn child'.

The Pro-Life submission to the committee argued the demand for a referendum to ban abortion:

> The Pro-Life Campaign's submission is based on the view that all human beings possess an equal and inherent worth by virtue of their humanity, not on condition of size, level of physical, emotional or mental capacity or development, dependence, race, ethnic origin, financial status, age, sex or capacity for interpersonal relationships.
>
> Constitutional democracy is based on the equal and inherent value of every human life and the equality of all before the law. If these values are not respected, one simply cannot have a democratic society.

The submission continues:

> The Pro-Life Campaign believes that the public commitment to putting in place the supports women need will be strengthened by a referendum restoring adequate legal protection to the unborn. Polls show a consistent and substantial majority of the public support such a referendum.
>
> Our submission responds to the Green Paper on Abortion's review of the medical issues, showing that the legalisation of induced abortion is not needed to safeguard medical treatment of women, and surveys its discussion of the legal issues, in particular answering objections to Option One, a constitutional amendment to ban induced abortion.

In its submission the Campaign considers the seven options set out in the Green Paper and declares its belief that only the first option seeks to ban induced abortion entirely and that each of the other six options would allow a different level of legal abortion.

Irish experience over the past twenty years of referendums dealing with abortion has shown how elusive the best solution is.

The Constitution Many submissions referred to Article 6 of the Constitution which declares that 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. The people have vested in the Houses of the Oireachtas the responsibility for deciding what needs to be done to protect and promote the common good and for ensuring that it is done. This responsibility extends to proposing amendments to the Constitution. Thus Article 46.2:

> Every proposal for an amendment of this Constitution shall be initiated in Dáil Éireann as a Bill, and shall upon having been passed or deemed to have been passed by both Houses of the Oireachtas, be submitted by Referendum to the decision of the people in accordance with the law for the time being in force relating to the Referendum.

Accordingly, our Constitution does not recognise a right of popular initiative in regard to constitutional amendment. The responsibility for formulating an appropriate form of amendment is vested in the Houses of the Oireachtas.

In his analysis of Irish constitutional arrangements in 1932 Professor Kohn made the case against the popular initiative as follows:

> Its crudeness in the face of highly complex problems of modern legislation, its anarchical interference with representative government, its inevitable production of incoherent legislation, its intolerance of religious and racial minorities – these and kindred defects of the system have often been stressed. Recent experience in continental countries has emphasised its most insidious feature: the irresponsibility of the anonymous legislator. Popular support may easily be mobilised by skilful agitation for a law or petition embodying a high sounding postulate, but a second referendum or initiative designed to introduce consequential legislation and possibly entailing material sacrifices, may be ignominiously defeated by the sponsors of high principle. (Kohn, L, *The Constitution of the Irish Free State*, Dublin 1932)

Referendum or legislation? The experience of the 1992 referendum on the substantive issue led many people to despair of our ever being able to formulate an amendment proposal which would meet the needs of the situation that has arisen as a result of the *X* and *C* cases. The Constitution Review Group (1995-96) studied the problem of how one might deal with the consequences of the *X* case and concluded:

> While in principle the major issues discussed … should be tackled by constitutional amendment, there is no consensus as to what that amendment should be and no certainty of success for any referendum proposal for substantive constitutional change in relation to this subsection [Article 40.3.3º].
>
> The Review Group, therefore, favours, as the only practical possibility at present, the introduction of legislation covering such matters as definitions, protection for appropriate medical intervention, certification of 'real and substantial risk to the life of the mother' and time-limit on lawful termination of pregnancy.

Dr TK Whitaker, chairman of the Constitution Review Group, told the committee:

> … in essence what the advocates of a new referendum desire is to annul the *X* case decision. I would prefer, if at all possible, to avoid the expenditure of public energy and resources on a referendum. The kind of legislation I would have in mind is restrictive legislation and it would, first of all, where suicide is the threat to the mother's life, require two specialists – psychiatrists – to certify that the suicidal disposition is genuine and poses a substantial threat to life, despite her having had expert counselling and therapy.
>
> The second paragraph would prescribe, even where a certificate is given, that no termination be allowed after the first 14 weeks of pregnancy. The third element in the restrictive legislation would be in all cases of substantial threat to the mother's life, termination of pregnancy at any stage to be lawful only if it is unavoidably associated with medical treatment or action necessary to protect the life of the mother.

Some organisations expressed a preference for legislation over a referendum. The Church of Ireland stated that the issue of abortion:

> … doesn't lend itself to the sort of clear definitions that law requires. Because of the complexity of the issue we believe that it must be addressed by legislation rather than in the Constitution. Legislation has greater potential for reflecting the complex opinions on the issue within Irish society.

The Methodist Church in Ireland agrees:

> Complex social issues should not be dealt with by constitutional amendments, rather by appropriate legislation. The constitutional route is, we believe, inappropriate both because it is too blunt an instrument for such issues – giving rise to the danger of neglecting real issues through over-simplification, but also because the Constitution is inherently the wrong place for specific matters, rather being the place for laying down general principles for guiding legislation and establishing the outer boundaries of behaviour necessary to maintain the integrity of society.

The Irish Congress of Trade Unions also favours the legislative route. The ICTU in its submission:

> … opposed any further amendment to Article 40.3.3^{o} of the Constitution as any new wording introduced by any amendment would inevitably be vague and imprecise and give rise to further uncertainty.
>
> Congress supports the enactment of legislation to give effect to the decision of the Supreme Court in the *X* case so as to ensure that where there is a real and substantial risk to the life of the mother, facilities to legally terminate pregnancies are available in this jurisdiction. Sections 58 & 59 of the Offences Against the Person Act 1861 should accordingly be repealed.

The Dublin Well Woman Centre in its written submission said:

> The Constitution is not the appropriate means of addressing the complex social, moral, ethical, religious and health issues which lie behind Irish abortions. Legislation needs to be passed that tackles the anomaly between Article 40.3.3º of the Constitution and the Supreme Court's judgment in the *X* case. One way of doing this would be to legislate for the *X* case judgment, although this would require rigorous definition of those medical circumstances in which a woman's life is in danger. An alternative may be to legislate for the time limits at which abortions may be performed.

On the other hand concerns regarding the clarity of the legal position and the saving of the life of the mother were raised by Senator Mary Henry:

> I would like to see us clarify what is legal from the point of view of the life of the mother so that if a person who really feels that they are terminating a pregnancy before the child is viable to save the life of the mother that there can be no question of a challenge, that this is lawful… My main concern is the life of the mother, that a doctor who may now feel that they can never be challenged about what they're doing because it is genuinely to save that woman's life, that they can't be put in a situation where someone says, 'Hold on a moment – you're terminating this pregnancy, that child isn't viable, that's an abortion!' That's my really serious worry.

Preferendum A number of organisations and groups put forward a proposal for a preferendum, that is to say, a plebiscite in which the voter can express, in due order, his or her level of preference for each of a number of proposals. These included the Irish Family Planning Association (IFPA), Lawyers for Choice, Abortion Reform and Women's Aid.

The Irish Family Planning Association in its submission to the committee said:

> We strongly recommend that the electorate be given the opportunity to express their full preferences in respect of the various options as set out in the Green Paper, ranging from Option (iii) to Option (vii) (e), excluding Option (iv). This expression of views should take the form of a preferendum in which each voter would be able to express their preferences for each of the choices on a similar basis as a Presidential election or single-seat by-election …

The evidence of Abortion Reform to the committee concurs with the IFPA:

> The advantage of a preferendum-type vote would be that it would enable a better reflection of the broad spectrum of views which currently exists on the issue of abortion among

> the Irish people. This type of vote would be better able to engender a consensus as to some sort of compromise on an issue that has always been seen as politically divisive.

Representatives of the de Borda Institute addressed the committee on the technical issues involved in a preferendum. Philip Kearney said:

> Our recommendation is that if there is a referendum on the topic of abortion it should be preceded by a non-binding multi-option vote in which all the preferences are counted. In the longer term we would, of course, seek to change the Constitution to cater for binding multi-option preference voting.

John Baker said:

> What we have put forward are the main reasons a multi-option vote in advance of a referendum would be a good idea. The first is that each of the proponents of each significant position would be able to put their views before the public so no one would feel their views hadn't been given a proper hearing. Second, this would make effective participation for all concerned because it's a complex issue – there are a number of reasonable positions and it allows each position to be heard. Third, the final agenda for a binding referendum would be decided by all the people in a multi-option preferendum.

Peter Emerson, director of the de Borda Institute, pointed out:

> As you know the Green Paper has already suggested that there are several [options] with, as we said in our paper, one or two variations on one or two of those themes anyway. At the moment it is a multi-optional debate. If you decide that the society is only to be given two options, I think you have made a decision which is in disagreement with the authors of the Green Paper and I think if you want to keep it as a multi-optional debate, then it is in your remit.

There is no provision for a preferendum in the Constitution and indeed the Constitution Review Group made no proposal to introduce one. A preferendum on abortion would therefore be a consultative plebiscite only, to be followed by yet another constitutional referendum on the most popular option. However, because of the nature of a referendum there is no guarantee whatsoever that the most popular option would be passed in a straight vote. The alternative would be to amend the Constitution to provide for a preferendum, in advance of holding a referendum on abortion. The committee rejects that option for the following reasons.

- The referendum system offers the voter the right to say 'Yes' or 'No' to an option formulated by the Oireachtas. It is the task of the Oireachtas to draft the precise wording of the Bill to amend the Constitution which is put before the people and the

Oireachtas may be relied upon to define the precise issue for the referendum.

- At a referendum there is a majority one way or the other on the issue before the people. A preferendum might result in an option which had never obtained the support of a majority of the electorate being nonetheless adopted following the vote.
- With referendums on complex issues, it is often necessary to formulate the proposal in a particular way so that the electorate can vote 'Yes' or 'No'. Preferendums introduce more complexity and the possibility of confusion.
- The referendum system has worked well in practice and does not require change.
- It is not clear who would formulate the range of proposals to be put to the electorate and how they would be so formulated.
- Because there are three or more proposals, the terms in which each is formulated could be used to manipulate or distort the choices to be made by, for instance, splitting a proposal supported by a majority into a number of proposals and leaving a proposal supported by a minority intact and therefore predominant.

Chapter Three

Medical Aspects

Abortion has been described as a medical procedure. This chapter deals with the medical issues that have occasioned discussions in the submissions and at the hearings: 'abortion is never necessary to save the life of the mother', the threat of suicide, the cases of rape and incest, the case of foetal abnormality, the physical and psychological damage caused by abortion.

The life of the mother

A great number of the submissions received by the committee maintained that abortion is never necessary to save the life of the mother. Many submissions suggested that the Institute of Obstetricians and Gynaecologists and the Irish Medical Council are in agreement with this submission. Thus the Tralee Charismatic Prayer Group headed their petition:

> We, the members of the Tralee Charismatic Prayer Group, are absolutely opposed to the legalisation of any form of abortion in Ireland. We have the backing of the Medical Council and the Institute of Obstetricians and Gynaecologists who are authorities on this matter and say that abortion is never medically necessary and should not be legalised under false pretences. We favour a pro-life worded referendum to absolutely ban abortion.

Where a matter is complex and technical it is reasonable for those of us who are non-specialists to rely on authoritative sources. In this chapter the positions of the Institute of Obstetricians and Gynaecologists and of the Medical Council are examined.

In the discussion of the definition of abortion the committee found that there was a wide range of meanings for the word. Therefore abortion could not be used with safety in legal formulations without at least qualifying it in some way. In the sense in which many lawyers and doctors commonly use the word, abortion may be necessary to save the life of a mother. Many doctors and lawyers readily use abortion in this morally neutral sense because an abortion carried out by a doctor to save the life of a mother is lawful. Such abortions are also moral in the view of the major religious bodies. Catholic teaching describes these lawful and moral abortions as 'indirect abortions'.

Direct/indirect The direct/indirect distinction derives from the moral doctrine of 'double effect'. This doctrine applies where an action has two effects, one good and one bad. The termination of a pregnancy to save the life of a mother is an example. The killing of the unborn (the bad effect) results in the survival of the mother (the good effect). The

doctrine sets out the criteria that must be satisfied to justify such acts. Firstly, the purpose desired must necessitate the means adopted. Thus if another means could be used to achieve the good effect without involving the bad effect it must be used. Secondly, the good effect must outweigh the bad effect. Thirdly, to satisfy the moral principle that the end never justifies the means, the means chosen must lead indirectly and not directly to the evil effect. In saving the mother the means must only indirectly involve the life of the unborn (the unborn must not be targeted). The removal of the cancerous womb of a pregnant woman would satisfy this criterion because the womb is being directly removed and the abortion of the unborn is an indirect consequence. In an ectopic pregnancy sited in the fallopian tube the tube may be removed surgically to avoid dangerous complications but the death of the unborn is a side-effect and therefore an indirect abortion.

It should be noted that the use of the direct/indirect distinction implies that there are permissible indirect abortions.

The pro-life medical position is based on a distinction between direct and indirect abortion so it does not want a total ban. Catholic teaching, being the source of the distinction, does not want a total ban either. The committee, with its responsibility to protect and promote the common good, simply could not entertain an absolute constitutional ban on abortion because it would throw into jeopardy the lives of considerable numbers of pregnant women.

A limited ban? The pro-life movement does not in fact want a total ban on abortion, it wants a partial ban – a ban on direct abortions. The distinction between direct abortion and indirect abortion was developed by moral theologians to allow the morality of certain acts to be judged. As Rev Paul Tighe, a representative of the Irish Bishops' Conference, said:

> Within the Catholic tradition we would always have distinguished between a direct abortion and an indirect abortion.

The medical evidence The committee sought to establish in an authoritative manner current medical practice in Irish maternity hospitals.

Professor John Bonnar, chairman of the Institute of Obstetricians and Gynaecologists, which represents between 90% and 95% of the obstetricians and gynaecologists in Ireland made a written submission to the committee on their behalf. The submission is dated 29 February 2000 and the operative parts are set out in full as follows:

> 1 The Institute of Obstetricians and Gynaecologists is the professional body representing the speciality of Obstetrics and Gynaecology in Ireland. The Executive Council of the Institute has examined the Green Paper on Abortion and the members have been consulted. We welcome the Green Paper, which provides a comprehensive, up to date and

objective analysis of the issues arising in the care of the pregnant woman. Our expertise is in the medical area and our comments are confined to these aspects.

2 In current obstetrical practice rare complications can arise where therapeutic intervention is required at a stage in pregnancy when there will be little or no prospect for the survival of the baby, due to extreme immaturity. In these exceptional situations failure to intervene may result in the death of both mother and baby. We consider that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example for social reasons, and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother.

3 We recognise our responsibility to provide aftercare for women who decide to leave the State for termination of pregnancy. We recommend that full support and follow up services be made available for all women whose pregnancies have been terminated, whatever the circumstances.

In his oral presentation, Professor Bonnar elaborated on paragraph 2 of the submission:

> We have never regarded these interventions as abortion. It would never cross an obstetrician's mind that intervening in a case of pre-eclampsia, cancer of the cervix or ectopic pregnancy is abortion. They are not abortion as far as the professional is concerned, these are medical treatments that are essential to protect the life of the mother. So when we interfere in the best interests of protecting a mother, and not allowing her to succumb, and we are faced with a foetus that dies, we don't regard that as something that we have, as it were, achieved by an abortion. Abortion in the professional view to my mind is something entirely different. It is actually intervening, usually in a normal pregnancy, to get rid of the pregnancy, to get rid of the foetus. That is what we would consider the direct procurement of an abortion. In other words, it's an unwanted baby and, therefore, you intervene to end its life. That has never been a part of the practice of Irish obstetrics and I hope it never will be.

As far as the law is concerned, Professor Bonnar urged caution:

> What I am describing here in this Green Paper submission is that we wouldn't want any intervention by the law that would compromise existing practice which is geared to the protection of both. In dealing with complex rare situations, where there is a direct physical threat to the life of the pregnant mother, we will intervene always.

Divergent opinions were expressed in regard to the characterisation of medical treatment essential to protect the life of the mother.

Professor James Clinch, former chairman of the Ethics Committee of the Medical Council, told the committee:

> If there was a constitutional ban on the direct killing of the content of the uterus that would not change my practice.

Professor Eamon O'Dwyer, Professor Emeritus of Obstetrics and Gynaecology, National University of Ireland, Galway said in his written submission to the committee:

> After forty years as a consultant obstetrician gynaecologist I can state:
>
> – there is no conflict of interest between the mother and her unborn child
>
> – there are no medical indications for abortion
>
> – there is no risk to the mother that can be avoided by abortion
>
> – prohibition of deliberate intentional abortion will not effect, in any way, the availability of all necessary care for the pregnant woman.
>
> There is therefore a fundamental difference between abortion procured with intent to abort, for social reasons for example, '… deliberate, intentional destruction of unborn life' … and destruction of unborn life incidental to requisite medical treatment which is lawful and ethical, however distressing.

Dr PJK Conway, a practising obstetrician and gynaecologist, addressed the question of where a termination of pregnancy was necessary:

> I gave three examples that we have had of mothers whose pregnancies were less than 28 weeks. In the last 20 years, out of 24,000 deliveries, we transferred three mothers with severe toxaemia to Dublin because, whatever chance the babies had of surviving, they had none in Portlaoise because we don't have intensive care and ventilators and so on. They were all sent to Dublin and they were all delivered because that is the treatment for the severe disease that they had. You deliver them and the baby takes its chances, but when it's that immature you don't expect the baby to survive. It would be a miracle if it did. I fully agree with that. We all do that and have done it ever since I have been a consultant and since I have been involved in obstetrics.

Dr Declan Keane, Master of the National Maternity Hospital, Holles Street, Dublin, said:

> I think where you are actually directly terminating a pregnancy, whether that be by surgical or medical means to end a pregnancy in the interests of a woman, that, to me, is termination of pregnancy or abortion in any shape or form you wish to define it.

Dr Peter McKenna, Master of the Rotunda Hospital, Dublin, said:

> Personally, I think that you are better to be up front and clean about this and say that the pregnancy is being aborted. That is the treatment. It's not that it is a side effect of the treatment, it's not that it's an unintentional side effect of the treatment. The treatment is you end the pregnancy. That is, I think, abortion. Therefore, putting a total constitutional ban on abortion will inevitably maybe not this year, maybe not next year but the year after next … inevitably somebody's life is going to be put at risk, if they don't leave the country either the doctor is going to have to break the law or the woman is going to die. I would be absolutely unequivocal about that.

Dr Seán Daly, Master of the Coombe Women's Hospital, Dublin, said:

> I think that if we go down the road of trying to slice up the term 'abortion', then we are only going to complicate things for ourselves even more. At the end of the day, we do need to be able to practise and if this committee, and ultimately if the country or however it is constructed, decides that there is never an indication for abortion or for the premature ending of a pregnancy, then I certainly believe that is going to make if difficult to practise in the current environment in which we practise.

The committee heard evidence about certain rare life-threatening conditions. Dr Declan Keane, Master of the National Maternity Hospital, Holles Street, Dublin, referred to a condition which he described as haemolysis elevated liver enzymes and low platelets (HELLP):

> HELLP syndrome, which is a variant of pre-eclamptic toxaemia, a condition where the mother has severe hypertension where the liver is involved … We had a case in 1998, as I say, where the woman was severely ill with this condition. She was transferred to a neighbouring general hospital under the care of the liver specialist and the medical opinion that we got from the liver specialist was that this woman was going to die if her pregnancy did not end. It was a very difficult decision to make. We obviously had to not only talk at length with the parents involved but with our legal team as well. But there was no other way in which this woman would have lived if the pregnancy had continued.

Continuing his evidence Dr Keane referred to another rare condition:

> I note that the Green Paper and indeed the submissions have talked about other possible indications which would include severe cardiac disease in pregnancy and Eisenmenger's syndrome has been mentioned. The Coombe Hospital had a woman who died from Eisenmenger's syndrome only last year and I suspect that the master of the Coombe may wish to make a comment on that later on. Certainly in my experience

> in Oxford we unfortunately again had to terminate two pregnancies in women with Eisenmenger's syndrome because the real risks to the woman, if the pregnancy had continued, were considerable.

Dr Peter McKenna, Master of the Rotunda Hospital, Dublin, described a number of cases from his experience:

> I think I can say unequivocally that possibly once a year a woman would be seen in this country who, if her pregnancy is not terminated within a matter of probably hours or days, will die from a complication. The complications that I would allude to would be the one which we have personal experience of recently and that is, fulminating high blood pressure associated with heart failure, associated with a molar pregnancy and a live, an ordinary ongoing pregnancy, a most unusual condition, one which I will probably never ever see again. But the only way in which that woman could be stopped from dying of heart failure that day was by terminating the pregnancy.

Dr McKenna, in describing the condition of patients with rare complications, had this to say:

> These are women who are so sick you can't actually get them out of the country. I am not talking about people who have, say, Eisenmenger's heart disease that are well enough to leave the country. I am talking about people who are in a bed and who are so sick that you can't move them.

Dr McKenna concluded his evidence:

> The procedures, which I have referred to as abortion, may be referred to by other people as treatment. Now as I said before, I think that if the treatment is to empty the uterus, I can't think of any more apt term to call that than an abortion. It doesn't imply that you want to end the life of an unwanted baby; it is simply a description of what you are doing. And it may be quite as simple, the difference may be quite as simple as somebody being able to say to themselves well there is no abortion in Ireland. That's, you know, where we can all rest assured in our beds at night. But I wouldn't take that point of view. I feel that if there is a problem, why not name it and address it and try to deal with it in a way that people can understand? I don't think that not calling it that really clarifies it. I mean one of the consistent threads that I do get in the mail is that I am 'muddying the water'. I'm only muddying the water for people who don't think clearly, I think.

Dr Sean Daly, Master of the Coombe Women's Hospital, Dublin, also addressed the issue of rare complications:

> I think that the current practice … as we practise it at the moment, we do in general deal with the complications that

> arise. If we have a very bad high blood pressure problem during pregnancy, the treatment for which would be to deliver the baby or essentially to deliver the placenta, then we do practise that. Where it is going to get more difficult for us though is in cases of complex heart disease in the mother where, in essence, what we would be seeking to do is not to treat the complex heart disease but to end the pregnancy in order to reduce the risk to that woman. The Medical Council guidelines suggest that we cannot wilfully destroy a foetus or a baby and, while none of us would wish to do that, ultimately that may be the result of what we do.
>
> I think the whole issue of intent is an important one in that intent can be a double-edged sword. I could claim to be trying to do some heroic therapeutic intervention to a baby and, inadvertently, cause a miscarriage. I never intended to do it, but in essence I shouldn't have been doing it in the first place. I could get myself protected under the law by that. So it is a double-edged sword. Certainly none of us wants to practise outside the law, nor indeed would we – those who are practising – feel comfortable doing that. That's why the onus is on you, I suppose, to come up with a wording which will allow us to practise in order to protect as much as we can the life of the mother and the child. … there is no problem in my mind that the life of the mother is paramount and that we must do what we can to ensure that the mother survives.

Later, Dr Daly returned to the issue of complications and said:

> I think that ultimately, in the coming years, we are going to be faced with more pregnancies complicated by maternal disease rather than less. There are going to be more women who survive congenital heart problems, coming through getting pregnant, than there were twenty or thirty years ago. We are more likely to see complicated pregnancies as time goes on and I think that we need, within the law, to be able to treat that woman as best we can in order to ensure her survival. Ultimately, if she does not survive, the baby will not survive either.
>
> It is all about risk at the end of the day. Currently, and people can argue about the numbers, but broadly speaking, maternal mortality in Ireland is about ten per 100,000 so one per 10,000. If you have somebody who has Eisenmenger's syndrome, for example, her risk of dying is 25% to 30%. So, you are now changing her risk from one in 10,000 to 2,500 in 10,000. We need to decide whether or not we believe that that is a significant change. If you do, then you need to try and manage that pregnancy as best you can. Ultimately, if the mother dies, the baby is likely to die. If you look at the maternal mortalities that are occurring at the moment, many of them are related, well, certainly a number which have occurred in the Coombe Women's Hospital recently, have been related to congenital heart disease. That is not to say

> that they would have definitely been avoided had there been termination of pregnancy.
>
> However, there is a substantial risk and I think that that is what we need to be open with our patients about. If a woman, fully informed, decides that she is happy to take that risk, then we will, of course, look after her as best we can. If, on the other hand, she decides that she is not willing to take that risk – and it is a very big risk – then, I think that there should be an option there for her to have a termination of pregnancy.
>
> The other situation is the very difficult pre-eclampsia and those early pregnancy complications which can sometimes necessitate having to deliver. You are really trying to deliver the placenta but ultimately you obviously deliver the baby, or cancer of the cervix presenting early in pregnancy when clearly you have to do a hysterectomy. That is an early termination of pregnancy, be it at twelve weeks, and that is what we should call it … I can see where some people are differentiating that from other types of abortion but ultimately they are all early terminations of pregnancy.

The issue was also raised by the chairman when Dr Michael RN Darling appeared as a representative of the Church of Ireland:

> Chairman: … Dr Darling, you are a member of the Institute of Obstetricians and Gynaecologists, I take it, and you participated in their consultation procedure?
>
> Dr Darling: I did.
>
> …
>
> Chairman: You expressed concerns about the principle of double effect. I take it from that you would be concerned that while it may be a workable moral principle or a principle connected with conscience, that it doesn't provide certainty for you as a medical practitioner at the coalface.
>
> Dr Darling: That's right. It comes back to definition. To me whether you are removing a uterus because it's got a cancer in it and happens to have a baby as well, that's an abortion to me, regardless of how you classify it. The system works because it is accepted medical practice. Without going into the theological arguments I suppose I was trying to, in answer to a previous query, to say that in current practice in my definition, abortion does occur, not frequently, but it does occur for very strong medical reasons.
>
> Chairman: And you referred to these three or four cases in recent years and I take it that, as was indicated to us by the masters, that these related to Eisenmenger's type syndrome?

> Dr Darling: There was one Eisenmenger's, two, I think a thing called HELLP, which is a liver failure situation, and another condition, hydatidiform mole. They are there to be scrutinised.
>
> Chairman: And I think you can speak for everyone in this respect, it's correct to say the Church of Ireland is anxious to see that all those kind of cases are covered as medical intervention and are recognised and accepted.
>
> Dr Darling: Yes, exactly.

Before concluding this discussion it should be pointed out that Professor Eamon O'Dwyer made the point strongly that termination of a pregnancy early in a case of Eisenmenger's syndrome does not guarantee or ensure the life of the mother.

However he indicated that others might take a different view to his:

> I wouldn't quarrel with the people who take the opposite view or different view, and say that you have to interrupt the pregnancy. That's their view and I respect this view, but there is another side and I think it is only fair to be objective.

Professor O'Dwyer wrote to the committee subsequent to the hearings confirming his objective clinical judgment that he did not favour termination in cases of Eisenmenger's Complex.

In assessing the medical evidence great weight must be attached to the opinions of the masters of the maternity hospitals who spoke to the committee. They and their staff assist at about forty percent of the births which take place in the state each year. Their evidence is of particular importance because of the greater concentration of skills, experience and technical facilities in their hospitals.

There is general agreement that it is of paramount importance to protect the life of the mother, and since all the members of the Institute of Obstetricians and Gynaecologists require that principle to operate fully, any strategy to deal with the *X* case must respect that principle.

The committee received suggestions for wordings for a pro-life amendment from many groups and individuals. However well intentioned these may be, the committee was not convinced that they accommodated existing medical practice as outlined to the committee. The following are some of the suggested wordings:

Youth Defence: 'No law should be enacted, nor shall any provision of the constitution be interpreted, to render induced abortion, or the procurement of induced abortion, lawful in the State'.

The Pro-Life Campaign has suggested two different wordings in recent times. The first is that to Article 40.3.3° should be added:

> It shall be unlawful to terminate the life of the unborn unless such termination is the unsought side-effect of medical treatment necessary to save the life of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life.

The second is in its submission to the committee in 1999 where it states that the following sentence could be added to Article 40.3.3°:

> No law should be enacted, and no provision of this Constitution shall be interpreted, to render induced abortion lawful in this State.

A group of barristers proposed the following: 'Nothing in the Constitution would render lawful the deliberate, intentional destruction of the unborn or its deliberate, intentional removal from its mother's womb before it is viable.'

Professor Eamon O'Dwyer suggests that after the words 'vindicate that right' in Article 40.3.3° the following phrase be inserted '… Nothing in this Constitution shall render lawful the deliberate, intentional, destruction of unborn human life'.

The Society for the Protection of Unborn Children: 'No article in this Constitution can be interpreted as allowing direct abortion'.

Family and Life: 'Where abortion is understood to signify the intentional killing of the unborn, no law can be enacted, nor shall any provision of this Constitution be interpreted so as to render abortion lawful.'

Roderick O'Hanlon, who in his submission supported the draft amendments of the Pro-Life Campaign and Youth Defence, recommended the addition of an opening sentence to whatever formula was adopted: 'The unborn child shall, from the moment of conception, have the same right to life as the child born alive'.

A proposal to prohibit abortion while protecting the life of the mother was made by Máire Kirrane:

> Insert after Article 40.3.2°:
>
> 3° Subject to the provisions of sub-sections 4 and 5 of this section: it shall not be lawful to procure, or attempt to procure, or in any manner to aid or abet or assist any person, to attempt to procure, or to procure the miscarriage of a pregnant woman [An Induced Abortion] within the state or in any place subject to its jurisdiction.
>
> 4° For the purpose of this section an Induced Abortion is attempted or procured by any act or procedure carried out with the *intent* and for the sole purpose of procuring the miscarriage of a pregnant woman.

> 5° Nothing in the section, however, shall be invoked to prohibit, control or interfere with any act, made, done or carried out by, or on the instructions of a medical practitioner in the treatment of a pregnant woman patient in the ordinary course of medical practice, and where there is a real and substantial risk to her life, notwithstanding that such treatment would, or could, have as its consequence the termination of that patient's pregnancy.

This formulation, however, in resorting to the expression 'and where there is a real and substantial risk to her life', to ensure that the actions of medical practitioners must conform to a legal test, introduces the possibility of suicide as grounds for abortion.

The Medical Council The Medical Council is the body which regulates the medical profession under the Medical Practitioners Act 1978. The Medical Council's mission is to protect the interests of the public when dealing with members of the medical profession. The twenty-five members of the council are elected by the profession or appointed by academic bodies and the Minister for Health and Children every five years. One of their functions is to publish a set of professional standards or ethical guidelines for the profession. The principles underpinning the guidelines are:

- the guidelines do not have statutory force; they represent advice on generally accepted standards of practice
- the guidelines do not constitute a rulebook or code of practice. Rather, they identify key ethical and professional principles
- the clinical independence of doctors practising in Ireland must not be undermined by these guidelines. Each doctor must examine the ethical principles relevant to individual cases and make a personal decision about their application
- the guidelines may form the basis for judging the practice of a doctor who is the subject of a complaint
- breaches of the Guide to Ethical Conduct may constitute professional misconduct.

The Medical Council has a Fitness to Practice Committee which investigates complaints against doctors. Inquiries by this committee are held with legal representation. Serious allegations are dealt with under the criminal standards of evidence and proof. A penalty imposed by the Medical Council must be confirmed by application to the High Court.

In section F of the guidelines, which deals with reproductive medicine, the provision relating to the child in utero is:

> The deliberate and intentional destruction of the unborn child is professional misconduct. 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. Refusal by a doctor to

> treat a woman with a serious illness because she is pregnant would be grounds for complaint and could be considered to be professional misconduct.

The Medical Council guidelines do not use the term abortion. Professor Gerard Bury, president of the Medical Council, in his evidence to the committee pointed out:

> Abortion is not mentioned in this document [the guidelines]. Abortion is a lay term. If it's going to be used technically, in my understanding as a general practitioner, it relates to any termination of pregnancy, for natural or other reasons, prior to about fourteen weeks of the pregnancy. That's the only technical sense in which it's used. The broader use of abortion seems to be as a lay term meaning a whole host of different things to different people …. The definition, then, of that lay term is entirely equivocal and open to debate ….

Professor Bury was careful to stress the limitations of the guidelines:

> The ethical guidelines form the basis for the professional principles that we ask colleagues to abide by. As we have tried to stress, this is not a code book. This isn't a set of equations in which you look up the answer to your current problem and simply follow what the text says. These are core principles which we require doctors to implement carefully and conscientiously in the context of the clinical situation facing them and their patient.
>
> …. The code is not a prescriptive document. Whether in this area or in others where dilemmas in medical practice arise, it does not take a prescriptive view for good sound reasons. One, the scientific basis for medicine changes on a regular basis. We both add and delete to our core of acceptable practice. Secondly, we've emphasised the clinical independence of practitioners in this country. It's one of those aspects of medicine which has stood the country and the population very well over many years. We do not want to impinge and cannot be seen to impinge on that aspect of clinical independence. It is still the responsibility, and will remain the responsibility, of individual practitioners to take the core principles which are enunciated in these guidelines, in whichever current edition is in publication or in force, and to apply them to the clinical situation in which they find themselves.

These guidelines have not been subject to legal adjudication. Professor Bury recognised their inherent ambiguity:

> I think that the substance of that paragraph [The Child In Utero] deals with assurances to the doctor involved that a woman must be offered and made available to her whatever treatments are appropriate. Again, this comes back to direct and indirect effects, such as the arguments being teased out.

> There is no doubt that the council wishes to see women not denied appropriate care. Again, I would have to say to you that I don't want to get into speculating over the extent to which a treatment may be defined as intended to treat the woman rather than to bring about another effect. The council will take a very careful view should such a case arise in listening to submissions about that. We recognise that certain types of treatment may bring about the death of the child. It depends on intent, it depends on purpose.

The threat of suicide

In the ruling in the *X* case the Supreme Court said that abortion was lawful if a threat of suicide posed a real and substantial risk to the life of the mother. Therapeutic interventions that result in the death of the unborn are justified by the courts on the basis that there is a real and substantial threat to the life of the mother. The threat of suicide, which proceeds from psychiatric rather than physical conditions, could be justified on the same grounds, if in fact, it posed a real and substantial threat to the life of the mother. From the pro-life point of view suicide is a condition that might be readily feigned or liberally interpreted by a doctor to allow a stream of abortions. It represents for them, therefore, a perfect example of the slippery slope in action.

The committee sought to find out what was the incidence of suicide in pregnant mothers and in what ways a threat of suicide could be established as a real and substantial threat.

Dr Sean Daly, Master of the Coombe Women's Hospital, Dublin, told the committee:

> I am not a psychiatrist so I would not claim to be an expert in the evaluation of a woman who was threatening suicide. I do believe that suicide is rare during pregnancy and I think there is very good medical literature to support that view. That is not to say that it couldn't be a genuine risk. It has not been an issue, to the best of my knowledge, in recent times and I do not know of any abortions that were carried out because of that indication in this country.

Dr Peter McKenna, Master of the Rotunda Hospital, Dublin, told the committee:

> In medicine it is very dangerous to say things don't happen. I certainly was of that opinion but last year – the first time again – we had a woman – I had never seen it before – was brought into hospital, attempted suicide quite far on in the pregnancy, and it was a very serious suicide attempt, so it can happen. When you are dealing with humans you simply can't say it never will happen. I think you are probably on fairly safe ground to say though that the incidence of suicide in pregnant women is less than in the non-pregnant female population of a comparable age. I think that probably is true

> but that's not the same as saying no pregnant woman will ever seriously commit suicide.

On the incidence of suicide rates in pregnancy Dr Anthony Clare, Medical Director, St Patrick's Hospital, Dublin, told the committee:

> The literature on suicide and abortion, which I, with a colleague, Janet Tyrell, in 1994, reviewed for the *Irish Journal of Psychological Medicine*, is pretty miserable. It is a rather sparse literature compared to that on the psychological consequences of abortion. Many of the studies are faulty in terms of their sample selection and the absence of any appropriate control groups and in overall design. Many women, for example, up to forty per cent in some highly quoted studies, supposedly refused abortions have actually gone off and had the abortions elsewhere depending on availability. Nonetheless, these caveats notwithstanding, suicide rates in pregnancies are low, certainly lower than in non-pregnant women.
>
> These findings are in the main derived from studies in countries in which legal abortion is available and one of the studies quoted in your briefing document, I think Louis Appleby's retrospective studies spanning ten years, found that the risk of suicide in pregnancy in the UK was one sixth of that expected for non-pregnant women. He actually put figures on it. A total of fourteen pregnant women committed suicide during 1973 to 1984 compared with an estimated and statistically expected 281.5. That gives an overall observed to expected ratio of 0.05% or, to put that into simple figures, pregnant women had one twentieth of the expected rate of suicide. That has led to the statement that in fact pregnancy protects women from suicide, though no one would advise that as a treatment. The mortality ratio for teenage pregnant women was 0.28 so that, although at low risk compared with teenage non-pregnant women, this group did carry a risk of suicide five times greater than that for pregnant women as a whole. What we are dealing with are very, very small numbers and a very small risk.

On the question of the number of suicides that followed a refusal of abortion, he said:

> It's very hard to find this kind of work properly studied because most jurisdictions that carry out decent medical research happen to be the same jurisdictions that have legal abortion. One study in Sweden between 1938 and 1958 found three cases of suicide registered in people who had been refused abortion, none over the next twenty years. There are a number of other studies but I have to say that one's got to be very careful about how you interpret them, so that suicide as a consequence of termination being refused is a low risk but it's not an absolutely non-existent risk. It can and has happened.

Dr John D Sheehan, consultant psychiatrist at the Rotunda Hospital, Dublin, confirmed this:

> In the UK, the report on confidential inquiries into maternal deaths in the United Kingdom – the latest one is the 1994 to 1996 publication – looking at that three-year period, 1994 to 1996, in the UK, with a population of roughly sixty million people, the estimated number of pregnancies among that group was three million in the actual three years. The total number of deaths due to suicide in women who were pregnant in the three-year period was five. So the actual number of women who commit suicide who are pregnant is extremely small. Most authors will describe the risk and describe suicide in pregnancy as a rare event.
>
> … The actual authors of the confidential inquiry quoted Louis Appleby, who is a professor of psychiatry in Manchester. Appleby has a very widely quoted paper on suicide rates in pregnancy and after delivery. The statement that's attributed to Appleby is that, in a sense, pregnancy is a protective factor against suicide.

Professor Hannah McGee, representing Psychologists for Freedom of Information, said:

> Our evidence would concur with the general thrust of the findings that have been presented to you that completed suicide during pregnancy is significantly reduced over and above levels in non-pregnant women of similar ages. However, the protective factor may not be as powerful as the one in twenty you've heard from the Appleby study in the early 1990s in the UK. This was based on death certification. A more recent and detailed analysis in the US in 1999 by Marsoc … where they were able to have completed autopsy or forensic examination in all cases shows that the risk of suicide in pregnant versus non-pregnant women reduces by about a third. So pregnant women have about a one in three chance of non-pregnant women of similar ages of committing suicide. Importantly, however, although the percentages in all of these studies are low, they represent real individuals.

Predictability In seeking to establish how a threat of suicide might be established as a real and substantial risk, the committee sought to establish how psychiatrists can predict suicide in such cases.

Dr Anthony Clare said:

> Well, you'll be told, perhaps to your alarm, that psychiatrists are not very good at predicting suicide. I say to your alarm because, of course, under mental treatment legislation psychiatrists are permitted to detain people against their will on exactly that prediction. … I think Michael Kelleher predicted that for every hundred cases of suicide predicted the prophecy was wrong ninety-seven times. Now in the case

> of the Mental Treatment Act we accept that rather poor score rate because to save three from killing themselves, which is after all an irreversible decision, we're prepared to be wrong quite a few times, to err on the side of caution.

Dr John D Sheehan concurred:

> There is no test or in a sense there is no fail safe way of saying the person will or will not commit suicide. It actually doesn't exist. What one usually does is that if you take a person who presents, whether pregnant or not pregnant, if we just take the concept of how does the doctor manage someone who's suicidal, the usual way is clearly you have to assess that person very carefully and you have to assess the multitude of factors that can be involved in suicide. Then if a person has what we call suicidal intent which often – in other words, they may have a plan made, they may have stored tablets, they may have arranged times that they'll actually commit suicide – well the usual intervention at that point then would be mobilising supports for the person, perhaps admission to hospital, involving the family, if the person has had a major depression you treat the depression, if a person is drinking excessively you would obviously help them to stop drinking excessively. In other words, the interventions are directed at helping and supporting the individual and treating whatever condition is there.
>
> … In terms of assessment, the majority of people who threaten suicide have transient suicidal thoughts and, for example, twenty-four or forty-eight hours later when you talk to them, they will say they may have taken an overdose of tablets, but will say to you 'That was a very stupid thing I did and I am very sorry I did it'. The majority of people who attempt suicide or threaten suicide are actually not mentally ill. The group that actually make very serious attempts at suicide – in other words, if you look at the other end of the spectrum – have what we call suicidal depression. If you look at the tragedy say of a woman who commits suicide after having a baby, by and large you would expect that woman to have what we call a psychosis, which would be her believing that she is an inherently bad or evil person and that perhaps her little baby is inherently bad and the only way to save herself and the baby from the world is to end their lives.

Dr Geraldine Moane, representing Psychologists for Freedom of Information, said that there are well developed instruments and guidelines for suicide assessment and intervention which were recently published in the Harvard Medical School *Guides to Suicide Assessment and Intervention*. She said:

> In the instance of abortion, we propose that it would be possible to make a judgment about the risk to life posed by the threat of suicide and to make a decision based on that judgment.

Finally, Dr Sheehan made the point that abortion itself tended to increase the chances of a woman's committing suicide. Referring to a Finnish study published in the *British Medical Journal,* he said:

> They looked at the general population rate and compared that with women who delivered babies, women who miscarried and women who had terminations. The interesting finding there was that after miscarriage or termination, the suicide rate was actually increased relative to the general rate and again relative to the rate after delivery.

The cases of rape and incest

The Green Paper points out:

> Statistics on rape collected by the Gardaí and the Dublin Rape Crisis Centre are available. However it is difficult to gauge the extent to which cases of rape and incest may be under-reported and the actual number may be rather higher than the official statistics indicate. Likewise no information is available on the extent to which such cases result in pregnancy or the outcome of the pregnancy.
>
> In 1998, 292 cases of rape were reported or known to the Gardaí. In the same year eighteen cases of incest were reported.

Rape Crisis Centres provide counselling and therapy for victims of rape, sexual assault and child sexual abuse. Statistics produced by the Dublin Rape Crisis Centre for the period July 1997 to June 1998 show that, based on its client group, 36% of adult rape and 17% of child sexual abuse is reported to the Gardaí. The Centre's statistics show that 118 clients were identified as being at risk of pregnancy. Of these 21 (18%) became pregnant. Eight women continued with the pregnancy and kept the baby, one woman opted for adoption, five women terminated their pregnancies, two women miscarried and the outcome is unknown in the case of five women.

In its submission, the Pro-Life Campaign points out:

> It is difficult to estimate the incidence of pregnancy due to sexual assault: studies have defined sexual assault differently, and assaulted women may be sexually active and hence the pregnancy may not have resulted from the assault. Different studies give estimates varying from 0.6% to 5%. The relative rarity of rape-induced pregnancy coupled with the fact that women traumatised by rape need to be treated with great sensitivity and hence are not often suitable subjects for research explains why there are few studies in the management of pregnancy resulting from sexual assault.

Fred Lowe, a psychologist, in his written submission put most emphatically the woman's right to choose in rape as well as other cases:

> There is no simple solution to the abortion problem, because it is a clash between two rights, the right of the mother not to have something invade her body against her will, and the right of a foetus to be protected. When the foetus has got there by force, as in cases of rape, or by deception, as when a man cuts the top off his condom, or claims he has had a vasectomy, the woman should have the right to refuse to carry the foetus. To force the woman to relinquish control over her body is to deprive her of a basic human right, the right to own and control what happens to her body. The crime of rape exists because someone has taken away that right and the law sees it as almost as serious as murder. For the country then to pass a constitutional law to force the rape victim to endure the effects of rape, by making her give birth to the rapist's child, is to make her the victim of a kind of secondary rape, which should perhaps be called 'state rape'. It is an odd constitution indeed that upholds the right of a rapist to force a woman to have his child. It is time it was changed.

Dr Anthony Clare said:

> I feel it repugnant that we would live in a society where someone who is raped or who has been forced … who would be made pregnant as a result of consistent, persistent or even one-off sexual abuse in a family or by a stranger is forced then to undergo ... to carry that pregnancy against her will. Yes, I find that repugnant.

Dr Peter McKenna said:

> I would have to say that if it happened to a member of my family, whatever their wishes were, they would be effected. Whether they wished to carry the pregnancy or whether they wished to have a termination, that would be done.

Professor Walter Prendiville, consultant gynaecologist, Coombe Women's Hospital, Dublin, said:

> … the committee has already heard from a previous expert witness declaring the profound distress of a woman who has been raped. I believe that most members of the medical profession and the public are supportive of early termination of pregnancy in this circumstance.

Professor Hannah McGee, representing Psychologists for Freedom of Information, said:

> We would believe that, in terms of option seven, that we would support, where there is a serious risk to the mental health of a woman pregnant as a result of rape or incest, that there be access to abortion in that context.

Dr John D Sheehan said:

> The vast majority of people whom I would see who've been victims of incest have not been pregnant, and I would see the actual major psychological consequences of that trauma. That can be a very long-lasting and profound effect. But in terms of determining from a literature point of view and a research point of view is there, in a sense, evidence to say that abortion or termination would be the correct thing to do in the case of rape, there isn't such literature there.

Dr TK Whitaker, Chairman of the Constitution Review Group, 1995-1996, told the committee:

> Incest and rape are particularly difficult issues, arousing much sympathy because of the absence of the mother's consent, indeed, the invasion of her body and her probable abhorrence about being pregnant at all, especially with an unwanted child. However, having brooded over this, my view remains that the innocent life is entitled to protection but, on the other hand, that the State should be generous in the help offered to the mother during pregnancy and in providing for the care and upbringing of the child afterwards, whether by the mother, foster parents or adoptive parents.

Professor William Binchy, Legal Adviser to the Pro-Life Campaign, said:

> Humanitarianism and a humanitarian society, in my judgment, gain their strength from confronting the hard cases and doing the right thing rather than the wrong thing in those hard cases. If one excludes the option of the easy but ultimately unjust solution in those circumstances, an obligation falls on the society to make a greater effort.

Richard Greene, representing Muintir na hÉireann Teoranta, said:

> … in the horrific matter of rape and incest, the utmost genuine compassion and care, medical attention, support and love must be given to a woman or girl in this situation, but we must remember that an abortion of her unborn baby will never undo the rape. All the so-called hard cases amount to a very, very small percentage of those 5,000 women and girls who, according to reports, go annually to the UK to obtain an abortion.

Dr PHC Trimble, representing the Church of Ireland, said:

> Pregnancy after incest and pregnancy after rape are understandably difficult and emotive situations, perhaps the most difficult in the list of exceptions, and some would argue that abortion in these cases is the lesser of two evils and the compassionate solution. However, going back to the principle outlined … it denies the personhood and right to life of the foetus and it can itself re-traumatise the mother.

Ann Power, speaking on behalf of the Irish Bishops' Conference, said:

> 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 non-ovulant, 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.

Rosemarie Rowley, the writer, emphasised the limitation of abortion as a remedy in these cases:

> … because the feminist ideology favours abortion, it tends to disregard the evidence of such things as post-abortion distress or trauma. However, we now have an opportunity to look at the evidence. The evidence for post-abortion trauma is mounting. All estimates agree, from the tables of psychology books to the surveys of life organisations, that serious emotional distress is at least 10% and it is believed to be 25%.

The case of foetal abnormality

There are many causes of congenital malformations. Approximately half are due to genetic abnormalities. As the Green Paper points out, in about 40% the cause is unknown and the remaining cases are due to chromosomal abnormalities, teratogens (anything capable of disrupting the foetal growth and producing malformation) and other factors. Major malformations are structural abnormalities that have serious medical, surgical or cosmetic consequences. Minor abnormalities which have no serious consequence however are common and affect approximately 4% of children. Abnormalities may be inherited (a chromosome defect or a gene flaw) or acquired, which means that the embryo was initially normal but was damaged during its development by an injurious agent, e.g. drugs, infection, irradiation or maternal metabolic disorder.

Examples of genetic abnormalities include:

- anchondroplasia – a condition causing dwarfism and hydrocephalus
- cystic fibrosis and haemophilia.

Other malformations include neural tube defects. These are the more common birth defects. In Western Europe the incidence is approximately 5 per 1,000 births. There is a spectrum of neural tube defects ranging from minor defects to anencephaly. In anencephaly the brain fails to develop and the death rate is 100% with most infants dying during delivery. Chromosomal defects account for a small percentage of abnormalities (approximately 1%). Down's syndrome is the most common chromosomal abnormality and is responsible for 30% of all cases of severe mental handicap. Its frequency is approximately 1 in every 700 births.

A number of submissions propose that abortion should be permissible on grounds of foetal impairment in cases of extreme abnormality or where the condition of the foetus is incompatible with life. Most submissions express strong opposition to any such provision.

Many countries permit abortion on grounds of foetal impairment. Foetal impairment is sometimes referred to specifically, for example in England and Wales, 'where there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped'. In other countries there is specific provision in this regard. However, in some cases an abortion may be obtained on the grounds of adverse effect on the mother's mental health.

In giving evidence to the committee Dr Declan Keane, Master of the National Maternity Hospital, Dublin, outlined the scale of neural tube defects in Ireland:

> Ireland has the second highest risk of neural tube defects in the world, in which although the risks are coming down, we would still have a significantly high figure in this country, probably about four to five women per thousand. That would be either spina bifida or anencephaly. Spina bifida is more difficult because many babies and indeed most babies with spina bifida will live, very often with a compromised lifestyle. Anencephaly is that condition where the brain is not developed and, of course, if the brain has not developed then it is inconsistent with extra-uterine life.

In response to a question from the committee regarding the termination of a non-viable foetus Dr Keane replied, 'I think we would only be happy in this country in terminating a pregnancy for a foetal abnormality if, as you say, we were 100% sure'.

In his evidence to the committee Dr Peter McKenna, Master of the Rotunda Hospital, Dublin, stated that approximately fifty women out of the total number who travelled to the UK for terminations did so for foetal abnormalities. He said, 'I am unaware of any hospital or institution that has ever terminated a pregnancy in this state for foetal abnormality'. In response to a question as to whether the law should be changed he stated:

> There are two alternatives, one is that the law be changed to allow to terminate pregnancies in the face of such serious handicap. That is an enormous and seismic shift in this country if such a law were to be allowed and I would have to say that I am far from sure that is the correct thing to advise … what I would suggest that we do arrive at, is that in those cases where this is necessary that we have all the mechanisms in place, that these people can be referred to the correct places, that the cost is not an issue, that safety is an issue and that the future wellbeing and their future reproductive health can be discussed openly, and that they be given the best advice. That would be my more immediate concern rather than advising that we would so enormously change to termination on the grounds of foetal abnormality.

Dr Sean Daly, Master of the Coombe Women's Hospital, Dublin, asked whether he thought there was an argument for providing a facility, either in this country or by way of referral to a special unit overseas, for the termination of an anencephalic foetus, replied:

> Where there's an anencephalic – or indeed where there are other conditions where it is clear that the foetus is or baby is not going to survive – then I think it is difficult to ask a woman to continue that pregnancy if she doesn't want to. Having said that, many women in Ireland and many women that I have dealt with do want to continue the pregnancy and wish to deliver the baby alive, to have whatever time to have with it. But I would support the idea that there should be a provision for women who don't want to do that.

When asked if he would like to see a situation where the law would allow him to deal with pregnancies which had no viability, he said:

> Yes, I think I personally would. I think if part of your practice is the diagnosis of congenital abnormalities, it is difficult to bring a couple through that, and then walk away from it to a certain extent. It does place a considerable burden on them, if they choose to terminate the pregnancy, to try and find information to ensure that they get continued good care. The difficulty with bringing in legislation for congenital abnormalities is where you draw the line. Again, while there are certain conditions that are clearly incompatible with life, there is a huge grey area. Then you get quality of life issues, and it becomes very complex. Personally, I believe it would be very difficult to bring forward a list that includes many more cases than anencephaly. It just gets so complicated. As we decode the human gene and prenatal diagnosis comes to the next level, we are going to be able to diagnose so many things. We can diagnose cystic fibrosis in pregnant women now. I would be very uncomfortable about using cystic fibrosis and adding that to the list. There are very few conditions in which the foetus or baby is not going to survive absolutely.

In evidence to the committee Dr Berry Kiely, a representative of the Pro-Life Campaign, referred to the preventative measures for neural tube defects:

> I would like to make a small point in relation to anencephaly and spina bifida. It is important that everybody is aware that most of these can be prevented. Our whole approach to that condition should be preventing it. It is a simple matter of giving a woman before she becomes pregnant if possible or as soon as she becomes pregnant a small dose of folic acid. That is what is required to prevent neural tube defects. That is a public health problem which needs to be addressed much more actively. I appreciate that this is not part of the committee's brief. Since this has come up so many times, I think it is important to emphasise that we should be preventing neural tube defects, not being concerned whether we should terminate them or not.

On the same issue of neural tube defects Dr TK Whitaker told the committee:

> On the question of what are called 'lethal deformities' one of them is anencephaly, which is a condition where there is no hope whatever of the infant, even if it's born, remaining alive and I find myself in a quandary about that situation where I might be induced to say yes, once that it is clear, one could allow a termination of the pregnancy in that case and I remain somewhat doubtful about that. There are other cases such as cystic fibrosis and so on where it may be fatal in the long term but there is a reasonable prospect of a span of life in which the brain would still be active and alert and I couldn't bring myself to agree to a termination of pregnancy in such cases.

A number of witnesses differed in their approach as to the best method of dealing with lethal deformities in pregnancy. Dr PJK Conway, a consultant obstetrician gynaecologist, expressed the following view:

> Most of these abnormal babies that won't survive after birth are picked up after sixteen weeks at a time when it is quite dangerous to induce abortion physically. There is a paper from America, reported in the *New England Journal* in 1996, which states categorically that the maternal mortality is higher in those who are induced to get rid – I am using the term of people who do not want the baby – to get rid of the baby which is abnormal than if they are allowed to go and have a natural pregnancy and a natural delivery … It would be far healthier for her to carry on her pregnancy both physically and mentally than to go to England and have an abortion and I would give her that strong advice.

Another common congenital condition is that of cystic fibrosis, a disease of childhood where the lungs, liver, intestine and other organs

are affected. It is a very debilitating condition requiring very intensive treatment. One person in twenty is affected by the cystic fibrosis gene. Ireland has approximately the same genetic incidence of the disease as Denmark and Scandinavia. In Scandinavia antenatal diagnosis and termination of pregnancy is regarded as normal if a baby is known to be affected by cystic fibrosis.

Dr Brian Denham, a leading paediatrician and an expert on the condition of cystic fibrosis, believes that the families of cystic fibrosis sufferers should receive sustained support and counselling to deal with such a debilitating condition. According to Dr Denham there is no termination of pregnancy available in Ireland for families of cystic fibrosis sufferers. In evidence to the committee he outlined the current position:

> Any that need a termination travel overseas but there is an antenatal diagnostic facility that is provided quite widely now in Dublin, Galway and Cork to detect whether or not a child is affected by what is ultimately a fatal disease, although it takes a very, very long time and requires an immense family effort. I cannot emphasise enough to the committee the burden of care that families of children with very severe chronic illness accept. The families are wonderful, the patients are wonderful but the treatment takes up so much of the family time and so much effort and goes on for so long that these families have no time for anything else. Our function as doctors is to support them as very best we can.
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> For some families the idea of having another child is intolerable because they know what it will do to them and to their existing child. Some families accept it without too much anxiety. Either way, our duty as doctors is to support them and help them look after their children to the best of their ability.

A special problem In his evidence to the committee Dr Declan Keane, Master of the National Maternity Hospital, Holles Street, Dublin, pointed out:

> Every woman [certainly in all three Dublin maternity hospitals] will have a routine scan on her pregnancy between 18 to 20 weeks and we are diagnosing foetal abnormalities, many of which are inconsistent with life outside the womb. Some of these women will take the option of travelling abroad. Many in our profession would consider that regrettable because they often travel to places where the pregnancy is terminated, where no post-mortem or autopsy is done on the baby and, therefore, the ability to counsel that woman on subsequent pregnancies is reduced.

The committee believes there is a need for the Department of Health and Children to address the questions raised by Dr Declan Keane in regard to post-mortem reports.

The physical and psychological effects of abortion

The committee received submissions and heard evidence in relation to physical and psychological effects resulting from abortion. While these could indicate the nature of the effects which resulted from abortion, they could not quantify it owing to the lack of research and statistics.

Professor Anthony Clare adverted to the lack of research:

> Much is made often of the psychological consequences of abortion. We looked at that, its effects on mental health. Most studies do not find an increased morbidity following abortion but, again, there are difficulties undertaking this research and, for example, the present predicament we face is that we've no idea what kind of psychological morbidity follows in many Irish women who go for abortion because they drop out of sight once they've had their terminations. It's not something that they are necessarily going to discuss in great detail with their doctors. Much of the evidence is anecdotal. Many psychiatrists, such as myself, will have seen women who have got guilt and regret, which is particularly activated often when they become pregnant again, perhaps in a stable relationship or whatever, and they do recall their termination and abortion, but it's anecdotal. There are after all 5,000 a year and there are many, many other women, presumably, out there who have made that decision in the most difficult circumstances and lived with it.

The medical evidence suggested that Irish women who have abortions in England and Wales were more likely to have a termination at a later gestational stage than their English or Welsh counterparts and that they face increased physical and mental risks. A major concern, raised by the medical experts, of terminations of pregnancies either for foetal abnormalities or social and economic reasons, in the UK, was the lack of post-natal counselling and medical care. Dr Declan Keane stated:

> The unfortunate scenario at the moment is that women with abnormalities go to units in the United Kingdom … most of which do not perform an autopsy on the baby so the pathology back-up for subsequent counselling, indeed the psychological support of that woman, is also lacking in these institutions.

Addressing the question of counselling and aftercare, Dr Sean Daly said:

> I think all women should in an ideal world have some medical or nursing midwifery interaction before they would opt for a termination of pregnancy, that we should be able to provide that and that resources should be made available to provide that. That is important for a number of reasons. Some of these women will have medical conditions which would mean that there are perhaps certain institutions that they

> might opt to go to in the UK for a termination of pregnancy that would not be ideal for them. We can't give good advice about the possible risks. The people who come back with problems afterwards are, in general, I think, slow to access medical care. I think that if there were sufficient resources we should be trying to minimise the number of crisis pregnancies as we have discussed and to provide care for women who seek to terminate pregnancies in total.

There was a consensus that measures should be adopted to reduce the necessity for terminations. Professor Patricia Casey, a psychiatrist in the Mater Hospital and an organiser of the '5,000 Too Many …' conference, stressed this:

> I treat women who have had abortions and who suffer the adverse psychological consequences. I, therefore, as a health issue, believe it's imperative that we do what we can to reduce the necessity for abortion and the consequences that affect some women.

Chapter Four

Religious/Ethical Issues

Religious bodies inform the moral perspective of many. By Article 44.1.1° of the Constitution the state undertakes to respect and honour religion. The committee met with representatives of the religious bodies in Ireland and heard their views.

Mr Arif Fitzsimons, outlining the Islamic view for the committee, had this to say:

> The basic view that Islam has to abortion is that it is forbidden and is a crime except it is proven by medical experts that the mother's life is at threat … Muslims believe that life begins at conception … Thus, as the embryo-foetus is a human being it has, according to Islam, the right to protection by law … Islam is against abortion with the exception of if the mother's life is threatened by the continuation of the pregnancy, which is proven by a specialist doctor.

Dr Harold C Miller, Bishop of Down and Dromore, reaffirmed for the committee what he described as the 'essential and official stated position' of the Church of Ireland, the Lambeth Declaration on Abortion:

> 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 the violation of the personality of the mother) save as a dictate of strict and undeniable medical necessity.

Dr Miller went on:

> … we are agreed that abortion should be permitted in situations where continuance of the pregnancy represents a substantial medical risk to the life of the mother, even if in a few exceptional cases this requires direct rather than indirect abortion.

Dr Trevor Morrow, Moderator, addressed the committee on behalf of the Presbyterian Church in Ireland:

> In 1982, in a full debate on the matters raised, a number of resolutions were passed. In one, the general assembly declared their opposition to abortion on demand for purely social reasons or as a means of birth control. A resolution attempting to get support for abortion in the hard cases of rape or gross abnormality detected in the foetus was defeated and replaced with a resolution stating that in exceptional cases where medical abortion might be necessary the most stringent safeguards should be provided to prevent abuse.

> Since that time there has been a report from a committee on ethical issues to our general assembly in 1993 on life before birth …. This summarises well our church's current thinking. It again reinforces our theological stance which is that human life is sacred and uniquely valuable, we are made in the image of God, human life begins at conception, the taking of human life can only be considered in the most extreme cases. Again the 1992 report acknowledges the hard cases of rape, incest, foetal abnormality, and indicates that some Presbyterians would consider an abortion in such cases. As against this it seems clear that – we are quoting – 'significant numbers of Presbyterians are convinced by the arguments for the absolute rights of the unborn. For them the practical decisions are clear even if they are demanding and traumatic. In faith they believe that our God will provide the grace which is sufficient for those who willingly accept their burden as a labour of love'.

Robert Cochran, Secretary and Convenor, spoke as follows on behalf of the Methodist Church in Ireland:

> … we are not in favour of easy or widespread abortion. In fact, we are not generally in favour of it at all, but we do believe that there are a certain limited number of special circumstances, generally medical circumstances, where, if I might use the cliché, it is the lesser of two evils. Associated with this is our strong belief that the right to the mother's life and well-being must take precedence, if that choice has to be made.

Chief Rabbi Gavin Broder outlined for the committee the views of the Jewish community in Ireland:

> The subject of abortion is one which has, certainly of recent times, become of more interest and a number of great rabbis have looked into the subject to try and get an understanding and inference from the Bible and other Jewish material to express the view on abortion.

The Chief Rabbi spoke of a number of sources which reveal that the soul of the foetus has significance:

> One of the main laws that we have is the keeping of the Sabbath – we may not violate it in any way whatsoever. Nevertheless, if there is any slight question regarding saving the unborn foetus, then one may desecrate the Sabbath.
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> There is another inference which tells us whoever sheds man's blood by man, his blood shall be shed, which some commentators understand to mean whoever sheds the blood of man in man, his blood shall be shed – referring, of course to the foetus. So we, therefore, see an indication from the Talmud itself that only if it is hazardous to the mother may one abort.

In his opening statement on behalf of the Irish Bishops' Conference, the Bishop of Kildare and Leighlin, Dr Laurence Ryan, spoke of the Catholic tradition:

> Our view in this matter is shaped by a conviction that each human life is of unique value, that its dignity and worth must be respected. This conviction is at the heart of Catholic moral teaching but it is not unique to the Catholic tradition. At its most basic, respect for the worth and dignity of every human being requires that we respect his or her right to life since this is the most fundamental right. The violation of this right is an injustice. It is gravely wrong to directly and intentionally take an innocent human life, born or unborn, irrespective of its stage of development. Every human life is unique and irreplaceable. No one should be treated as if his or her life were of less value than that of any other. Any statement of moral principles about how human beings should treat one another and any just legal system must be based on a recognition of the dignity common to all.
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> The life of the mother is precious and unique but also the life of the child in the mother's womb is equally precious and unique. Both lives are equally entitled to be treated as ends in themselves and to be protected from unjust attack. This is the consistent teaching of the Catholic Church. Concern for the life of the mother must go hand in hand with concern for her unborn child.
>
> Obstetric practice in Ireland has an outstanding record of success in caring for the lives of mothers and their babies. The excellence of maternal care in this country indicates that recourse to direct and intentional abortion is not necessary to save the lives of mothers and the absence of abortion does not endanger their lives … Sometimes the death of an unborn child may be an unsought and unwelcome side-effect of medical treatment that is necessary for a mother who is ill. In those sad and tragic circumstances, the death of the child has not been chosen and is not the purpose of the treatment.

The religious bodies in general emphasised the need for education, compassion and non-judgmental care for women faced with unwanted pregnancies. They called for much more attention to be devoted to the social and personal circumstances which lead women to seek abortion and pressed for the development of advice and support agencies offering realistic and caring alternatives to abortion. Dr Ryan spoke of the deep regret of the Irish Bishops' Conference 'that so many Irish women feel compelled by circumstances to believe that they have no alternative to abortion when faced with pregnancy'. He continued:

> We need to ensure that those who feel abortion represents the only way out of crisis pregnancy or a difficult situation are offered a truly life giving choice. In this context, we would like to recognise the work done by agencies such as CURA

> and LIFE. They offer support and understanding to those for whom the prospect of the birth of a child creates difficulties which they feel unable to face.

Members of the committee were particularly interested to have the views of the religious bodies on the issue of abortion in the cases of suicide, foetal deformity and rape or incest.

Sheikh Hussain Halawa, the chief representative of the Islamic faith in Ireland, responded to committee members' questions as follows:

> Generally Islam strictly forbids suicide. Even if someone is sick according to Islam he is not allowed to commit suicide … if the baby or embryo is abnormal Islam does not allow abortion … If a doctor says that at most he will live twenty-four hours, he still has the right to live these twenty-four hours.

Sheikh Hussain Halawa spoke of the baby born of rape as innocent and to be treated on the same footing as others:

> He has not committed any sin, so the baby is completely equal to other babies born. When he will grow up he will have the same rights and the same duties.

Dr PHC Trimble, a representative of the Church of Ireland, spoke of his worry:

> … that if suicide risk was taken as a criterion for termination of pregnancy that women already cornered in difficult circumstances may see threatened suicide or attempt at self-harm as a way to extricate themselves – and an unsatisfactory way, in the long-term – to extricate themselves from that situation. We may actually be providing them with a less good option from providing good care for psychiatric illness and good support for their plight. The difficulty is in the assessment of the suicide risk and in applying termination of pregnancy as a solution rather than looking to other ways of resolving the situation.
>
> … I would rather provide appropriate support for the women to see them through the situation than provide what may appear to be a solution … terminating the pregnancy, which, in effect, may not help the woman's plight and may lead her, when well, to look back with regret at what had happened and to be troubled psychologically with the consequences of an intervention that has, in fact, added to her difficulty rather than helped in the long term.

Dr Trimble then spoke on the issue of severe foetal abnormality:

> 'Severe' could cover a range of abnormalities, which are not necessarily incompatible with life. The detection of such abnormalities is itself not without the potential for physical

> and psychological complications. Even simple tests can have a profound effect on the mother's attitude to the pregnancy and can impair her acceptance of the developing baby. The more invasive tests can themselves result in the abortion of a normal foetus as a complication unintended of the test.
>
> There are also wider implications. Abortion of abnormal individuals has an effect on society's perception of the disabled and, in particular, acceptance of disabled children. The detection of abnormality, and even the counselling process, puts pressure on the mother to make decisions regarding the continuation of her pregnancy. The process has even been described as giving rise to a situation where there is a duty to abort. So a process, an intervention which is designed to improve the position of the mother and give greater choice, can perversely create a situation where she feels pressured to make a particular choice.

Finally Dr Trimble addressed the 'difficult and emotive' situations of pregnancy after incest and pregnancy after rape:

> … some would argue that abortion in these cases is the lesser of the two evils and the compassionate solution. However, going back to the principle outlined in the … where the Church has previously stood, it denies the personhood and right to life of the foetus and it can itself re-traumatise the mother. Establishing the circumstances, that the pregnancy was due to rape, could clearly be very traumatic to the mother and presentation may be late because of her reluctance to come forward in these cases.

Rev Norman Cameron, speaking on behalf of the Presbyterian Church in Ireland, told the committee that abortion was permissible to save the life of the mother where there was a clear and substantial risk of suicide.

> We believe that such cases are very rare … we also believe that suicide risk is very low, indeed pregnancy is protective against suicide but we do believe that in rare cases it can still occur. … We prefer option five in that it provides a legal framework to assess abortion. It seeks to establish in legislation what appears to be the current position in the Republic. It is stricter than the *R v Bourne* case … we feel our church will accept a position stricter than the *R v Bourne* case, meaning the *X* case.

Rev Dr Trevor Morrow, also speaking on behalf of the Presbyterian Church in Ireland, acknowledged that some Presbyterians would allow abortion in the hard cases of rape, incest and foetal abnormality but that 'significant numbers of Presbyterians are convinced by the arguments for the absolute rights of the unborn'.

In its submission to the committee the Council on Social Responsibility of the Methodist Church in Ireland, while firmly ruling

out abortion on demand, noted its belief 'that abortion is a permissible choice in a small number of very specific cases' including in cases of rape or incest and in cases of gross abnormality of the foetus, for example in cases of anencephaly. The church favours legislation going beyond the *X* case to include the above circumstances. The preferred option for the Methodist Church is option seven, excluding, however, abortion for economic or social reasons or on request.

Speaking from the perspective of the Jewish community, Rabbi Broder dealt with the question of suicide as follows:

> The case you mentioned of suicide, that is something which most authorities would consider something just obviously hazardous to the mother's health. Some wouldn't go so far as to suggest that it had to be a case of suicidal – if it had other facts, perhaps extreme pain, deafness, possibly resulting in another serious illness, that would fall under the same category. Now that's with regard to the illness. Now, that is something which would have to be medically proven, and she would have to have some history or some psychological condition or some mental condition which would have a past record. That would then be a legitimate request for abortion and, perhaps, like I said, mandatory in those cases.

Rabbi Broder then spoke about cases of rape and incest:

> The case of rape, although unfortunate circumstances, unless it leads to the condition we just mentioned of serious mental or psychological problems, that wouldn't be a reason for abortion because, like in the secondary set of cases, there is an entitlement for the child to have his life. In such a situation, we would say that it would be the burden of the assailant or society to protect and to look after the child and the mother as best as possible, but it's not a reason to forfeit the child.
>
> … The same would apply in incest and adultery and any illegitimate birth because that child still is a living being and has to be given every accord to be able to move forward. The reason that has been propounded for this is that, by legitimising – not by legitimising – but by giving a complete open reason for abortion in a case such as that of an illegitimate child of incest or adultery, that would somewhat open up a floodgate of abortion. Jewish belief is rather that, if you have a strict set of moral conduct, then it is better to keep that moral conduct with a most severe consequence, of the illegitimate child, for instance, rather than to reduce the severity and make it more open to everybody else.

The position of the Irish Bishops' Conference in relation to suicide was outlined by Dr Lawrence Ryan:

> Well my attitude is that every effort should be made to save the mother who is … threatening suicide, that psychiatric help

> and all of that should be used to help her but to directly take away the life of the unborn child for that stated purpose, that should not be permitted.

Dr Ciaran Craven expanded upon Dr Ryan's remarks as follows:

> I think the committee has already heard significant medical evidence, not alone from the obstetricians but, indeed, also from certain eminent psychiatrists, particularly those who specialise in liaison psychiatry and I think it would be clear to members of the committee that the preponderance of evidence, in terms of the international medical literature, would be to the effect that, first of all, suicide is a rare event and, secondly that suicide in pregnancy is even a rarer event still which is very very difficult to predict.
>
> I do not think I am doing an injustice to the evidence which has already been adduced before the committee if I were to say that there is no empirical evidence in the international medical literature to the effect that an abortion is necessary in terms of treating a pregnant woman who expresses suicidal ideation, but not being an expert in the area I would not be competent to comment beyond simply summarising the evidence which, I think, has been adduced before the committee already.

In response to a question on the position of the Catholic Church in regard to rape or incest, Fr Paul Tighe spoke as follows:

> I think the Church's teaching in that area would be to say that to abort in those circumstances is wrong … even if the person was following their conscience convinced that it was right, what in fact they are doing would objectively be wrong.

In its written submission to the committee in November 1999, the Irish Bishops' Conference also dealt with the issue of rape or incest:

> When pregnancy is the result of incest or of rape, the experience for the girl or the woman is truly horrific. She may react with resentment, anger and rejection of the pregnancy, which she can feel to be a continuation of the violation of her body.
>
> Nevertheless, however abhorrent and degrading the circumstances of the conception, a new human life has come into existence. It is an innocent human life, a life given by God and called to live with God forever, a life which has a right to be welcomed into the human community. To end this life by abortion is a further violation of the woman's body and may in fact increase her distress.

It was clear from the evidence presented to the committee that most of the churches were opposed to dealing with the issue of abortion in the Constitution alone.

Bishop HC Miller said that the official view of the Church of Ireland throughout the abortion debate was that the constitutional way 'is not the best method of dealing with this issue'. The Church favours:

> … as the only practical possibility at present, the introduction of legislation covering such matters as definitions, protection and appropriate medical intervention, certification of real and substantial risk to the life of the mother and a time limit on lawful termination of pregnancy.

The representatives of the Presbyterian Church in Ireland favoured a 'twin track approach'. Rev Norman Cameron explained their position:

> It would be good to have a twin track approach. I think for many of us we have an underlying fear that any legislative change is going to open the door to perhaps abortion on demand. I feel that in the Presbyterian Church, as it has discussed this, there is a sympathy for the hard cases and, as a church, we want to show compassion for the hard cases but in line with that there is also the real fear that even to legislate for the hard cases will open the door too much as has been the experience in England and Wales. It's obviously up to the legislators whether they can find a framework that is tight enough. I suspect they will not be able to but it is up to the lawyers to try to find that legal framework that will be tight and strict enough and maybe it will require constitutional backup and maybe that is the advantage of having a twin track approach but we felt that the Constitution was a bit too blunt an instrument and it should at least be backed up with laws that were a bit more detailed to allow for the exceptions that there will be. It was too restrictive – a constitutional ban on its own.

Robert Cochran spoke of the strong belief among Methodists that the matter of abortion should be dealt with by 'ordinary legislation not by constitutional change'. He continued:

> The Constitution is the right mechanism for broad parameters of social policy. Legislation is the right mechanism, in our view, for filling in the details in particular circumstances. It may be that in issues like this there is also a need for delegated legislation, in some form, to deal with the particular circumstances of individual cases. That is something we can move on to.
>
> We think that the emphasis on constitutional change is, therefore, dealing with things in a way that the system was never designed to deal with. That was not what the Constitution, in our view, was ever intended to do. To try and make it deal with detailed issues is, in fact, a distortion of the purpose of it and it does not work very well. In fact, the evidence, since we have passed certain referendums, reinforces that view – that it doesn't work very well in terms of the *X* and *C* cases for example.

> Our tradition and our legal system are to use legislation for that. That is our general approach. I might add that this approach is not a view just in relation to abortion. We have taken the same view in relation to other issues that have come up, for example, the divorce referendum. We have taken exactly the same view that the Constitution was not the way to deal with that. It was a legislative matter. So that is the consistent view on that.

The Irish Bishops' Conference, however, was clear that the best way forward was through constitutional amendment. The position was emphasised by Dr Ryan:

> Having studied and reflected on the Green Paper the Bishops' Conference remains of the view that the best option is that of seeking a constitutional prohibition on direct and intentional abortion. We believe that what is required is a constitutional amendment that would protect the right to life of the unborn child while recognising that an expectant mother who is ill must receive such medical treatment as is necessary even when that treatment has a side effect that puts her unborn child at risk. Our view in this matter is shaped by a conviction that each human life is of unique value, that its dignity and worth must be respected. This conviction is at the heart of Catholic moral teaching but it is not unique to the Catholic tradition. At its most basic, respect for the worth and dignity of every human being requires that we respect his or her right to life since this is the most fundamental of all rights and, without it, other rights are rendered meaningless. We believe that if any legal or political system is to be truly just it must seek to uphold this fundamental right.
>
> … Finally, the Bishops' Conference believes that it is possible to formulate a constitutional amendment so that the right to life of the unborn child will be adequately protected.

When asked if the above meant that the Bishops' Conference was firmly behind Option One in the Green Paper, an absolute constitutional ban on abortion, Archbishop Desmond Connell responded:

> We would have to say that the way in which it is put in the Green Paper would perhaps create some difficulty depending upon how one understands abortion. If you say an absolute ban on abortion, it may include indirect as will as direct abortion. So we were unable to say that we would endorse No. 1 but quite certainly what we believe No. 1 intends is what we would wish.

To the question as to a constitutional wording that would cover the position of the Bishops' Conference, Dr Connell replied 'We are not experts in the framing of law. We felt it would not be appropriate for us to attempt to do that'.

The Association of Irish Humanists maintain that Ireland has a substantial abortion problem. By prohibiting abortion in Ireland but allowing any woman who wishes to do so to have an abortion in England or elsewhere abroad, we as a nation are not facing up to reality. Justin Keating, gave evidence to the committee on behalf of the Association of Irish Humanists:

> It seems to me that legislators, from my own experience, must always pay attention to the situation that actually exists – not to an ideal one, but to the one that is there on the ground.

National irresponsibility and hypocrisy The pro-choice view is that we are evading our responsibility to our own citizens and leaving them to be looked after by our neighbours. They argue that by banning abortion in Ireland we seek to claim a moral superiority; in a context in which thousands of young Irish women go abroad each year to have abortions we are being hypocritical. Abortion Reform, a pro-choice umbrella organisation, whose affiliates number Women's Aid, Lawyers for Choice, Catholics for a Free Choice and the Irish Family Planning Association, comments in its submission that 'our reliance in Ireland on services available in another jurisdiction is morally irresponsible …'

In response to the committee's call for submissions from the public, Ursula Barry wrote:

> I am extremely concerned at the lack of provision of abortion services within the state and believe that relying on another jurisdiction is politically and ethically irresponsible … It also means that women are travelling to Britain often alone and/or in secrecy and availing of private medical services without proper access to their medical records. There is evidence to suggest that Irish women are having abortions later than other women due to the fact that they are forced to access services in another state.

Sandra McEvoy, a member of Cork Women's Right to Choose Group, said in a personal submission:

> Having read the Green Paper, I feel it is important to state an objection to the option of a further referendum to put an absolute ban on abortion in place. Given that so many Irish women seek abortions in England every year, such a move would be hypocritical as well as divisive …
>
> As a non-Catholic citizen in a state which is increasingly plural in other respects, I feel that it is important that the state takes account of the views of those who do not accept Roman Catholic teaching on abortion.

In stark contrast Family and Life in its submission strongly asserts that a ban on abortion rightly establishes the state's responsibility for everyone, the born and the unborn:

> Irish basic law is totally opposed to granting any individual, either as a servant of the state or a private individual, the power to take the life of another innocent human being. A law like the British 1967 Abortion Act allows a whole class of people (i.e. pregnant women) in far from limiting circumstances to kill another whole class of people (i.e. their unborn children) as a matter of right and without the due process of a court of law. This is totally contrary to Irish law. The Christian character of the Constitution and the declared right to life of the unborn cannot be reconciled with a judicial interpretation permitting abortion, still less any law permitting abortion. (This is true of British and American law, both of which justified their abortion laws by assuming that the unborn was not a 'complete' human being.)
>
> … We acknowledge that the legalisation of abortion is supported by some, among whom are prominent politicians, doctors, lawyers and other professional people. Their support for abortion arises from their own personal beliefs and political views, and not from medical or legal needs. No judicial interpretation, added amendments or legislation permitting abortion in Ireland or its promotion elsewhere could be reconciled with the Christian character of the Irish Constitution.

The Pro-Life Campaign's submission to the Working Party on the Green Paper directly repudiates the idea of hypocrisy in Ireland's stand:

> Proponents of legalising abortion argue that, because of the tragic fact that several thousand women go to Britain for abortions, abortion should be legalised in the Republic. This is a false and hypocritical argument. What is tragic is that those women undergo abortion, not that the abortions happen in Britain. They would be just as tragic if they happened in the Republic.
>
> Abortion is only tragic because it is the taking of the life of an unborn child, and for that reason is profoundly distressing for the women. If it were a medical operation like having an appendix removed, it would not be tragic. It is gross insensitivity and hypocrisy for the proponents of abortion to trade on the tragedy by suggesting that it constitutes a reason for legalising abortion in Ireland. The only way to avoid the tragedy is to avoid what makes it tragic, namely, the abortion itself.

A woman's right Some submissions approach abortion as an issue of women's rights. They argue that because abortion is not permitted in Ireland, women are denied a right to bodily integrity and to freedom of conscience, unless their life is at stake, and that this constitutes a denial of their civil rights. It is also argued that women are denied their moral integrity, that is, recognition of their capacity to make good, rational and moral decisions about their lives. It is claimed that

in treating women in this way the state fails to trust half of its citizens to make decisions about their health and this is an indicator of 'the central patriarchy of the state'.

One such group which favours the woman's right to choose is the Association of Irish Humanists. In the course of her evidence their chairperson, Mary Hardiman, stated:

> The Green Paper on Abortion states 'It is argued that the common good cannot be promoted through the violation of basic rights, such as the right to life, and the common good requires the restriction of individual rights in some respects.' Now this argument by definition applies only to a small minority in this country, and that's pregnant women with crisis pregnancies. People are not merely a means to an end but are ends in themselves. The woman treated as an incubator of a foetus by law is merely a means to an end and is, therefore, not being regarded as a conscientious person. While we continue to criminalise abortion, we deny thousands of women their rights, the right to bodily integrity, the right to speak freely, the right to access necessary medical care.
>
> Denying a pregnant woman the right to choose is a form of coercion or social control which, as we all know, has been a devastating feature of our past history.

Anne Marlborough, a member of Abortion Reform, in her submission to the committee said:

> The provision of abortion in circumstances beyond those specified in the *X* case raises many issues of fundamental rights. The rights which would indicate that there ought to be an individual right to choose to have an abortion are the rights of equality, privacy, bodily integrity, self-determination and physical liberty. The source of such rights is the fundamental rights section of the Irish Constitution which comprises both specified and unspecified rights. These rights also enjoy varying measures of protection under international human rights instruments such as the Covenant on Civil and Political Rights and the UN Convention on the Elimination of All Forms of Discrimination Against Women. Only option 7 (e) fully vindicates these rights of women.

The concept that organisations which espouse the rights of women who choose to exercise control over their bodies are pro-abortion was challenged by the Cork Women's Right to Choose. Sandra McEvoy elaborated on their written submission before the committee:

> What does being pro-choice mean? It's a moral standpoint that recognises the complexity of the issues around fertility control and around abortion in particular. It should be emphasised that it means being pro-woman but not pro-abortion. On the contrary, it involves arguing that women should have access

> to the full range of reproductive choices. The word 'choice' should be emphasised because the idea of having choice implies access to genuine alternatives. The views of the pro-choice movement should not be misunderstood or misrepresented on this issue. We would argue that Irish women already exercise their right to choose. The fact revealed in published figures is that many Irish women believe that they have a right to choose abortion though they travel to Britain to exercise that right. It's currently estimated that approximately one Irish pregnancy in ten ends in abortion, a figure which suggests that these women make their decisions within a sphere in which the legislation prohibiting abortion in Ireland or church teaching has little bearing.

Abortion Reform also advocated changing the current abortion legislation in Ireland. Ivana Bacik stated:

> All of us know women who have had abortions in Ireland but those women are silenced under the present legal regime. They are women who face a double crisis. On top of the pregnancy which has given need for an abortion for them, they also face the added crisis involved in the difficulties in making the journey to England and in the legal and social stigma still attaching.
>
> We say that the needs of these women offer a strong practical reason for legalising abortion in Ireland but it is also important to remember the broader context and, as we said in our submission, control of fertility is increasingly being seen as a human right which is essential to women's control over their lives, to their existence as autonomous members of society and their ability to participate fully in the economic, political, social and indeed cultural life of their country. Our present law makes us deny Irish women full participation in our society. In this context, we should be particularly concerned about the inequality of access to abortion. Irish women who are disadvantaged economically or socially face added significant difficulties in seeking abortion in what is already a crisis situation for them.

The Thomas More Medical Association's submission strongly criticised the feminist argument:

> One of the most significant movements in recent times has been that of the demand for equality for women. The basic tenet of feminism is that being human, a living member of the species Homo Sapiens, entitles that being to certain rights, regardless of sex or other criteria. If any class of human beings is treated as less than equal and this practice is condoned by the state, the very foundations of feminism are undermined. In this regard it is worth noting that the American feminist Rachel McNair has pointed out that the attitude that leads to placing the ending of a child's life by

> abortion as a right is 'toxic' for the feminist cause. 'Promoting abortion as necessary for the equality of women implies that women require surgery to achieve equality with men, and that the whole premise of male domination, women's biological inferiority, is correct,' McNair argues.

The Association also points out that induced abortion, as well as killing the child, places the mother at risk:

> Even in countries which operate legalised abortion regimes, infection and haemorrhage are not uncommon, uterine perforations may lead to hysterectomies and other surgical procedures. An incompetent cervix [procedure] or scarring of the uterine tissue may lead to miscarriages of subsequent 'wanted' pregnancies, ectopic pregnancies and premature births. These facts are not highlighted when induced abortion is being promoted.

In her address to the committee, the writer Rosemarie Rowley, who declared herself to have been always a feminist, pointed to a weakness in the way feminism has developed as an ideology:

> … there has been a certain tendency of the ideology to ignore or suppress the information [about post-abortion syndrome] simply because it doesn't fit in with the picture, the received wisdom. When you have a goal you tend to ignore the evidence as you go along. This is a feature of all ideology, that as you go along, as things appear, you tend to ignore them because in a way they are sort of contradicting your thesis. The thesis in feminism is that abortion is a goal for women and that it helps women. I am saying that if you look at the experience and if you look at the way it has been handled, in fact it is actually anti-woman.

Abortion is a private medical concern The Open Door Counselling organisation in its submission to the committee says:

> The decision to terminate a pregnancy should, as a matter of public policy and legislative action, be viewed as a medical issue in order to ensure that procedures considered appropriate in a variety of given circumstances be available as deemed necessary by patients in consultation with their medical advisers. This pragmatic approach removes the question from the unresolvable arena of moral debate which has already caused the debasement of Irish law.
>
> This approach is consistent with allowing medical necessity to determine the circumstances in which abortion may be legal under both the 1861 Offences Against the Person Act, as has been more than adequately demonstrated in the working of the UK legislation, and the Supreme Court in *X* (1992).

Truls Christiansen, a medical doctor, in his submission says:

> I am very much against a total ban on abortion. It is necessary at times, and I feel Ireland should look after its own problems by providing this procedure here. It is too difficult a task to pick which cases should be chosen, or deserves to have an abortion. I feel this is a case which should rest between the pregnant woman and her doctor; and should hence be provided for anybody who wishes it – after due counselling.

Youth Defence, in its written submission, comments:

> … When a woman becomes pregnant whatever the circumstances, she becomes a mother to a child, which became a child at the very moment of conception. And the question before us is whether we are willing to walk down that road to the death culture, whether we are willing for the sake of some false notion of freedom, or just because it is easier, to say to these women in crisis pregnancy, that it is your choice and therefore your problem, that we are willing to let loose the madness of abortion which reaches into the womb to tear limb-from-limb a living baby.

Social and economic strains The social and economic strains on women who opt for a termination of pregnancy in the UK were highlighted by Ailbhe Smyth, Director of the Women's Education Research Centre, in a personal submission:

> … I am appalled and saddened that each year many thousands of women are obliged to travel abroad to seek an abortion because of our failure to enact legislation and to provide reproductive health services in Ireland which would enable all women to exercise their moral and social rights as citizens in this country without fear of sanction or stigma. I am concerned that very many women travel to the UK for an abortion in extremely difficult circumstances, and that, furthermore, unknown numbers of women are unable to travel to obtain abortions because of their socio-economic circumstances.

Sandra McEvoy, a member of Cork Women's Right to Choose Group, in her evidence to the committee, indicated the level of the financial burden involved:

> While the 1995 Abortion Information Act removed some of the barriers to women accessing abortion services abroad, it did not remove the financial and other barriers faced by women, such as those living in poverty, minors and asylum seekers. The current cost of an abortion at the Marie Stopes Clinic in Britain can be as much as £750. Taking this together with travel costs puts abortion services beyond the reach of many Irish women who, as we know, have a higher risk than men of living in poverty.

The Well Woman Centre, an organisation established with the aim of giving women access to decision making over their own reproductive

well-being and family planning options, provided counselling for over 1,351 women in 1999. In its submission to the committee it stated that a constitutional ban on abortion placed further distress on women. Alison Begas, in her evidence on behalf of Well Woman, told the committee:

> We would indicate that our experience over the last 20 years makes it clear that no constitutional ban or legal sanction can effectively restrain Irish women who choose to seek a termination. We are opposed to the insertion of clauses in the Constitution which tend [towards], or have the intention of, criminalising those women who are faced with the need to seek termination. We would like to see the removal of the stigma of criminality from abortion. It is the experience of our counsellors that many women feel that difficult as the decision already is for them, it becomes even more difficult when they are aware of doing something that may be classed as criminally wrong, as they are already very tough on themselves in the counselling sessions, and this exacerbates the problem. We emphasise our position as being pro-choices for women, and I must emphasise the plural there. Our commitment is to giving women access to all options and facilitating decision making themselves, based on knowledge of all the options available to them.

However, the Pro-Life Campaign in its submission to the Working Party on the Green Paper claimed:

> … what the proponents of legalised abortion want is for abortion no longer to be regarded as a criminal matter at all but simply a matter of 'women's health'. This involves a complete denial of the humanity and equal and inherent worth of the unborn and is a view only held by a minuscule and entirely unrepresentative handful of people.

Chapter Five

The Experience of Abortion

The vast majority of the written submissions received by the committee disclosed a passionate concern to ensure that abortions should never be carried out in the state. The submissions showed a particular concern that any departure from an absolute ban on abortion would 'open the floodgates'. When the committee conducted hearings it became apparent that the judgment in the *X* case had not created a dynamic for abortion. Constitutional or legal initiatives aimed at dealing with the consequences of the *X* case would not affect actual conditions in Irish hospitals. It became apparent that the issue of abortion in Ireland centred on the five to six thousand Irish women who go to Great Britain each year for abortions. No person requested to see the committee about the actual experience of abortion in Great Britain. However it is essential that the committee outline the nature of the experience from available sources.

Statistical position

The Green Paper states:

> There is evidence that Irish women have for many years travelled abroad for abortions. However with the introduction in England and Wales of the Abortion Act 1967, Irish women have been travelling there in increasing numbers. From 1970 to 1998 almost 95,000 women who had abortions in England and Wales gave Irish addresses. However it is often speculated that the real figure may be higher insofar as some Irish women may give British addresses for reasons of confidentiality.

The table below shows the abortion rate in England and Wales for Irish women normally resident in the Republic of Ireland in 1971, 1979, 1981 and 1991 onwards. (The abortion rate is calculated in this table as the number of abortions per 1,000 women aged between 15-44).

Year	Number	Female Population 15-44	Abortion Rate
1971	578	545,953	1
1979	2,804	675,085	4.1
1981	3,603	705,926	5.1
1991	4,154	791800	5.2
1992	4,254	783,700	5.4
1993	4,402	787,600	5.6
1994	4,590	792,200	5.8
1995	4,532	805,200	5.6
1996	4,894	822,586	5.9
1997	5,336	836,200*	6.4
1998	5,892	850,500*	6.9
1999	6,226	861,000*	7.2

* estimated

Source: Green Paper on Abortion

The Office for National Statistics for England and Wales compiles statistics on the number of Irish women who have abortions in England and Wales each year and who are normally resident in the Republic. As with all abortions performed in England and Wales, the vast majority of abortions obtained by Irish women (99.7%) are carried out on the grounds that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury either to the physical or mental health of the pregnant woman or to the physical or mental health of any existing child(ren) of the family of the pregnant woman.

Eighty percent of Irish women seeking abortions have their pregnancy terminated by twelve weeks' gestation, eighty percent of them are single and fifty-three percent are twenty-four years or younger. The trend has accelerated, the abortion rate having risen from 4.1 in 1979 to 7.2 in 1999.

Our understanding of Irish women's experience of abortion rests on statistically uncertain ground. A number of submissions suggested that the true figures for Irish women who have had abortions is far greater than those captured in the statistics for England and Wales. The committee had available to it the study entitled *Women and Crisis Pregnancy*.

Women in crisis pregnancy

In June 1993 the Minister for Health commissioned a study on women and crisis pregnancy in Ireland from a research team comprising three researchers from the Department of Sociology in Trinity College Dublin – Evelyn Mahon, Catherine Conlon and Lucy Dillon. Their report *Women and Crisis Pregnancy* was published by the Stationery Office in 1998. It is a report based largely on interviews with women who have had crisis pregnancies. As a qualitative report, it needs to be supplemented by research based on statistical resources. In the absence of such quantitative research. It provides the best picture available to us of what abortion means to Irish women.

The study examined three groups of women with crisis pregnancies: one group who had chosen abortion, a group who planned to keep their babies and a group who planned to give their babies up for adoption. It examined contraceptive practices of women with crisis pregnancies and their use of pregnancy counselling and information services. It also examined the factors which influence a women's decision to opt for abortion, lone motherhood or adoption.

Women faced with crisis pregnancy have much in common. In the majority of cases they are single and this factor alone often renders the pregnancy a crisis one. More especially, being single and pregnant has always been a source of stigma, both to the woman herself and to her family. This parental and social stigma is the first aspect to a crisis pregnancy that many women have to confront.

The second aspect they must deal with is that the pregnancy was not intended. Women with crisis pregnancies are usually at school, in college, in jobs in which they require further training, or in casual work with no maternity leave. Their first reaction is to see motherhood as incompatible with the lives they now lead. They are faced with a choice of continuing their present life by having an abortion, leaving it temporarily while they choose adoption, or deciding in the long term to adjust their lives to motherhood. A pregnancy is therefore a crisis when it means that women cannot continue their economic participation. Up to the time of their pregnancies, women were continuing their development as autonomous adults and in many cases fulfilling their parents' expectations. A pregnancy is a crisis because a woman feels she has let her parents down and because she cannot continue her normal working life.

Pregnant women see motherhood as a very demanding, responsible role, an economic role as well as a caring one. If women have not attained a position of economic autonomy through work or marriage, they cannot fulfil the role of mother; this also renders the pregnancy a crisis one.

Most women share the same familiar ideas about the kind of social arrangements they would like to be able to provide for a child, that is, emotional and financial stability in a traditional family form or in the context of a secure relationship with the father of the child. A crisis pregnancy does not occur in such a context. The woman or her partner are not financially secure or their relationship is not one which can accommodate a child. Yet women feel that a child's needs are best served by these socially desirable arrangements.

These social factors: the social stigma of pregnancy, the combination of work and family life, the optimum conditions for childraising and a woman's relationship with a partner all shape the parameters of women's decision-making around a crisis pregnancy.

A woman in trying to resolve her crisis pregnancy will be beset by the competing demands of many roles: as a daughter, as a student or worker, as a mother and as a partner. While many discuss crisis pregnancy, and particularly abortion, in the context of the rights of the mother versus those of the unborn, *Women and Crisis Pregnancy* indicates that such an approach fails to incorporate the many facets of a woman's decision-making.

All women with a crisis pregnancy deliberate on how best to cope with that crisis in the context of these competing roles and the four social factors already noted: stigma, motherhood, children's needs and relationships. It is important therefore to see such factors as moral dimensions of their decision-making. The study articulates the reasons why some women felt unable to proceed with their pregnancy, and why abortion seemed the best option for them.

Deciding on abortion The authors of *Women and Crisis Pregnancy* conducted interviews with women who were attending abortion

clinics in England to have their pregnancies terminated. The interviews were conducted before having the abortion or, in a small number of cases, at the abortion clinics after having the abortion. By then, women had made their decision and the authors sought to capture their reasoning at the time they were about to have the abortion.

The interview sequence enabled them to describe the lead up to the pregnancy, and what went through their minds from the time they first suspected to the time they established that they were pregnant. Every woman's story was different. Some women unfolded all of their thoughts in one or two very long sequences while others discussed different aspects of their decision-making processes at different stages of the interview.

While the debate on abortion pivots on the right to life of the unborn versus the mother's right to choose, women's decision making around abortion – while sometimes including a consideration of rights – is embedded in a number of practical concerns. These concerns are set out in the table below. As can be seen from the table, many of the themes raised by women relate to women themselves and their readiness for children, in addition to the stigma of lone parenthood and a woman's right to choose. While abortion is often considered tantamount to a rejection of nurturance, this is a simpler view than the one taken by the interviewees. Many women set high demands for motherhood and spoke of how little they could offer a child and the way this contrasted with how much they would like to offer a child, or what they considered appropriate to offer a child.

Themes related to abortion decision from 88 interviews analysed	Number who mentioned theme
Career/job related concerns	36
Stigma of lone parenthood	30
Child needs	30
Financially unready	28
Not ready for a child now	27
Could not cope	24
Too young	22
A child already	19
My body, my right	17
Education and training17	
Never wanted a child	10
Stigma on parents	7
No way I could have a child now	6
Too old	4

Source: *Women and Crisis Pregnancy*

The decision to have an abortion is often made within a social context which includes others. While only 10 of the 88 women interviewed told their parents, 57 told their partners, 47 of whom called their decision a joint one. In addition, 32 women were accompanied to the clinics by their partners while a further four were accompanied by one of their parents.

Social stigma Abortion is illegal in Ireland and considered immoral by a high proportion of the population, so it is a stigmatised form of behaviour. Secrecy is inevitable. But lone parenthood is also a source of social stigma and abortion protects women from experiencing this stigma. Consequently secrecy about the pregnancy is antecedent to and in most cases a prerequisite of secrecy about the abortion.

In their interviews women explained why they kept their pregnancies secret from their parents. Their reasons included: a concern that parents might actually try to encourage them to continue with the pregnancy or prevent them from having an abortion; fear of parents; a fear that a disclosure of pregnancy would be used pejoratively against them or would bring disgrace to their parents; reluctance to generate parental stress and a realisation of parents' strong anti-abortion views.

Demands and needs of motherhood Pregnancies are now more likely to be planned or occur within appropriate social arrangements. However, not all women wish to become mothers and ten of the women interviewed in the abortion sample said they never wanted to have a child. However, other women while wanting to become mothers were not ready to have a child, or could not cope with a child at that particular stage in their lives.

The child and its social and emotional needs The modernisation of motherhood has changed the role of mothers from one of emotional and caring support to one which combines both caring and financial roles. Women's increased independence and obligation to work has changed both the nature of marriage and women's perception of the demands of motherhood. As mothers, women now carry the double burden of income earner and carer. In addition, as children and childrearing become a planned part of people's lives, parental perceptions of children's needs have changed. Parents are increasingly conscious of the role they play in the development of children into well-adjusted adults. They feel that this process requires emotional, social and financial security and stability. Traditionally all of these needs might have been seen to be encompassed in the role of the 'traditional' family. The pattern of that family was one in which the father was the principal breadwinner and the mother the carer. Increasingly in Ireland mothers are breadwinners as well. Equally important is the assumption of many women that effective childrearing and caring is best carried out within a stable family unit. Increasingly that now means one in which both mother and father play both roles. It is within these dimensions – the centrality and importance of a family life, the need for a child to have an active father, and the emotional and economic needs of children – that women's decision making on abortion is shaped.

Partners and abortion decision making By the time the pregnancy was diagnosed, women's relationships with their sexual partners varied. The role of their (sexual) partners in the decision-making process varied according to whether the women told them about the pregnancy and whether or not there was still a relationship between them. Fifty-seven women of the 88 interviewed told their partners they were pregnant and planning to have an abortion and of those 47

described their decision to have an abortion as a 'joint one'. Women described their partners as supportive of their decision and partners helped to pay the costs incurred in having an abortion. Thirty-two partners accompanied women to the abortion clinics.

Even in cases where the partners were told and the decision taken was described as a joint one, the primary decision was seen as the woman's, with the partners saying that they would support whatever decision she made.

Partners that were not told The principal reason for non-disclosure was that women never or no longer had any relationship with the putative fathers/partners: for instance, 7 women reported that their pregnancies were the result of 'one night stands'; 3 said that their relationships were not serious but involved casual sex with men they knew; while 6 others said they no longer had any relationship with this partner. So sexual intimacy is not necessarily followed up by confidential disclosure that pregnancy has occurred. Consequently some men will never know that intercourse resulted in pregnancy. Given the time lapse between sexual intercourse, detection of pregnancy and the decision-making process, this pattern of a 'past relationship' is not surprising.

Moral issues and the abortion experience All of the parameters of a woman's decision-making processes can be termed 'moral' as she invokes them in making her judgment and in arriving at her decision to have an abortion. The fact that in many instances these reasons are clearly articulated may give a sense of emotionless rationality, but that interpretation would belie the truth.

'Everything goes through my mind' Women with a crisis pregnancy are under considerable stress. Each woman weighs up the conflicting expectations of her: to be the praiseworthy non-pregnant daughter, to complete training that will enable her to live an economically viable life, her role as a mother and in some cases her role as a partner in a relationship. The burden of the decision to abort a pregnancy is an onerous one, in which everything goes through a woman's mind.

Moral ambivalence Many women gave very practical reasons for having abortions. Not surprisingly this process was often accompanied by ambivalence in relation to the moral aspects of their decision and fears about regrets in the future. Women when beset by such doubts and fears devised coping strategies to enable them to go through with the abortion. One such strategy was not seeing the pregnancy as a baby.

Block thoughts out of her mind A second strategy used was to stop analysing the decision in such moral terms, by blocking such thoughts out of their minds.

Bodily autonomy While pro-choice views often stress the 'it's my body' perspective on abortion the research team found that while this was an important theme for some women, it was never the sole reason for having an abortion.

Coping with anti-abortion views Women also had to cope with strong anti-abortion views. They examined and critiqued the views of those who were anti-abortion, in particular men, from a more women-centred perspective.

Abortion and its aftermath Many of the women interviewed reported that a number of factors helped to normalise the experience for them. Abortions are carried out in specialist clinics and so offer a very supportive service to their patients. The majority of patients who attended the clinics were there to have an abortion. As they waited in the reception rooms, the women were silent and ashen faced and their accompanying partners pale and stressed. Like any operation at that stage women simply want to have it over them. Yet one of the key differences was that at any stage a woman was free to change her mind and not proceed with the operation.

Not the only one The journey to England was always a difficult one and women were afraid that they would be seen. However, once women reached the clinic they realised that there were several others who were having abortions, so this became a form of group support.

In many clinics, Irish women tend to have their abortions on certain days to avail themselves of cheaper flights. Women were often surprised to see so many women from Ireland, and they invoked the numbers of Irish women having abortions as part of their rationale.

Women thinking that 'I'm not the only one' – sought solace in the high numbers of Irish women in an attempt to counteract the isolated nature of abortion. The secrecy around abortion in Ireland means that the only visibility of a peer group is those going through a similar experience at the clinics. Meeting others at the clinics reinforced feelings of solidarity among women having an abortion. The staff were friendly and often particularly sympathetic to Irish women who had to travel for abortion.

These interactions helped women to get through the experience of abortion. Yet women still worried about the aftermath of their experience.

Post-abortion relief Given the initial shock and crisis response to discovering they were pregnant, abortion was more usually followed by relief. When women have thought through it themselves and made a decision, few have any doubts about what they did.

Every stage of the process from discovering that they were pregnant, through the search for information, their experience of counselling, their discussion with their partners and the abortion itself has its own particular trauma. It is a process that takes several weeks in which other aspects of their lives are placed in suspension as they negotiate their own decision-making process. It is never an easy decision. It is never lightly taken.

Chapter Six

Reducing the Rate of Abortion

Many who appeared before the committee saw the need to do everything possible to reduce the rate of Irish abortions.

Professor John Bonnar said:

> Some of the abortions sadly relate to poor advice or lack of education in family planning. We want to help these women so that we will do our utmost to reduce the number who are seeking abortion as a solution to their social problems.

Dr Sean Daly said:

> By improving sex education, improving contraception – making it more widely available – we should be able to reduce the number of unwanted pregnancies and clearly all, or a lot, of the efforts should be put into that. This is a much easier problem to prevent than ultimately to manage. I think if that was grappled with more aggressively then we could reduce the number of women who would look to terminate a pregnancy.

Professor Walter Prendiville said:

> Essentially, I am saying that I believe – and I certainly think it is worth exploring – that education of very young people, accessibility of contraception and a responsibility to sexuality that prevails in northern Europe – and it does not prevail even in England nor in Ireland amongst our teenagers – is the only way we are going to change our society. I think that what we legislate for will actually not make any difference to 99% of the women who have an abortion.

This view was also strongly supported by Dr TK Whitaker:

> If the legislative restrictions that I indicated stand up, I would be very happy not to have money or time spent on a referendum and more and more resources devoted to … first of all, trying to ensure that there aren't unwanted pregnancies and then, if there are, that they are carried to completion with every help that the State can give and that the children of these pregnancies are helped to have good parents, whether their own mother or foster parents or adoptive parents.

The committee found widespread support for a plan to reduce the rate of abortion.

Thus, the Pro-Life Campaign:

> While calling on the government to restore the fullest possible protection to the unborn, the Pro-Life Campaign also calls upon the government to tackle, in a creative and sensitive manner, the disturbing and growing number of crisis pregnancies. … What is singularly lacking is a coherent government strategy for addressing what everyone agrees is the very disturbing rise in the number of Irish women seeking abortions in Britain. However, the rising trend of abortion is not inevitable. Statistics from Poland and certain areas in the USA show, when the conditions that pressurise women to opt for abortion are addressed, the trend can be slowed down and even reversed.

The Irish Congress of Trade Unions:

> Increased resources should be made available to health boards, schools and family planning service providers, so as to enable more education, information and comprehensive family planning services to be available to all who require and need them.

The Well Woman Centre:

> In the United Kingdom, one in every five pregnancies ends in abortion. In Ireland, one pregnancy in every ten ends in abortion – this in a country where abortion does not exist. Clearly, our education system is failing to equip young women and young men with information and a sense of personal responsibility regarding family planning. As far as Well Woman is concerned, the current high (and growing) numbers of Irish pregnancies ending in termination represents an embarrassing failure to educate our young people.

The Women's Education Research and Resource Centre:

> … there is an urgent need for a significant restructuring of the health and educational systems so as to ensure that the promotion and protection of the health and well-being of women and girls is safeguarded and the scale of unwanted pregnancies in this country is reduced.

The Irish Family Planning Association:

> The IFPA regrets to note that once again the government has allowed the blinding light of the abortion 'debate' to distract it from taking concrete measures to minimise unplanned pregnancy in the state. The committee would do great service by spurring the government to action in this respect, even before beginning an examination of the legislative and constitutional options.

Cherish:

> Cherish acknowledges the importance of the function of education in the process of tackling crisis pregnancies. Cherish believes that all young people should be given the opportunity to gain for themselves the knowledge, skills and experience necessary to meet their own individual needs and those of others.

The Association of Irish Humanists:

> Humanists do not regard abortion lightly as another form of fertility control. In fact we are firm advocates of education for life from an early age, with ready availability of all forms of family planning, emergency contraception etc., in order to reduce the number of induced abortions.

The Women's Health Council made one of the most developed submissions on the issue. It declared that:

> Whichever of the seven legal options proposed by the Green Paper is implemented, crisis pregnancy will remain a reality in twenty-first century Ireland unless a specific, targeted, coherent and cohesive approach is taken to tackling its root causes and current outcomes.

It recommended that:

> … a National Strategy be developed with the aim of reducing the rate of crisis pregnancy significantly over a short time frame. Such a strategy should involve policies, actions and initiatives at national, regional and local level, with a view to implementing evidence-based formal policy, procedures and programmes within five to ten years.

The elements of a plan

A plan to reduce the rate of abortion must:

a) seek to prevent as many crisis pregnancies as possible from occurring

b) ensure that where crisis pregnancies do occur, women have the knowledge and understanding to allow them to make a decision based upon all of the options open to them – abortion, lone motherhood or adoption.

a) *Preventative measures*

Education Education is the first instrument that people who wish to tackle a social problem usually reach for. People tend to equate

knowledge with virtue – if you know what is good you do what is good. This has led to demands for more and more courses to be placed on the heavily laden curricula of the schools. The courses often require that teachers be given special formation in order to be able to deliver them. Sometimes there is compelling criticism that a new subject may overload the curriculum. Curriculum designers may respond to this by seeking to have the elements of the programme delivered through a number of existing courses at second level. To deliver a civics programme, for instance, one might target history, geography, religion, economics and home education. This stratagem, however, requires extraordinary feats of co-ordination by the teachers.

The committee is aware of the limited value that can be placed on education programmes. It is also aware of how difficult it is to create the attitudes and skills that personal and social education programmes aim to achieve – such as assertiveness and self-discipline. In spite of this the committee believes that the community must make an exceptional educational response to the exceptional problem it faces in trying to reduce the rate of abortion.

It is also aware of the need, in relation to the problem of abortion, to help the development of good relationships within the family so as to create a primary supportive context for the girl who finds herself with a crisis pregnancy. An education programme must provide support for parents. They are currently a neglected resource.

The educational sector has already responded. In 1995 the Stationery Office published *Relationships and Sexuality Education* – the report of the expert advisory group chaired by senior inspector Emer Egan. The group first of all set its work in the context of our educational culture, stating:

> The Irish education system has as a general aim the development of all aspects of the individual. Any programme which seeks to educate the whole person must have due regard for relationships and sexuality education as part of that total programme. While in law parents are the primary educators of their children, research has shown that many look to schools for support in helping them fulfil their obligations in this very important aspect of their children's development.

It defined relationships and sexuality education as a lifelong process of acquiring knowledge and understanding and of developing attitudes, beliefs and values about sexual identity, relationships and intimacy. This education is delivered consciously and unconsciously by parents, teachers, peers, adults and the media. It pointed to certain aspects of contemporary life that called for relationships and sexuality education:

- earlier physical maturation of children
- evidence of earlier sexual activity

- the informal and unsupervised contexts within which children acquire information about sexuality
- the changing roles of men and women in society
- health issues related to sexual practice
- young people becoming aware through travel, the media and the communications revolution, of different sexual mores and cross-cultural influences
- pressures on family life.

In 1997 the Department of Education and Science began a process of introducing Relationships and Sexuality Education (RSE) in both primary and second-level schools. The intention is that this will be incorporated into the Social and Personal Health Education (SPHE) which will become part of the core curriculum.

Teachers have been trained, schools are developing policies on RSE and materials have been produced in order to provide effective relationships and sexuality education for all Irish young people.

Health boards have also had an important role in establishing services to reduce unhealthy sexual behaviour among young people at risk, outside of the school setting. One example is the Teenage Health Initiative of the Eastern Regional Health Authority. This programme is specifically targeted at young people in disadvantaged areas who have been identified as being at risk.

The Green Paper points out that the following issues need to be considered and debated:

- education on the use of contraception is not currently included in the RSE curriculum. Further consideration needs to be given to how best to ensure that young people have access to full information in this regard
- the need for approaches other than a school-based one, e.g. community-based 'outreach' programmes, media-based educational campaigns. Teenage health initiatives on the lines of those developed by the Eastern Regional Health Authority could be extended to other boards
- educational campaigns designed to cultivate more responsible attitudes to alcohol, with particular regard to alcohol and sexual activity and the risks involved
- educational programmes targeted at parents to encourage the open discussion of sexuality in the home.

Notwithstanding these educational initiatives, the *Women in Crisis Pregnancy* study makes it clear that there is considerable ignorance of fertility cycles and a lack of knowledge about how to ensure effective contraception. The organisers of the '5000 Too Many … Reducing the Abortion Rate by Providing Real Alternatives' conference, Breda O'Brien and Professor Patricia Casey, point out that countries such as the Netherlands are realising that giving young people skills to avoid

early sexual activity is crucial and that information is not enough. They say boys are often completely neglected in RSE and that modules should be developed emphasising the role of fathers and the responsibility attached to every act of sexual intercourse. They say that in view of *Women in Crisis Pregnancy*, which showed that fear of parental disappointment was a key factor in choosing abortion, parental involvement should be part of any RSE programme on an ongoing basis, not just part of a consultative process in formulating school policy. They point out that information on alternatives to abortion was neglected during the eighties because students' unions were focused on access to abortion information. A working group on alternatives to abortion should be set up on each campus. It should aim to provide clear unambiguous information on the supports available to those continuing pregnancies. It should concentrate on areas where students convene or instinctively seek information, such as student handbooks and websites.

In its written submission the Women's Health Council also recommends the implementation of comprehensive relationship and sex education programmes at all levels of the educational system:

> The programmes should cover inter alia sexuality, fertility and methods of contraception, information on safe sex practices and a module raising awareness about violence against women. Male responsibility should be a major factor in any education programme concerning sex, contraception and reproduction.

Breda O'Brien points out that encouragement of young people to use contraception does not address all of the issues involved:

> … Douglas Kirby is recognised as the prime researcher in sex education in the United States. … He made an interesting comment in 1991 and I can leave this with you rather than reading out the sources and references. He said it may actually be easier to delay the onset of intercourse than to increase contraceptive practice. That has been borne out around the world. I have a number of references which I will not go into but according to The Guardian on October 13 last year, the British Pregnancy Advisory Service in a study of 2,000 women who had sought abortions said contraception cannot be relied on to prevent pregnancy in the UK; the New Zealand Medical Journal, 1994, a study of women – the British Pregnancy Advisory Service of women presenting for abortion, fifty-nine percent of them cited contraceptive failure. That was thirty-eight percent condom failure and seventeen percent pill failure. If contraception were the answer there would be no abortions in Britain and if contraception were the answer there would be no abortions in the US either. A similar study in New Zealand – again women presenting for abortion – sixty-one percent of women had been using a method of contraception in the month they got pregnant. Some twenty-five percent had been using the pill, twenty-nine percent using condoms that experienced failure. The most

> interesting statistic for me is that one-fifth, approximately twenty percent, had been using contraception perfectly. It was not human error. It was pure contraceptive failure. Then there is an Irish study by Dr Maeve Robinson which was 163 patients attending an Irish family planning clinic. Of 163 patients, 83 had used contraception and experienced contraception failure. So there is no magic bullet. It would seem intuitively that the way to go is to encourage young people to use contraception but it does not seem to be that way.
>
> What is emerging from the United States … the American Government has recently mandated $250 million for what they call 'abstinence education'. I prefer the term 'delaying sexual activity'. The RSE – Relationships and Sexuality Education the proper term for it – is just a module within social, personal and health education. I think that is a much more healthy way of looking at it. As advocates of health, can we be advocating to young people that contraception is the answer to everything, particularly condoms, particularly when we have a growth in the incidence of human papilloma virus which condoms do not protect against and which are implicated in cervical cancer?
>
> The implications for young women engaging in sexual intercourse at an early age are much more serious than for young men. Young men do not escape unscathed but young women have much more serious consequences. Chlamydia, which has reached epidemic proportions in the United States, actually results quite often in pelvic inflammatory disease which results quite often in infertility. These are very serious things that we need to look at when we are advising young people. I think we have this … I was talking to a group of young people recently and this person, a very bright, articulate young woman, said to me the media are not remotely interested in the seventy percent. I said: 'what seventy percent'? She said the seventy percent that are not sexually active, the ones who do not go off the rails, the ones who are quite sane and sensible, we are quite boring, you never hear about us. We have concentrated all our efforts on the thirty percent and have assumed that the seventy percent are an aberration and that we cannot move the statistics in the other direction, that the seventy percent must become lower and the thirty percent must become higher. The evidence from the United States is very promising in that it can be done. The average age of losing virginity has increased by a year, which is significant if you think of young people over the past number of years since the mandating of the DSA – delaying sexual activity – model …

The committee is aware from its knowledge of other social programmes which require responses from government departments, public bodies and voluntary organisations that a single focus is indispensable. Without a single focus it is highly unlikely that research

would be carried out in a programmed way, that the endeavours of the implementing bodies would be sufficiently co-ordinated and that the necessary public response would be galvanised. The planning structure proposed in the next chapter would provide this.

Contraception An education programme aimed at placing sexuality in a wholesome relationships context and proposing delayed sexual activity as an ideal but also providing information on contraception is a positive, but necessarily limited, factor in a plan to reduce crisis pregnancies. Contraceptive services, including post-coital emergency contraception (the morning after pill), are probably a more important factor.

A range of family planning and health services is currently provided by the health boards, general practitioners and other agencies such as the Irish Family Planning Association and the Well Woman Centres.

The Green Paper identifies the following issues as needing to be settled:

- the availability of the widest possible choice of service for women seeking advice on and services for contraception
- the production of an information booklet or leaflets which would be widely available regarding the correct and safe use of contraceptives
- improved access to contraception, including identification of and extension of services to meet current unmet needs
- the availability of contraception at little or no cost to everyone who needs it
- improved access to emergency contraception, especially outside the major urban areas
- more widespread availability of sterilisation and vasectomies as part of the public health service
- an examination of the role of GPs in the provision of family planning services.

Women and Crisis Pregnancy confirmed findings of earlier research that many women who have abortions did not use contraception or used it incorrectly. The study found that social and personal factors militated against consistent use of contraception. The fact that young women were sexually active was not generally disclosed to their parents. Many believed that their parents would disapprove or be shocked if they found this out. This included a fear of contraceptive pills being discovered by parents, concern over how their doctor might respond to a request for the pill, and a fear that being on the pill would result in women being perceived as sexually available. Many women were therefore reluctant to use the pill unless in a long-term relationship.

The study also found that women felt that to carry condoms was to compromise their reputation. However, the principal impediment to

the effective use of condoms was found to be the failure of men to assume responsibility for contraception. In the face of objections from their partner, some women were not assertive about condom use, fearing that insistence would threaten their relationship. As a result, effective contraception was compromised.

A plan needs to be drawn up which would provide contraceptive services in all parts of the country and to all the people who need them. As the Adelaide Hospital Society recommended in its written submission, the government should introduce a national network of contraceptive provision, including a number of choices for adolescents (family medical practitioners, Family Planning and Well Woman clinics, hospitals, community nurse specialists etc). The emphasis should be not just on availability but also on accessibility, especially for the poor, the young and the socially deprived sections of our community. Provision of contraception and education should be made as far as possible according to people's choice.

Post-coital contraception The evidence the committee heard on emergency contraception suggested that it was strategically important to a plan to reduce crisis pregnancies. Dr Harith Lamki, a consultant obstetrician and gynaecologist in the Royal Maternity Hospital in Belfast, told the committee:

> … in the Royal Maternity Hospital we run a very big morning after pill clinic, which means we have a big reduction in the number of unwanted pregnancies at present.

Evidence of whether the morning after pill, which prevents a fertilised ovum from being implanted in the uterine wall for a period of about seventy-two hours following fertilisation, is an abortifacient was heard by the committee. The problem centres on when the unborn comes into being. Some would argue it is when an ovum is fertilised. However, great numbers of fertilised ova are lost in the natural course of things and never become implanted in the uterine wall. As a result some argue that implantation is the decisive event in the development of unborn life.

Professor Gerard Bury, President of the Medical Council, was asked if a doctor who prescribed the morning after pill would be acting unethically. He said:

> It currently is a part of normal practice that hasn't been challenged or, in fact, even addressed within the ethical guidelines. It is seen as normal practice.

Dr James Clinch, asked about use of the morning after pill, said:

> If you actually believe that there is a child there I don't think you will use the pill … if you don't believe there is a child there you will use it. And if you have doubts you will, in fact, go along with your doubts. So, I think that people who sincerely believe that there is a child there will not use it.

The Family Planning Act 1979 specifically prohibits the importation, sale and distribution of abortifacients. In as much as the morning after pill is available and prescribed the legal presumption must be that it is not regarded as an abortifacient. Reverend Father Paul Tighe, lecturer in moral theology and a representative of the Irish Catholic Bishops' Conference, when asked about the Roman Catholic Church's position in regard to the administration of the morning after pill after rape, said:

> In 1986, the British and Irish bishops' bioactive committee looked precisely at this issue and it examined the main form of morning after pill that was commonly administered in those circumstances [rape]. It said that the morning after pill could be effective in two ways: it could be effective by preventing conception occurring or it could also be effective by acting as an abortifacient by preventing implantation. It said that if, in the circumstances of rape, where an act of violence has been done and there is no obligation on a person to conceive, if the morning after pill could be taken with a safe expectation that it were likely to be effective as a contraceptive, then it was morally licit to do so – even if you could see that there was that risk, that side effect, that it could actually act as an abortifacient if the person were already pregnant. But if it were prudent in the circumstances to judge that it was being administered as a contraceptive measure, then that would be morally licit.

This test might reasonably be applied to all cases where emergency contraception is needed. In any event, the committee attaches importance to the general availability of the morning after pill. The availability of the morning after pill can help to reduce the number of crisis pregnancies. Any legal uncertainties that may exist in regard to it should be removed.

The committee received some evidence on the failure rate in condom use and on the effectiveness of condoms against some sexually transmitted diseases. Contraceptive services must, therefore, be based on scientific assessment and young people especially must be well informed on any risks involved in their use.

Given the complexities involved in this programme, the need for a single planning focus is evident.

b) *Options in crisis pregnancies*

The second part of the plan must seek to deal with the crisis pregnancies that will occur in spite of education and contraceptive services. In regard to crisis pregnancies, the state must ensure that options other than abortion are promoted. Before dealing with these options, however, it is necessary to deal with two elements which affect in a general way the perception of all the options – social understanding and counselling/information.

Social understanding A pregnancy develops into a crisis because of the personal, relationship and social issues that shape a woman's life at the time of her pregnancy. Women and Crisis Pregnancy describes the factors influencing the decisions of those women who decide to have an abortion. It found that women frame their decision making in the context of competing conflicts and demands on their lives.

The reasons women seek abortion were the subject of two major US studies by Dr Charles Kenny. The first important finding that emerged was that women seek abortion because they believe that their life will end if they have the baby. By that they do not mean physical life, but life in a broader metaphysical sense encompassing career and family prospects.

Popular attitudes and lack of understanding puts pressure on women with crisis pregnancies to opt for abortion. There is a need for a vigorous programme aimed at promoting a proper social understanding for women in crisis pregnancies. A second major finding of the US studies was that women who seek abortion acknowledge the reality that they are carrying a baby and that the foetus is a human being. Consequently, programmes of prevention directed at trying to convince women that the baby is human are misplaced and unnecessary – women already know that.

Another valuable component of a social understanding programme was presented to the committee by Professor Patricia Casey – the projection of positive images of motherhood. Professor Casey outlined an advertising campaign that was carried on national television stations in many states in the US. These advertisements were conducted from the perspective of the expectant mother. The advertisements painted a picture of the turmoil of the woman and then gave images of possibilities that exist for that woman. The advertisements projected the conviction that women can overcome the crisis and can go on to live positive, fulfilling lives if they choose the option of continuing the pregnancy. It appears from pre- and post-assessment studies that there has been a reduction in the numbers seeking abortion in jurisdictions where these advertisements were shown.

A social understanding programme needs a single planning focus to sustain it.

Counselling/Information The Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995 established an entitlement to receive counselling and information on abortion services available abroad. The Act stipulates that counselling must be non-directive and, where abortion is discussed, must also include a discussion of all other options. A range of agencies provide pregnancy counselling and some receive financial assistance from the Department of Health and Children towards the provision of such a service. Not all of these agencies will provide women with information on how to obtain an abortion.

In the area of counselling/information, general practitioners, with their special knowledge and geographical distribution, form an important element of the counselling/information network. The Irish College of General Practitioners (ICGP) produced an information booklet for general practitioners in 1995. The booklet says that, reflecting the reality in society at large, there exists amongst general practitioners a diversity of opinion regarding the issue of abortion outside the state and the dissemination of information toward that aim. The 1995 Act recognised an entitlement to seek abortion information and counselling and the right of doctors to refuse to co-operate in this process.

The booklet continues:

> However, GPs are united in their desire to help any woman with a crisis pregnancy. Quite apart from moral considerations abortion is medically undesirable and, with appropriate use of contraception, should be preventable. Yet the numbers seeking abortion in Britain does not appear to have fallen. Many women bypass their GPs when travelling for an abortion and receive no medical follow up afterwards. That is a situation which the vast majority of GPs would like to change.

In response to the *Women and Crisis Pregnancy* report the ICGP postgraduate resource centre recommended that the ICGP should:

- support the provision of a comprehensive family planning service within general practice
- support the provision of pregnancy counselling within general practice
- provide initial and ongoing education and training to facilitate the provision of these services
- provide appropriate assistance for provision of these services, in terms of patient education leaflets, posters, guidelines for doctors etc.
- support the establishment of inter-referral protocols to facilitate a comprehensive service within general practice
- examine ways in which GPs could convey to the public the range of services they are willing to provide
- examine ways in which the public can be informed of the confidentiality of the doctor-patient relationship.

The rights of doctors who have a conscientious objection to abortion or contraception are recognised and supported. They may exercise the legal right to inform women of their disagreement with or objection to abortion or contraception. This objection does not absolve the doctor from a duty of care for a patient distressed by a personal crisis.

However, counselling services do not seem to match the require-ments. The Green Paper observes:

> A number of submissions cite inadequate provision of current counselling services as contributing to the numbers having abortions. They say that many women receive no counselling before making a decision to have an abortion. There also appears to be a lack of clarity about the position of General Practitioners and agencies who do not provide counselling on all of the options. … Submissions seek the provision of a national network of non-directional crisis pregnancy counselling services which would be free of charge and available on request. Appropriate training of all staff involved in counselling is also considered a priority.

Women and Crisis Pregnancy found that thirty-three percent of women who had an abortion obtained information about the clinic which they attended from a source other than a doctor or agency in Ireland – in other words they did not use the counselling route at all. Another group attended their general practitioner, but not all doctors were willing to provide counselling, and some did not provide information on abortion as an option. The study found that charges and waiting periods for appointments with some counselling agencies acted as a disincentive. Women's expectations and requirements of the counselling agencies varied, ranging from seeking information only to seeking a full discussion on their pregnancy and all of the options which they should consider.

The study concluded that a significant number of women lacked information on the availability of counselling services and that many women decide on abortion without receiving any counselling. Many are unclear about the availability of counselling and the legal position on information and there was some dissatisfaction at having to undergo counselling as a prerequisite to information.

In their submission to the committee the organisers of the '5000 Too Many …' conference, Breda O'Brien and Professor Patricia Casey, raised other issues on counselling:

> Currently women who choose abortion do so almost immediately and resent what they perceive as the imposition of counselling. This implies a distrust of the counselling process. Research should be conducted as to the training and accreditation of counsellors. Deficiencies have already been shown, for example, in their understanding of present adoption practices
>
> Currently, the only model available is non-directive counselling. Some believe strongly that there is no such thing as non-directive counselling, only non-manipulative counselling. Would a more honest approach be to attempt to provide women and men with the clearest available information on surgical procedures, potential risk to physical and mental health, stage of gestation and so on?
>
> In this context, Right to Know laws such as passed in American states should be investigated. A mother must be

given state produced materials at least twenty-four hours before an abortion. These include pictures of foetal development, information about the nature of the medical procedure, its risks both physical and psychological, information about alternatives and lists of local social service organisations which provide assistance to pregnant women. At the moment, a woman receives medical information, if at all, just before she is required to sign consent for the operation.

Right to Know laws passed in Pennsylvania resulted in an eighteen percent drop in first time abortions.

Even in the case where a woman chooses abortion, receiving respectful care and counselling can decrease the risks of subsequent medical and psychological difficulties.

The Women's Health Council proposed the structural change of detaching information from counselling. They recommend:

- information on all crisis pregnancy options including abortion should be available. This will involve severing the link between compulsory counselling and accessing information on abortion
- accessible, free, unbiased pregnancy counselling services should be available throughout the country for all women
- a standard approach to the provision and content of both information and counselling services should be set up with accreditation, agreed codes of practice and evaluation built in. Although regulation has been introduced by the Department of Health (1995) on the dissemination of information on abortion no such directive has been issued for information on crisis pregnancy or counselling. For the reassurance of the prospective users the Department of Health and Children should ensure that crisis pregnancy information and counselling meets agreed standards
- crisis pregnancy counselling services should also be available to *women who are considering continuing the pregnancy.*

Women and Crisis Pregnancy pointed out that the most likely outcome of a crisis pregnancy is lone motherhood. Women facing lone parenthood have to devise and negotiate new strategies and they need practical and emotional support to adapt to this role. Current pregnancy counselling services are perceived by the majority of the women in the study as directed at women who are considering abortion or adoption.

The Council also gave its support to the Irish College of General Practitioners recommendation on the establishment of inter-referral protocols between general practitioners to facilitate a comprehensive service within general practice. The service includes pregnancy counselling. A system is necessary to distinguish those general practitioners who provide this service from those who have a conscientious objection to abortion or contraception.

As is clear from the above discussion, the counselling/ information element is also complex and will benefit from a single planning focus.

Lone motherhood In Irish society traditional culture expects pregnancy and motherhood to take place within the context of marriage. Non-marital births have been, and continue to be, of social concern. The proportion of non-marital births has been increasing. In 1980 five per cent of the total births were non-marital, whereas by 1997 over twenty-six per cent were. As the Green Paper says:

> However, while pregnancy and motherhood outside marriage have become more common and more acceptable, such acceptance is by no means widespread or unqualified. For many women there continues to be a social stigma associated with pregnancy outside marriage or a long-term stable relationship. There continues to be public debate about the growing proportion of births to unmarried mothers and whether it is in children's best interests to be brought up in a single-parent family. For a significant number of women with unplanned pregnancies, having a baby outside a marital or a long-term stable relationship is problematic, because of family, social, educational or career considerations.

Currently the majority of single mothers continue with their pregnancies and become lone parents, a very small percentage have their babies adopted, while thirty per cent of non-marital conceptions are aborted (*Women and Crisis Pregnancy*). The difficulties faced by women with crisis pregnancies who decide to take the option of single parenthood are presented in *Women and Crisis Pregnancy*:

> Expectant single mothers are especially vulnerable socially, financially and emotionally. They are heavily dependent on the support systems of partners and parents. Unlike women seeking abortion or adoption, many in this group did not find support agencies with services to match their needs as they prepared to become single mothers. The support of family and partner was crucial, however. Some women also found that they had to cope with the stigma attaching to non-marital pregnancy. Work or education arrangements had to be revised to take account of the pregnancy. The degree to which parental or partners' assistance with childcare arrangements was forthcoming had a bearing on the continuation of education plans. Those who remained in their jobs while pregnant were in better-paid, skilled positions, with maternity benefits and these women anticipated being able to afford private childcare.

Maureen Gilbert, an independent member of the Women's Health Council, told the committee that practical supports are necessary:

> I think the stereotypical image of a lone mother in a bleak block of flats struggling to bring up her child is seen to be not only very bleak for that mother but particularly bleak for the child and, therefore, is perhaps not the option that people want to choose, and equally the well documented links

> between lone motherhood and poverty and some notion that again you would not be just reducing yourself to a life of poverty but also reducing your child to a life of poverty.

The Women's Health Council, therefore, proposed that the negative image of single mothers should be addressed with practical programmes targeted to address economic and social factors. Economic and social policy development should reflect the reality that there is no longer always an adult working full time in the home. Statutory childcare provision, adequate social housing and access to training and educational programmes (providing childcare) are necessary to begin to change the way people view the social and economic conditions of the single parent.

Women and Crisis Pregnancy suggests that ongoing support and counselling should be available to alleviate demands and anxieties created by the pregnancy and anticipated motherhood and that educational and training institutions should support young pregnant women by encouraging them and facilitating them in every possible way to continue with their education. The committee heard of some of the difficulties in achieving the right balance in a programme of support for lone motherhood from Breda O'Brien, one of the organisers of the '5000 Too Many …' conference:

> We do not want to increase, inadvertently by trying to reduce the numbers of those seeking abortion, the numbers of lone parents because, unfortunately, the reality is that it is an indicator of poverty, it is an indicator for long-term dysfunction. So there's a very delicate balancing act here but I think it is one that could be tackled. We have the resources, we have the research and the people capable of doing it.

It was clear to the committee that the lone parenthood element also requires a multi-faceted programme and would benefit from a single planning focus.

Adoption Legal adoption was introduced to Ireland by the Adoption Act 1952. Adoption was a popular option where birth took place outside marriage in the decades which ensued. The practice peaked in 1967, when ninety-seven per cent of non-marital births were adopted. Since then there has been a decline. For example, in 1984 there were 898 children placed for adoption by health boards and registered adoption societies. By 1997 the number had fallen to 108.

The Green Paper suggests that a combination of factors has led to the majority of unmarried mothers now keeping their babies:

> These include more enlightened attitudes to births outside marriage, greater family acceptance and support, greater State supports, improved opportunities for combining career with single motherhood, some negative media coverage of adoption. The availability of abortion outside Ireland means that women who do not want to continue with a pregnancy may decide to have an abortion and this of course has also affected the number of babies being placed for adoption.

> One of the negative factors for a woman considering placing her baby for adoption is that she must carry the baby for nine months, give birth and then face the trauma of being parted from her baby. Because there is no statutory provision for 'open adoption' in this country, the birth mother must resign herself to the possibility that she may never see her child again.

Maureen Gilbert told the committee that what will give a child the best start in the world is a big factor in what path is chosen in a crisis pregnancy.

> At the moment, the view of adoption is quite ambivalent in this area, that on the one hand a mother may feel that by having her child adopted this will give the child the best start in the world, in another way she may feel she will be very much criticised for giving away her child and so on. So, I think it is a particularly tricky option and perhaps particularly at this time, where there has been so much discussion of it.

Professor William Binchy, representing the Pro-Life Campaign, referred to the development of new forms of adoption:

> Two things that were understandably very heartrending for the mother would be the secrecy aspect and the finality aspect of adoption, that it is goodbye to your child forever more and it is a total termination of relationship. The whole trend, legally speaking, internationally now is towards open adoption. Elements of this have crept into the Irish system slowly, breaking away the notions of secrecy for example, and the whole notion of the finality aspect can also in terms of goodbye to a child, never seeing the child again, that is the area where the heartrending pain came in. If those areas can be broken down and have a form of informal adoption which has been worked quite successfully – and incidentally has been part of the culture of many countries for generations but is increasingly coming into the English speaking countries – that would take away some of the anxieties that the choice involves in those circumstances.

Breda O'Brien pointed out that newer forms of adoption were very demanding in terms of resources:

> Open adoption or semi-open adoption demands much more resources because the adoption agencies are, basically, undertaking to keep two parties – the adoptive parents and the original birth parents – in contact for a minimum of eighteen years. That is obviously very demanding on everybody involved. Neither Professor Casey nor I would like to advocate that adoption would be a majority solution but that it could be a solution for more women than it is currently.

Women and Crisis Pregnancy indicated that women who intended to have their baby adopted viewed the issue in terms of their own

circumstances rather than those of potential adoptive parents. These women tended, on moral grounds, to have rejected abortion from the outset. They had also rejected lone motherhood at this stage of their lives, because of the unfavourable view they had of such a situation, which they considered would have entailed dependence either on their family or on social welfare. They also felt that they would have to forgo future educational and employment opportunities and that they were not in a position to cater for their child's emotional and financial needs at this stage of their lives. These women wanted to maintain secrecy about their pregnancy because they felt that if their pregnancy was disclosed they and their families would be stigmatised. Secrecy would allow them to make a decision about adoption without being influenced by others. They were accommodated by agencies which care for women who adopt. After the pregnancy they were able to return to their community without any substantial change in their identity.

The study found that there was a lack of information available to women about adoption and the availability of services which facilitate adoption, including residential homes. It also indicated that once women moved into a residential home setting they were usually unable to continue with work or training. The study found that there was a need for better counselling for the women and their families. It also found that the women had no specific knowledge about their rights or those of the putative father in relation to their children.

The committee concluded that adoption required a positive promotion and this promotion would benefit from a single planning focus.

c) *Post-abortion services*

There is much secrecy in relation to the experiences of the women who travel from Ireland to have an abortion abroad. From the evidence available it is clear that many of them never receive post-abortion counselling or a medical check up.

Medical check-up The Institute of Obstetricians and Gynaecologists in their written submission, stated:

> We recognise our responsibility to provide aftercare for women who decide to leave the State for termination of pregnancy. We recommend that full support and follow up services be made available for all women whose pregnancies have been terminated, whatever the circumstances.

The Irish College of General Practitioners in their training and information package, recommend that general practitioners should arrange a follow-up service for women who have consulted them two to four weeks after they have had an abortion:

> Post-abortion medical check-ups are also important, because of the possible risks to women's health, particularly their reproductive health, should any complications go

undiagnosed. Such a check-up also provides the opportunity for women to obtain advice on appropriate contraception for the future and thereby reduce the incidence of further unwanted pregnancies.

The Women's Health Council recommends that post-abortion check-ups must be easily available to women to protect their health and well-being. It should be clear to women who need them where they can go for post-abortion check-ups in a non-judgmental setting.

A medical check-up programme needs to be vigorously developed and promoted.

Post-abortion counselling The pregnancy counselling agencies which receive funding from the Department of Health and Children provide post-abortion counselling as part of their service and it is desirable that women who have had an abortion avail of this.

The organisers of the '5000 Too Many …' conference recommend that post-abortion counselling should be provided free, with due recognition of the psychological complications of the procedure.

A post-abortion counselling programme needs to be vigorously developed and promoted.

Drawing the plan together

Thus far the committee has been analysing the elements of a plan aimed at reducing the rate of abortions carried out on Irish women abroad. The committee examined the features of crisis pregnancy and the source of decisions to have abortions. The committee identified education and contraceptive services as essential *preventive measures.*

The committee then examined *options in crisis pregnancies,* where preventive measures failed. The Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995 obliges counsellors of women in crisis pregnancies to present in an objective and non-directive manner the options available to them. The committee analysed how options other than abortion can be made as attractive as possible. The committee analysed two elements that affect the choice of a woman in a crisis pregnancy: the general social understanding of her plight and her awareness of the counselling/ information services that are available. Hence there are four crucial elements in a policy on crisis pregnancy – social understanding, counselling/information, motherhood and adoption. Each requires a programme.

Finally, the committee examined the care that might be provided for those women who have chosen to have an abortion. The committee identified two elements in *post-abortion services:* post-abortion counselling and medical check-ups. Hence the third element of the plan – post-abortion services, would consist of two programmes, namely post-abortion counselling and medical check-ups.

Chapter Seven

The Views of the Committee

The committee agreed that

1 A major problem facing Ireland is the large number of crisis pregnancies which result in recourse to abortion facilities available in Great Britain.

2 There is an urgent need to take measures to reduce the number of crisis pregnancies.

3 Women in crisis pregnancy must be offered real and positive alternatives to abortion. There is an urgent need to take measures to reduce the rate of abortion.

The committee agreed on a strategy to reduce the number of crisis pregnancies and thereby reduce the rate of abortion. The strategy should offer women in crisis pregnancy real and positive alternatives to abortion and bring healing and comfort to those who have had abortions. The objectives of the strategy should be:

- to reduce the number of crisis pregnancies by the provision of preventative services
- to reduce the number of women with crisis pregnancies who opt for abortion by offering services which make other options more attractive
- to provide post-abortion services consisting of counselling and medical check-ups.

The strategic plan should be implemented through three major divisions with delivery programmes as follows:

- **Preventative measures**
  Education programme
  Contraceptive programme

- **Options in crisis pregnancies**
  Social understanding programme
  Counselling/information programme
  Single mother programme
  Adoption programme

- **Post-abortion services**
  Post-abortion counselling programme
  Medical check-up programme

A number of the elements of the plan are implemented by various government departments, state bodies and voluntary organisations at present. However, where everyone is responsible no one is

responsible. The committee believes that the complexity of the programmes and the co-ordination necessary for their success require a single planning focus.

An agency under the sponsorship of the Department of Health and Children should have responsibility for drawing up a plan to reduce the number of crisis pregnancies, agreeing plan targets, and ensuring the efficiency and effectiveness of the plan. The agency should present an annual report through the Minister for Health and Children to the Houses of the Oireachtas. This will ensure sustained political concern for the work of the agency.

Agency membership should be drawn from the departments and public bodies engaged in delivering elements of the plan – the Department of Health and Children (the sponsoring department), the Department of Education and Science, the Department of Social, Community and Family Affairs, the Department of the Environment and Local Government, the Health Boards, the Women's Health Council and An Bord Uchtála. The agency should have participation by the voluntary organisations involved in providing services for elements of the plan, parents, the teaching profession, the medical profession and a number of technical experts from such areas as sociology, communications and psychology.

The agency should have overall responsibility for the plan and its implementation. It should agree annual targets for each of the programmes and it should monitor progress.

Many of the programmes would be organised by existing state agencies and voluntary bodies. However, the agency would organise certain programmes where required. It would be responsible for ensuring that codes of practice exist for service deliverers, that codes of practice are adhered to, that confidentiality is ensured, that vulnerable clients are protected, that service deliverers have proper training and sufficient resources, that the reach of the programmes is national and that the programmes are accessible to everyone.

It is difficult for the committee to estimate the additional expenditure of the agency. Comparing it to other state-sponsored bodies with such functions as research and promotion, it would be reasonable to estimate costs at five million pounds per annum or fifty million pounds at current values for a period of ten years. This is the minimum period necessary to achieve the objectives of the plan. Programme costs already committed by other state and voluntary bodies would be additional to this expenditure.

The committee also agreed that

1 The experience with the 1983 and 1992 referendums on abortion showed the general difficulty of formulating referendum proposals on abortion. The ambiguities exposed in the committee's attempts to seek definitions of abortion and associated terms confirm the difficulty of finding terms that will secure certainty of meaning.

2 A constitutional ban on abortion which compromises medical practice or essential treatment to protect the life of the mother is unsafe; it would put the lives of expectant mothers at risk. The committee could not propose such a ban to the Oireachtas. Under the Constitution it is the responsibility of the Oireachtas to formulate, evaluate and agree all proposals for a referendum that are put to the people.

3 Issues of international law are raised in the Green Paper and in the conclusions of the United Nations' Human Rights Committee on Ireland's Second Report under the UN International Covenant on Civil and Political Rights. The Government should prepare a comprehensive public memorandum outlining our precise responsibilities under all relevant international and European Union instruments.

4 The committee heard evidence from the Institute of Obstetricians and Gynaecologists and accepts that in current obstetrical practice rare complications can arise where therapeutic intervention is required at a stage in pregnancy when there will be little or no prospect for the survival of the baby, due to extreme immaturity.

5 To base a legal strategy to ban abortion on an express distinction between direct and indirect abortions is, given the medical evidence, unsafe. Direct and indirect effect is an ethical principle which informs general medical treatment in Ireland. It forms a crucial element in the Medical Council ethical guidelines in this area. It would be unsafe to employ such an ethical distinction in express legal terminology. The distinction between direct and indirect in law might make the law less certain and thereby inhibit doctors from carrying out procedures they currently carry out. The interpretation of the principle by the courts might preclude treatment under current medical practice. Current medical practice as outlined by the Institute of Obstetricians and Gynaecologists envisages the unavoidable death of the baby resulting from treatment essential to protect the life of the mother. The masters of the three maternity hospitals in Dublin would regard the use of the direct/indirect distinction as restricting in some cases their ability to save the life of the mother in their current practice.

6 Clarity in legal provisions is essential for the guidance of the medical profession. Any legal framework should ensure that doctors can carry out best medical practice necessary to save the life of the mother.

In spite of this degree of consensus the committee found that no option of the seven canvassed in the Green Paper commanded unanimous support. Each of three approaches detailed below were found to command substantial but not majority support in the committee.

The first approach is to concentrate on the plan to reduce the number of crisis pregnancies and the rate of abortion and to leave the legal position unchanged.

The members of the committee advocating this approach believe that the first and most important question to be asked about every policy that addresses the issue of abortion is does it reduce the number of Irish women who have abortions abroad.

They believe that the plan outlined above in this chapter is the best and most practical measure that could be taken to reduce the number of Irish women who have abortions.

They also believe that the plan, and the estimated IR£50 million required over a ten-year period to implement it, represent the best and most likely way in which real and measurable change for the better can be effected. The plan may need further elaboration, and will need detailed and ongoing scrutiny of its implementation, but is the best way forward.

The implementation of a plan of this scale and complexity will require thought and energy. Those members of the committee supporting this approach believe that there is a high risk that concentration on constitutional and/or legislative measures to address the issue of abortion is likely to divert attention from the plan and therefore reduce the focus on it.

In addition, they contend that constitutional and/or legislative measures will have no actual impact on abortions carried out in Ireland because there are none.

Committee members supporting this approach are committed to the action plan set out in the report. They believe that a major advantage of that commitment to the plan is that it will deliver practical results and assistance to women in need. It does not require any constitutional or legislative change.

Previous experience has shown that campaigns to amend the law on abortion, however well meaning and reasonable their proponents, have been divisive. There is no reason to think that any future amendments will not be equally divisive. In addition, there is no guarantee that at the end of the campaign any proposed amendment will be approved by the people in a referendum.

Even if a suitable wording were drawn up, and then put to the people in a referendum and carried, it would still be open to judicial interpretation, as are all constitutional amendments.

As is known, while the 1983 amendment to the Constitution was carried by a two to one majority, it was subsequently interpreted by the Supreme Court in the *X* case in 1992 in a manner which would not have been anticipated by a large number of the people who voted for it.

The *X* case judgment has had no effect on current medical practice in Irish hospitals. No abortions are being carried out in the state because of a threat of suicide and Medical Council Guidelines would suggest that any doctor performing such an abortion could be guilty of professional misconduct.

The members of the committee favouring this approach do not favour legislation as proposed in the second approach. The judgment involved in the second approach of whether a particular threat of suicide is real is a subjective one. Moreover, Irish obstetricians have not acted on either of the two judgments made by the courts and show no disposition to do so in the future.

Members favouring this approach strongly believe that promoting measures to help Irish women choose to have full-term pregnancies rather than go abroad for abortions is the correct and most effective way forward.

Accordingly, as far as any proposals that a referendum to amend the Constitution should take place, they remain to be convinced that such an approach will work out in practice, as those promoting it would wish it to.

An approach similar to the third approach was attempted in 1992 when a proposal submitted by the government to the people was defeated by sixty-five percent to thirty-five percent in a referendum. In any event any such change would have no effect in practice on the rate of abortion for Irish women.

Against that background, while members who support this approach are willing to give a sympathetic hearing with as open a mind as possible to any proposals based on the third approach that may be produced in the Dáil and its committees, they remain to be convinced that it would work and are particularly concerned about the diversion of attention and resources from the package of measures envisaged in the IR£50 million action plan.

As yet no constitutional wording in support of the third approach has been provided. The members supporting the first approach are open to be convinced, however, and any detailed proposals and/or wording will be scrutinised by them constructively and with great care.

They believe that in the event of a referendum being held, the public must also be allowed to consider the issues with great care and therefore they regard it as essential if there is any such referendum that it take place on its own, and on a day when nothing else is being put to the people to vote on.

The second approach is to support the plan to reduce the number of crisis pregnancies, accompanied by legislation which will protect medical intervention to safeguard the life of the mother, within the existing constitutional framework.

The starting point in the debate must be the fact that Ireland has a significant abortion rate even though these abortions are not being carried out in Ireland. The issue of abortion in Ireland must be examined with some sense of reality. There is little point in concentrating resources and political energy on a divisive referendum campaign which would have little or no practical effect.

In this context the most significant approach our political system can take is to take measures to reduce the demand for abortion. In that regard the members of the committee who support this approach believe that the proposed plan to reduce demand for abortion will be a major practical contribution to the situation. In this regard this approach has all of the benefits of the first approach.

This approach concurs with the recommendations of the Constitution Review Group chaired by Dr TK Whitaker which concluded that legislation within the ambit of the existing constitutional framework was the only practical way forward.

This approach recognises that while of course all legislation must be interpreted by the courts, it is the duty of legislators to decide in the first instance what the law should be, consistent with the Constitution and with European and international law.

This approach ensures that no change is proposed to the existing test for lawful medical procedures, i.e. that the procedures are necessary by reason of a real and substantial threat to the life of the woman (including a risk of self-destruction as found in the *X* case).

As with the referendum approach, this legislation would re-state the prohibition on intentional termination of pregnancy, and would provide a defence along the lines of the above test. Such legislation could introduce appropriate safeguards on availing of the medical procedures concerned. Suicide would continue to be regarded as a possible threat to the life of the woman, as it is at present, and suitable requirements could be specified. Because the legislation would be consistent with existing constitutional rights, unlike the referendum approach, no constitutional amendment is necessary in order to underpin the legislation. This approach therefore provides a more comprehensive guarantee to protect women's lives than does the referendum approach.

This approach has regard to the reality that many thousands of women choose to avail themselves of the relatively liberal regime in the UK, and that there is little sense in embarking on a further constitutional referendum process which will have no impact whatsoever on this reality and will achieve nothing in practical terms. Furthermore there will be a substantial body of opinion opposed to an amendment to remove the existing constitutional right of a suicidal pregnant woman not to be required to continue her pregnancy regardless of the threat to her life.

The proponents of a restrictive referendum appear to have taken an absolutist position that the factual assessment made by the courts in the *X* case was incorrect and could never in fact occur. This conclusion appears to be insensitive to the possibility – if not probability – of such facts arising in individual cases.

Proponents of the referendum approach suggest that this approach is 'unregulatable'. However there is no evidence to support this conclusion. Strong safeguards already exist against improper practices, such as the Medical Council underpinned by a legislative disciplinary framework. Indeed members of the committee who favour this approach would support further legislative conditions as part of a series of safeguards which would be required in any event, whether this approach or the referendum approach were to be pursued. The criticism ignores the fact that the referendum approach itself contemplates lawful abortion.

The referendum approach takes as a starting point the suggestion that there are doubts about psychological measurement of the threat of suicide. However, proponents of the referendum approach go on to draw the unjustified conclusion, for which there is no evidence, that termination of pregnancy can never be required to protect the life of the mother from self-destruction. They then seek to insert this unjustified inference in the Constitution.

The members of the committee who favour the second approach believe that this approach is the only one which comprehensively ensures protection for the right to life of the mother, while at the same time protecting the rights of the unborn.

The third approach is to support the plan to reduce the number of crisis pregnancies, to legislate to protect best medical practice while providing for a prohibition on abortion, and consequently to accommodate such legislation by referendum to amend the Constitution.

The members who support this approach are in full agreement with the action plan, which offers women in crisis pregnancy real and positive alternatives to abortion and contains measures to reduce the rate of abortion.

However, the members who support this approach believe that it is essential to provide constitutional and legislative certainty in regard to current medical practice. They do not accept that the plan addresses the controversial issues raised in the hearings in relation to the interpretation placed upon the Constitution in the *X* case.

The present legal position involves the Eighth Amendment to the Constitution, a criminal statute of 1861, various judicial interpretations of these texts, and ethical guidelines issued by the Medical Council. It is obvious that these measures are not consistent with each other. Clarity in constitutional and legislative provisions is essential for the pro-tection of expectant mothers and the guidance of the medical profession.

Under this approach legislation should be enacted to protect existing medical practice. The legislation should restate the criminal prohibition on abortion. The legislation should provide that it would be a defence in any prosecution to establish that the actions in respect of which the prosecution was brought were taken by a doctor who was a registered medical practitioner and that the doctor in question had reasonable grounds to believe and did believe in good faith that the actions taken were essential medical treatment to protect the life of the mother. The territorial scope of this defence could be limited to public hospitals. The defence should require the doctor to defend and vindicate both the life of the mother and the unborn as far as practicable. Defences based on social, psychological, or psychiatric grounds (including suicide) would be prohibited.

The effect of such legislation would be to restate in strong terms the prohibition on abortion in Ireland, while at the same time protecting medical practice under tightly controlled legal circumstances. The express wording of the legislation mirrors the correspondence received by the committee from the Institute of Obstetricians and Gynaecologists.

A referendum to amend the Constitution would be necessary to establish a proper constitutional framework for this legislation because the proposed legislation would infringe the *X* case decision in certain respects. Since the proposal relates to matters of life and death upon which it is clear a substantial number of citizens wish to be consulted the proposed referendum would provide such an opportunity.

Under this approach the Constitution would require amendment to facilitate the proposed legislation. However any constitutional framework must supplement and clarify the current constitutional provisions rather than repeal them. Under this proposal the accompanying legislation removes the ambiguities and uncertainties of current interpretation.

The members who support this approach are unable to support the second approach of enacting legislation within the framework of the *X* case. In their view the proposed legislation would change the current practice of the medical profession and establish an unregulatable basis for abortion. It should be noted that the Green Paper points out that the current medical ethical guidelines would not be consistent with legislation which provided for the suicide option.

They are also of the view that physical conditions are capable of scientific measurement and therefore permit the type of calculation of risk which enables doctors to predict outcomes and base their decisions about treatment on scientific grounds. However, on the basis of the evidence given to the committee, they are not happy with the quality of psychological measurement where there is a threat of suicide. The members who support this approach believe that their conclusions on the suicide issue are compelling on the basis of what they heard at the hearings.

Appendices

Appendix I

Green Paper on Abortion
1999

Appendix I
GREEN PAPER ON ABORTION
1999

Green Paper on Abortion

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INTRODUCTION

Abortion is an issue which has been the subject of intense and, indeed, divisive debate in practically every society. Over the past fifteen years or so, this debate has been particularly intense and divisive in this country.

In 1983, following a vigorous campaign by a number of groups who felt that there should be a specific constitutional prohibition on abortion, an amendment was made to the Constitution which sought to give effect to that aspiration. There was, however, at the time the contrary view that the Constitution already contained sufficient safeguards in relation to abortion and that the amendment was unnecessary and could possibly lead to ambiguities. In 1992, a case, which has become known as the *X* case, came before the Supreme Court where it was decided that, under the Constitution, abortion is permissible in the State where the continuation of the pregnancy poses a real and substantial risk to the life, as opposed to the health, of the mother and where such a risk could not be averted except by means of an abortion. A substantial risk to the life of the mother included a risk of suicide. This decision and its implications have been vigorously debated.

The *X* case concerned a minor who became pregnant as a result of a criminal offence and both she and her parents wished her to have an abortion in England. Since the Abortion Act of 1967 in England and Wales, at least 95,000 women giving an address in this country have had abortions there. Following concerns raised by the *X* case and in the light of a ruling by the European Court of Human Rights in relation to the provision of information, amendments were inserted into the Constitution in 1992 which provided that the freedom to travel abroad should not be limited and that information on abortion services abroad should be obtainable in legally defined circumstances. At the same time, a proposed amendment to deal with the substantive issue of the *X* case but excluding the risk of suicide was rejected by the electorate. The implications of this case are discussed more fully in Chapter 2.

The current situation therefore is that, constitutionally, termination of pregnancy is not legal in this country unless it meets the conditions laid down by the Supreme Court in the *X* case; information on abortion services abroad can be provided within the terms of the Regulation of Information (Services outside the State for Termination of Pregnancies) Act, 1995; and, in general, women can travel abroad for an abortion.

There are strong bodies of opinion which express dissatisfaction with the current situation, whether in relation to the permissibility of abortion in the State or to the numbers of women travelling abroad for abortion.

Various options have been proposed to resolve what is termed the 'substantive issue' of abortion but there is a wide diversity of views on how to proceed. The Taoiseach indicated shortly after the Government took office in 1997 that it was intended to issue a Green Paper on the subject. The implications of the *X* case were again brought sharply into focus in November 1997 as a result of the *C* Case, and a Cabinet Committee was established to oversee the drafting of this Green Paper, the preparatory work on which was carried out by an interdepartmental group of officials.

While the issues surrounding abortion are extremely complex, the objective of this Green Paper is to set out the issues, to provide a brief analysis of them and to consider possible options for the resolution of the problem. The Paper does not attempt to address every single issue in relation to abortion, nor to give an exhaustive analysis of each. Every effort has been made to concentrate on the main issues and to discuss them in a clear, concise and objective way.

Submissions were invited from interested members of

the public, professional and voluntary organisations and any other parties who wished to contribute. It was hoped that the submissions would help to inform the Group about the matters which are of public concern, and to identify possible options for resolving them. There was an unprecedented response of over 10,000 submissions, with further petitions containing some 36,500 signatures. The Government would like to thank all of those who submitted their views. Some of the submissions were very detailed and the authors had clearly given considerable thought to the issue. A wide range of views was expressed on what is clearly a matter of great concern to many people, as well as one which involves a significant number of Irish women every year making a difficult and often lonely decision to have an abortion abroad. It is important to stress that the purpose of inviting submissions was to inform the process of the preparation of the Green Paper on the range of issues surrounding the debate on abortion and to obtain the views of individuals and organisations thereon and not to conduct a plebiscite or a weighing of public opinion on the course of action the Government should take. While mindful of the submissions received, the Government has been anxious to discuss the range of views and arguments contained in the submissions as a whole, unpalatable though some may be to many people.

Very few medical bodies or organisations made submissions. While the Government recognises that, as with society generally, members of these bodies have a range of views on the issue, it nonetheless considers that it would be helpful to have the benefit of the opinions and expertise of their memberships on the abortion issue.

The broad approach to the preparation of the Green Paper has been twofold. In the first place the constitutional and legal issues raised by the court cases referred to in the terms of reference, and the possible options for addressing these, are discussed. However, the Government has been concerned to recognise that the cases which were the subject of these legal proceedings were not representative of the majority of cases in which Irish women decide to travel abroad to have an abortion. A significant number of submissions placed the issue in a wider social context and the Green Paper also discusses factors which have been identified as coming within this category.

In Chapter 1 of the Green Paper the medical issues which arise in relation to the treatment of pregnant women and which form part of the debate on abortion are discussed. Chapter 2 deals with the legal issues raised by the courts' interpretation of the Constitution and the law in relation to abortion. Chapter 3 details Ireland's obligations under international and European Union law and considers what implications these obligations might have for constitutional or legal change in relation to abortion. Wider grounds for abortion are examined in an international context in Chapter 4. A summary of the issues raised in the submissions received is contained in Chapter 5. Chapter 6 discusses the social context of abortion. Possible constitutional and legislative approaches to addressing the issues identified in the Green Paper are discussed in Chapter 7.

TERMS OF REFERENCE

The text of this Green Paper has been decided by a Cabinet Committee established to oversee the work of an Interdepartmental Working Group whose task was to carry out the preparatory work on the Green Paper. The Interdepartmental Working Group had the following Terms of Reference:

> Having regard to:
>
> Section 58 of the Offences against the Person Act, 1861*;
>
> Section 59 of the Offences against the Person Act, 1861*;
>
> Article 40. 3.3 of Bunreacht na hEireann*;
>
> The decision of the Supreme Court on 5 March 1992 in the *Attorney General v. X and Others* [1992] 1 I.R. 1;
>
> Protocol No. 17 to the Maastricht Treaty on European Union signed in February 1992 and the Solemn Declaration of 1 May 1992 on that Protocol*;
>
> The decision of the people in the Referendum of 25 November 1992 to reject the proposed Twelfth Amendment of the Constitution;
>
> The decision of the High Court on 28 November 1997 in *A & B v. Eastern Health Board, Judge Mary Fahy, C and the Attorney General (Notice Party);*
>
> and having considered the constitutional, legal, medical, moral, social and ethical issues which arise regarding abortion and having invited views from interested parties on these issues, to prepare a Green Paper on the options available in the matter.

The Cabinet Committee was chaired by Mr Brian Cowen T.D., Minister for Health and Children and the other members were Ms Mary O'Rourke, T.D, Minister for Public Enterprise, Mr John O'Donoghue T.D., Minister for Justice, Equality and Law Reform, Mr David Byrne S.C., Attorney General (up to July, 1999), Mr Michael McDowell S.C., Attorney General (from July, 1999) and Ms Liz O'Donnell T.D., Minister of State at the Department of Foreign Affairs. The Working Group which assisted in the drafting of the Green Paper comprised officials from the Department of Health and Children, the Department of Foreign Affairs, the Department of Justice, Equality and Law Reform and the Office of the Attorney General.

CHAPTER 1
PREGNANCY AND MATERNAL HEALTH

Introduction

1.01 In developed countries the threat of death in pregnancy and childbirth has considerably diminished in recent times. While childbirth is not completely safe, maternal deaths have become very infrequent during the past two decades. Ireland has enjoyed low maternal mortality rates that are amongst the best world-wide and which reflect the excellent ante-natal and obstetric services available in this country. Maternal deaths in Ireland are now so infrequent, however, as to make it difficult to draw

*Relevant extracts are provided in Appendix 1.

conclusions as to the general causes of maternal death from Irish data alone and therefore international experience in this area is also drawn on in analysing the issue.

1.02 At a general level, the interpretation of the published literature review on the causes of maternal mortality in developed countries poses certain difficulties. Many papers are anecdotal and describe particular interventions, including termination of pregnancy which resulted in a successful outcome for the mother. Other studies, however, conclude that clinical conditions can be successfully treated by medical or surgical management without recourse to termination of pregnancy. It can be difficult to interpret the overall situation, with different countries with varied cultures using different medical criteria, evaluating different outcomes and probably utilising a variety of statistical analytical techniques.

1.03 It is particularly difficult to evaluate the anecdotal reports which specify situations where termination was performed to save the life of the mother because of the difficulty in ascertaining whether or not the termination was responsible for avoiding a maternal death or whether this was attributable to the appropriate clinical treatment. Individual patient circumstances differ and individual clinicians may differ in their approach as to the necessity of termination of pregnancy where the mother's life is considered to be at risk. While the vast majority of conditions in pregnancy are managed successfully, the international scientific literature documents situations where elective termination was performed to protect the life of the mother. This chapter summarises the results of the medical literature review and also reflects the diversity of views expressed in submissions to the Working Group from a number of health care professionals and organisations on many of the issues surrounding termination of pregnancy and related medical conditions.

Maternal mortality

1.04 A maternal death is one occurring during pregnancy, labour, or as a consequence of pregnancy after delivery. Deaths are usually divided into direct maternal deaths due to a complication of the pregnancy itself or indirect maternal deaths due to a complication not specific to pregnancy but aggravated by the physiological changes, for example, as may be seen in underlying cardiovascular disease. Maternal mortality rates are the number of maternal deaths per 100,000 total births. At the turn of the century maternal mortality was approximately 400 per 100,000 births but has fallen to less than 10 in developed countries. In recent years, the direct maternal mortality rate in Ireland was 2 per 100,000 which is amongst the lowest in the world.[1]

1.05 The major causes of death in pregnancy include haemorrhage, pre-eclampsia (hypertensive disease arising in pregnancy), amniotic fluid embolism, ectopic pregnancy, pulmonary embolus and infection. Indirect obstetric deaths include stroke and cardiac disease. The other causes of death in pregnancy are cancer, accidents and a variety of miscellaneous conditions, including therapeutic abortion itself, although this is very uncommon. A recent evaluation of maternal mortality in Ireland by the Institute of Obstetricians and Gynaecologists confirmed the low direct maternal mortality rate in this country.[2] While some information was incomplete, it was noteworthy that no deaths from ectopic pregnancy were recorded in the study. The authors also commented that the absence of a termination of pregnancy service did not appear to have significantly influenced Irish maternal mortality rates. They also noted the difficulties in making valid comparisons of maternal mortality across different countries and recommended further research which would also provide information on situations involving incidents in which the mother almost died.

Abortion trends

1.06 There are many significant complications of pregnancy, most of which do well with appropriate management. Therapy is often directed at obtaining foetal viability with subsequent induction of labour to reduce the risk to the mother. In countries where termination of pregnancy is available where the mother's life is considered to be at risk, medical indications to terminate pregnancy are usually based on individual decisions which take account of the seriousness of the disease, response to treatment and involvement of vital organs such as the heart, liver and kidneys.

1.07 Legalised therapeutic abortion was originally introduced with the stated objective of saving the life of the mother. However, there has been a gradual relaxation in legal restrictions in many countries over the past 30 years. In England and Wales, indications to terminate pregnancy now include situations where the mother's life is considered to be at risk, where there is the possibility of permanent injury to the physical or mental health of the mother or family of the pregnant women and where there is a substantial risk of serious handicap if the child were born. Abortion rates have risen steadily in England and Wales since 1968 and in 1996, according to information published by the Office for National Statistics, approximately 180,000 abortions were performed in England and Wales at a rate of 13 per 1,000 women of childbearing age[3]. Analysis of the stated grounds for abortions carried out on residents of England and Wales for 1996

1 Central Statistics Office – Vital Statistics 4th Quarter and Yearly Summary 1996-1997.

2 Jenkins DM; Carr C; Stanley J; O'Dwyer T. Maternal Mortality in the Irish Republic, 1989-1991 *Irish Medical Journal* 89(4): 140-1.

3 Office for National Statistics, United Kingdom. 1996 Abortion Statistics, Series AB No. 23, 1997: ix.

(the most recent year for which a detailed breakdown is available) reveals that 0.06% of abortions were performed on the sole ground that it was deemed that the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated. The principal categories involved were (i) neoplasms, (ii) mental and behavioural disorders, (iii) diseases of the circulatory system and (iv) other pregnancy, childbirth and the puerperal-related conditions. Of the 4,894 abortions carried out in England and Wales on Irish residents in 1996, 0.1% (5 procedures) were considered necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman or where the mother's life was at risk.

Maternal mortality and termination of pregnancy

1.08 Approximately 50% of women have a normal pregnancy where there are no ante-natal complications and a normal delivery occurs. The incidence of conditions which render a pregnancy 'not normal' differs according to the population and the practices of individual obstetricians. In the vast majority of cases, the outcome of pregnancy is good. However, in certain cases the risk of maternal mortality approaches a level where some clinicians consider that termination of pregnancy is necessary to protect the life of the mother. The information provided here also refers to the international literature because the incidence of severe life-threatening complications is low and Irish statistics in isolation are unlikely to reflect the complete situation. The medical causes which have been linked to therapeutic termination of pregnancy broadly include cancer, eclampsia, ectopic pregnancy and cardiac disease.

1.09 In Ireland there is no medical evidence to suggest that clinicians do not treat women with cancer or other illnesses on the grounds that the treatment would damage the unborn. The Medical Council's Ethical Guidelines 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.' These guidelines also state that 'refusal by a doctor to treat a woman with a serious illness because she is pregnant would be grounds for complaint and could be considered to be professional misconduct.' Some submissions made reference to the distinction between what is referred to as 'direct' and 'indirect' abortion. In what is described as 'direct' abortion, the primary intent is the termination of the pregnancy with the objective of preventing or treating the underlying maternal condition. In 'indirect' abortion the intervention is not directed at the foetus but rather at the treatment of a specific condition of the mother which as a secondary effect, results in the death of the foetus. In practical, clinical terms, the treatment of many cancers including cervical, uterine, ovarian and in addition treatment for ectopic pregnancy may result in the death of the foetus. This is in contrast to intentional termination of pregnancy, for example, in rare cases of cardiac disease where the mother's life may be considered to be at risk if the pregnancy continues. These clinical situations are considered in more detail below.

Cancer

1.10 Cancer in pregnancy is a relatively rare event and occurs in approximately 1 in 1,000 pregnancies[4]. In general the management of cancer in pregnant women involves a multidisciplinary approach, including the obstetrician, medical oncologist and surgeon. The therapeutic approach is usually similar to that in non-pregnant women, with some modifications made due to foetal considerations and informed maternal choices. The major malignancies complicating pregnancy include those of the breast, the reproductive tract and those of the haematological system.

1.11 Breast cancer is a common condition and approximately 2% of breast cancers occur in pregnancy. There has been a number of studies on pregnancy and breast cancer which conclude that, in general, the prognosis for pregnant women is similar to the non-pregnant population.[5, 6, 7, 8] It has been recommended that pregnant women with breast cancer should be treated in a similar fashion to non-pregnant women. Studies also suggest that termination does not improve overall survival.[9, 10, 11, 12, 13] Chemotherapy for breast cancer is used in pregnancy, however, it may sometimes result in the death of the foetus.

1.12 Invasive cancer of the female reproductive tract (e.g. cervix or uterus) especially in the first 20 weeks and invasive cancer of the ovary are both considered situations where the mother's life may be at risk and intervention which results in the death of the

4 Antonelli NM; Dotters DJ; Katz VL; Kuller JA. Cancer in pregnancy; a review of the literature. Part 1. *Obstetrical and Gynaecological Survey*. 1996 Feb; 51(2): 125-34.

5 Gallersberg MM; Loprinzi CL. Breast Cancer and Pregnancy. *Semin-Oncol* 1989 Oct, Vol:16(5):369-76.

6 Greene FL. Gestational Breast Cancer: a ten-year experience. *South-Med J* 1998 Dec, Vol:81 (12): 1509-11.

7 Scott-Conner CE; Schorr SJ. The diagnosis and management of breast problems during pregnancy and lactation. *American Journal of Surgery* 1995 Oct; 170(4):401-5.

8 Isaacs - JH. Cancer of the breast in pregnancy. *Surgical Clinics of North America* 1995 Feb; 75(1): 47-51.

9 Parente JT; Amsel M; Lerner R; Chinea F. Breast Cancer associated with pregnancy. *Obstet Gynaecol* 1988 June Vol:71 (6 Pt 1): 861-4.

10 Sorosky JL; Scott-Conner CE. Breast disease complicating pregnancy. *Obstet-Gynaecol-Clin. North-Am*. 1998 June; 25(2): 353-63.

11 Espie M; Cuvier -C. Treating breast cancer during pregnancy. What can be taken safely? *Drug – Saf.* 1998 Feb; 18(2): 132-42.

12 Ezzat A; Raja MA; Berry J; Zwaan FE; Jamshed A; Rhydderch D; Rostom A; Bazarbashi S. Impact of pregnancy on non-metastatic breast cancer: a case control study. *Clinical Oncology Royal College of Radiologists*, 1996; 8(6); 367-70.

13 Merkel DE. Pregnancy and breast cancer. *Seminars in surgical oncology – 1996* Sep-Oct; 12 (5):370-5.

foetus may be unavoidable.[14, 15, 16, 17] Because of the proximity of the foetus to the organs involved, it is not surprising that therapeutic intervention, especially in early pregnancy, may result in foetal death or damage.[18, 19] Ovarian cancer is extremely rare in the childbearing period but presents great problems in management since treatment may involve removal of the ovaries, tubes and uterus. Uterine cancer is also rare in pregnancy. In early cervical cancer, management may be conservative until after delivery of the foetus.[20, 21] In invasive cancer, radical treatment including hysterectomy, radiotherapy, or a combination of both, may be necessary to save the mother's life. In situations of advanced disease that is not amenable to removing the uterus, high dose radiotherapy may be administered which may be followed by spontaneous miscarriage. Hysterectomy and radiotherapy in these situations are administered with curative intent.

1.13 Haematological malignancies including leukaemia and lymphoma are relatively uncommon but can occur in pregnancy.[22] Chemotherapy is potentially curative for these malignancies, however the cytotoxic drugs involved may have a deleterious effect on the foetus.[23, 24] In early pregnancy this may result in a spontaneous miscarriage. Cytotoxic drugs may also cause significant congenital malformations in the foetus when given in early pregnancy. Radiotherapy is used to treat a wide variety of malignancies and is also associated with congenital malformations and mental handicap in certain situations. While precautions are taken to minimise these risks, radiotherapy and chemotherapy can adversely affect the foetus and on this basis therapeutic abortion has been offered to women in other jurisdictions.

1.14 There are a number of other cancers where therapeutic abortion has been described in the international literature, including meningioma.[25, 26] Case reports which describe a successful outcome, however, do not provide sufficient evidence that the outcome would be different if therapeutic abortion was not performed. The interpretation of such reports is that the circumstances rely on the judgement of individual clinicians, in consultation with the expectant mother, who would have considered termination of the pregnancy essential to protect the life of the mother.

Cardiac disease in pregnancy

1.15 While the incidence of maternal mortality in Ireland is very low, experience has shown that where such deaths do occur, cardiovascular disease is an important contributor to such mortality. The nature of heart disease in pregnancy has changed in recent years. The recent confidential enquiry into maternal mortality in the United Kingdom provides insight into the cardiac causes of death in pregnancy.[27] In general, most deaths due to cardiac disease occur during the pregnancy, however, some may occur after delivery. Acquired cardiac disease is now three times as common as congenital cardiac disease. Of the acquired cardiac diseases, rheumatic heart disease continues to decrease and in contrast there have been significant increases in deaths due to aneurysms and ischaemic heart disease. This is considered to be partially due to the average age of pregnant women being higher than heretofore. The enquiry did not speculate on deaths that may have been preventable by elective termination of pregnancy; however, it documented certain cases where termination of pregnancy was an issue. Other cases which may have been preventable included deaths from myocarditis and other miscellaneous cardiac problems.

1.16 The treatment of cardiac disease with pulmonary hypertension (Eisenmenger's Syndrome) in pregnancy has proven to be controversial. While this is an extremely rare condition, it is nonetheless associated with a very high mortality, many of these

14 van Vliet W; van Loon AJ; ten-Hoor KA; Boonstra H. Cervical Carcinoma during pregnancy: outcome of planned delay in treatment. *European Journal of Obstetrics, Gynaecology and Reproductive Biology*. 1998 Aug; 79(2):153-7.

15 Jones WB; Shingleton HM; Russel A; Fremgen AM; Clive RE; Winchester DP; Chmiel JS. Cervical carcinoma and pregnancy. A national patterns of care study of the American College of Surgeons. *Cancer*. 1996 Apr 15; 77(8): 1479-88.

16 Allen DG; Planner RS; Tang PT; Scurry JP; Weerasiri T. Invasive cervical cancer in pregnancy. *Australian and New Zealand Journal of Obstetrics and Gynaecology*. 1995 Nov; 35(4): 408-12.

17 Nevin J; Socters R; Dehaeck K; Bloch B; van Wyk L. Cervical Carcinoma associated with pregnancy. *Obstetrical and Gynaecological Survey*. 1995 Mar; 50(3):228-39.

18 Doll DC; Ringenberg QS; Garbro JW. Management of cancer during pregnancy. *Archives of Internal Medicine*. 1988 Sep; 148(9): 2058-64.

19 Iversen T; Talle K; Langmark F. Effect of irradiation on the feto-placental tissue. *Acta Radiological: Oncology – Radiation – Physics – Biology*. 1979; 18(2): 129-35.

20 Sorosky JL; Squatrito R; Nolubisi BU; Anderson B; Podczaski ES; Mayr; Buler RE. Stage 1 squamous cell carcinoma in pregnancy: planned delay in therapy awaiting fetal maturity. *Gynaecological Oncology*. 1995 Nov; 59(2): 207-10.

21 van der Vange N; Weverling GJ; Ketting BW; Ankum WM; Samlal R; Lammes FB. The prognosis of cervical cancer associated with pregnancy; a matched cohort study. *Obstetrics and Gynaecology*. 1995 Jun; 85(6): 1022-6.

22 Zuazu J; Julia A; Sierra J; Valentin MG; Coma A; Sanz MA; Batlle J; Flores A. Pregnancy outcome in [RATIO]hematologic malignancies. *Cancer*. 1991 Feb 1; 67(3): 703-9.

23 Requena A; Velasco JG; Pinilla J; Gonzalez-Gonzalez A. Acute leukemia during pregnancy: obstetric management and perinatal outcome of two cases. *European Journal of Obstetrics, Gynaecology and Reproductive Biology*. 1995 Dec; 63(2): 139-41.

24 Lishner M; Zemlickis D; Sutcliffe SB; Koren G. Non-Hodgkin's Lymphoma and pregnancy. *Leukemia and Lymphoma*. 1994 Aug; 14(5-6): 411-3.

25 Pliskow S; Herbst SJ; Saiontz HA; Cove H; Ackerman RT. Intracranial meningioma with positive progesterone receptors. A case report. *Journal of Reproductive Medicine*. 1995 Feb; 40(2): 154-6.

26 Sharif S; Brennan P; Rawluk D. Non-surgical treatment of meningloma: a case report and review. *British Journal of Neurosurgery*. 1998 Aug; 12(4) : 369-72.

27 Why Mothers Die: *Report on Confidential Enquiries into Maternal Deaths in the United Kingdom, 1994-1996*. The Stationery Office, 1998: 103-114.

deaths occurring at the end of the pregnancy.[28, 29] It has also been described in Ireland (Murphy and O'Driscoll, 1982).[30] While much is known about this condition, the mechanisms involved are unclear with the result that successful treatment can be difficult to achieve. The pulmonary hypertension can become so severe as to cause acute cardiac failure which can result in death.[31, 32] Medical opinion is divided as to the need for an elective termination of pregnancy in such cases. Some studies have demonstrated that with advances in intensive care treatments, it is possible to obtain foetal viability and early delivery without placing the mother's life at risk.[33, 34, 35] Clinicians consider that there is a high mortality from this condition and some recommend an elective termination of pregnancy to protect the life of the mother.[36, 37, 38] If intervention is delayed, termination of pregnancy may not result in a successful outcome. It is further considered that there may be a 'window' period from eight to sixteen weeks where early intervention in the form of a therapeutic termination is more likely to be successful before dangerous pulmonary hypertension has developed in the mother, with the associated high mortality for this condition.

Ectopic pregnancy

1.17 Ectopic Pregnancy occurs in approximately 1 in 100 pregnancies and can present in a variety of ways from local bleeding to major shock associated with circulatory collapse. Most ectopic pregnancies occur in the fallopian tubes but they can rarely occur in the abdomen and in the cervix. In very rare cases, ectopic pregnancy has progressed to the birth of a viable child. It is unusual for ectopic pregnancy to be permitted to continue beyond eight weeks' gestation, as the complications associated with this condition usually become apparent by this time.

1.18 The diagnosis and management of ectopic pregnancy has undergone significant changes in recent years. Non-invasive methods now enable a more accurate and early diagnosis of ectopic pregnancy than previously.[39] This has resulted in the clinical presentation of some cases of ectopic pregnancy changing from a life threatening disease with fallopian tube rupture, to a more benign condition, because of the earlier diagnosis that is possible.

1.19 The earlier diagnosis in turn has resulted in changes in the way in which this condition is managed. If the diagnosis is made early, it is possible to perform less radical surgery before the woman's condition has deteriorated and before the fallopian tube integrity is lost. In previous years, many women required surgery which involved removal of the ectopic pregnancy and the fallopian tube. Laparoscopic treatment of ectopic pregnancy is now available and considered to be safe, effective and results in lesser morbidity for women. The majority of ectopic pregnancies can now be managed in this way.[40, 41, 42] It enables a more conservative approach to treatment where it is possible to preserve fallopian tubal integrity so as to maintain reproductive capacity. Alternatives to surgical intervention are also under evaluation in other countries. Some women with unruptured ectopic pregnancy are considered suitable for medical treatment alone which involves the injection of medical agents either intramuscularly or into the gestational sac.[43, 44]

1.20 Active intervention may not be required in all cases because some early ectopic pregnancies result in tubal abortion or reabsorption. These represent a small percentage of ectopic pregnancies, however.

28 Oliveira TA; Avila WS; Grinberg M. Obstetric and perinatal aspects in patients with congenital heart diseases. *Revista Paulista DC Medicina*. 1996 Sept-Oct; 114(5): 1248-54.

29 Weiss BM; Atanassoff PG. Cyanotic congenital heart disease and pregnancy: natural selection, pulmonary hypertension and anaesthesia. *Journal of Clinical Anaesthesia*. 1993 Jul-Aug; 5(4): 332-41.

30 Murphy JF; O'Driscoll K. Therapeutic Abortion: The Medical Argument. *Irish Medical Journal*, August 1982, Vol 75, No 8 304-6.

31 Tahir H. Pulmonary hypertension, cardiac disease and pregnancy. *International Journal of Gynaecology and Obstetrics*. 1995 Nov; 51(2): 109-13.

32 Corone S; Davido A; Lang T; Corone P. Outcome of patients with Eisenmenger syndrome. *Archives des maladies du Coeur et des Vaisseaux*. 1992 May; 85(5): 521-6.

33 Chia YT; Yeoh SC; Viegas OA; Lim M; Ratnam SS. Maternal congenital heart disease and pregnancy outcome. *Journal of Obstetrics and Gynaecology Research*. 1996 Apr; 22(2): 185-91

34 Atanassoff P; Alon E; Schmid ER; Pasch T. Epidural anesthesia for cesarean section in a patient with severe pulmonary hypertension. *Acta Anaesthesiologica Scandinavica*. 1990 Jan; 34(1): 75-7.

35 Avila WS; Grinberg M; Snitcowsky R; Faccioli R; Da-Luz PL; Bellotti G; Pileggi F. Maternal and fetal outcome in pregnant women with Eisenmenger's syndrome. *European Heart Journal*. 1995 Apr; 16(4): 460-4.

36 Gleicter N; Midwall J; Hochberger D; Jaffin H. Eisenmenger's syndrome and pregnancy. *Obstetrical and Gynaecological Survey*. 1979 Oct; 34(10): 721-41.

37 Bitsch M; Johansen C; Wennevold A; Osler M. Eisenmenger's syndrome and pregnancy. *European Journal of Obstetrics, Gynaecology and Reproductive Biology*. 1988 May; 28(1): 69-74.

38 Sulovic V; Radunovic N; Krstic N. Eisenmenger's syndrome and pregnancy. *Jugoslavenska Genekologija 1 Opstetricija*. 1983 Sep-Dec; 25(5-6): 131-2.

39 Editor. The changing face of ectopic pregnancy. *British Medical Journal* Vol 315 19 July 1997.

40 Louis-Sylvestre C; Morice P; Chapron C; Dubuisson JB. The role of laparoscopy in the diagnosis and management of heterotopic pregnancies. *Human Reproduction*. 1997 May; 12(5): 1100-2.

41 Hidlebaugh D; O'Mara P. Clinical and financial analyses of ectopic pregnancy management at a large health plan. *Journal of the American Association of Gynaecologic Laparascopists*. 1997 Feb; 4(2): 207-13.

42 D'Mello M; Wingfield M. Laparoscopic Management of Tubal Ectopic Pregnancies – The Irish Experience. *Irish Medical Journal* August/September 1999 Vol 90 No 5.

43 Porpora MG; Oliva MM; De Cristofaro A; Montanino G; Cosmi Eu. Comparison of local injection of methotrexate and linear salpingostomy in the conservative laparoscopic treatment of ectopic pregnancy. Journal of the American Association of Gynaecologic Laparoscopists. 1996 Feb; 3(2) : 271-6

44 Alexander JM; Rouse DJ; Varner E; Austin JM JR. Treatment of the small unruptured ectopic pregnancy: a cost analysis of methotrexate versus laparoscopy. *Obstetrics and Gynaecology*. 1996 July; 88(1): 123-7.

Most are managed by therapeutic intervention involving termination of the pregnancy.

Eclampsia

1.21 Eclampsia in pregnancy is a condition that results in convulsions and is associated with high blood pressure and dysfunction of the kidneys. Its onset is preceded by severe headaches, dizziness, visual disturbances, preliminary twitchings and mental confusion which usually precede the convulsions. These conditions are successfully managed in the vast majority of cases. In very rare circumstances, the mother's condition can deteriorate rapidly, despite treatment, and termination of pregnancy is considered by many clinicians as justified to protect the life of the mother.[45, 46, 47, 48, 49]

Other conditions

1.22 There is a miscellany of rare medical conditions that have been associated with increased mortality in pregnancy. Some include rare conditions involving liver failure,[50, 51] renal failure[52, 53, 54] and systemic lupus disease.[55, 56] Others include hyperemesis gravidarum,[57] in exceptional cases of which the mother's condition may deteriorate with damage to the brain, liver and kidneys.

1.23 The majority of these clinical conditions respond to medical management and the foetus is subsequently successfully delivered. In exceptional cases the risk of maternal mortality is high and termination of the pregnancy has been a consideration.

Psychological disorder and pregnancy

1.24 Disorders of mental health can be divided into the psychoses, where the patient loses touch with reality, and the neuroses, where the patient's symptoms are quantitatively rather than qualitatively different. The neuroses include the anxiety disorders, depression, obsessional disorders and dissociative disorders (e.g. hysteria). Neuroses are relatively common and affect between 10-20% of women. Depression is a common, life-disrupting illness that can affect both sexes and all ages. The scientific literature suggests that depression can sometimes be difficult to recognise, with the consequence that some individuals do not receive adequate treatment.[58] Depression is one of the recognised predisposing factors to suicide. Psychoses are rare in pregnancy with an incidence of 1 to 2 per 1,000 births and include conditions such as schizophrenia and mania. Therapy of psychotic disorders is directed at identifying an underlying cause if present (e.g. an organic lesion) and the provision of the appropriate medical treatment. In the neuroses, medical treatment may be effective as well as the provision of appropriate counselling and mobilisation of social and supportive networks.

Suicide and pregnancy

1.25 Suicide in pregnancy is a rare event and the international literature provides additional information on this subject. Suicide accounts for approximately 1% to 5% of maternal mortality in developed countries. The incidence of suicide in pregnancy has decreased; in the first half of this century more than 10% of women of childbearing age who committed suicide were pregnant, compared to only 2% today. The 2% corresponds to one suicide per 500,000 births. It is more common in the puerperal (post-delivery) period. Factors which may increase the risk of suicide include psychiatric disorder, especially in those with recurrent episodes and hospitalisations and adverse social circumstances.[59]

1.26 The epidemiological information suggests that pregnancy protects against suicide and in a large UK study the rate of suicide in pregnancy was found to be only one-twentieth that of a similar matched

45 Chen FP; Chang SD; Chu KK. Expectant management in severe pre-eclampsia: does magnesium sulfate prevent the development of eclampsia? *Acta Obstetricia et Gynecologica Scandinavica*. 1995 March; 74(3): 181-5.

46 Hsieh TT; Kuo DM; Lo LM; Chiu TH. The value of cardocentesis in management of patients with severe pre-eclampsia. *Asia Oceania Journal Obstetrics and Gynaecology*. 1991 March; 17(1): 89-95.

47 Probst BD. Hypertensive disorders of pregnancy. *Emergency Medicine Clinics of North America*. 1994 Feb; 12(1): 73-89.

48 Sibac BM; Akl S; Fairlie F; Moretti M. A protocol for managing severe pre-eclampsia in the second trimester. *American Journal of Obstetrics and Gynaecology*. 1990 Sep; 163(3): 733-8.

49 Elliott D; Haller JS. Eclampsia: a pediatric neurologic problem. *Journal of Child Neurology*. 1989 Jan; 4(1): 55-60.

50 Howard EW 3[d]; Jones HL. Massive hepatic necrosis in toxemia of pregnancy. *Texas Medicine*. 1993 Mar; 89(3): 74-80

51 Alsulyman OM; Castro MA; Zuckerman E; McGehie W; Goodwin TM. Pre-eclampsia and liver infarction in early pregnancy associated with the antiphospholipid syndrome. *Obstetrics and Gynecology*. 1996 Oct; 88 (4 Pt2): 644-6

52 Pajor A; Lukacsi L; Bakos L; Lintner F; Zsolnau B. Pregnancy in women with chronic renal disease: a 14-year study. *Acta Chirurgica Hungarica* 1991; 32(2): 175-82.

53 Pertuiset N; Grunfeld HP. Acute renal failure in pregnancy. *Baillieres Clinical Obstetrics and Gynaecology*. 1994 Jun; 8(2): 333-51.

54 Davison JM. Pregnancy in renal allograft recipients: prognosis and management. *Baillieres Clinical Obstetrics and Gynaecology*. 1987 Dec; 1(4): 1027-45.

55 Minakami H; Idei S; Koike T; Tamada T; Yasuda Y; Hirota N. Active lupus and pre-eclampsia: a life threatening combination. *Journal of Rheumatology*. 1994 Aug; 21(8): 1562-3.

56 Nicklin JL. Systemic lupus erythematosas and pregnancy at the Royal Women's Hospital, Brisbane 1979-1989. *Australian and New Zealand Journal of Obstetrics and Gynaecology*. 1991 May; 31(2): 128-33.

57 Nelson-Piercy C. Treatment of nausea and vomiting in pregnancy. When should it be treated and what can be safely taken. *Drugs Safety*. 1998 Aug; 19(2): 155-64.

58 Mourilhe P; Stokes PE. Risks and benefits of selective serotonin reuptake inhibitors in the treatment of depression. *Drug Safety*. 1998 Jan; 18(1): 57-82.

59 Smith LB; Sapers B; Reus VI; Freimer NB. Attitudes towards bipolar disorder and predictive genetic testing among patients and providers. *Journal of Medical Genetics*. 1996 Jul; 53(7): 544-9.

non-pregnant population.[60, 61, 62] It is important, however, to exercise caution when interpreting the epidemiological data from other jurisdictions with different cultures and where legal abortion is available.

1.27 While mental health disorders including schizophrenia and severe depression occur in pregnancy, the literature suggests that their frequency is less than in the non-pregnant population. On the other hand, the social pressures and general stress involved may lead to suicide ideation in some women.[63] The vast majority of these resolve; however, this issue causes difficulties for the attending doctor. While there are a number of clinical and social factors associated with suicide, it has proved difficult to predict those women who actually commit suicide. A thorough assessment of the clinical, social and mental health status of the woman is made before initiating the appropriate therapy.[64] Underlying mental conditions are treated and an attempt is made to resolve any social problems that may be associated with the pregnancy. It is considered important that major life decisions should not be made while suffering from acute psychiatric illness.

Summary

1.28 The excellent ante-natal and obstetric services that are available in Ireland have resulted in maternal mortality rates that are amongst the best world-wide. Maternal deaths in Ireland are now so infrequent, however, that it is difficult to draw conclusions from Irish data alone and therefore the international literature has been examined. This information must be interpreted with caution, however, because of cultural and treatment differences and analytical difficulties relating to these international studies. The further problem of anecdotal case reports where it was stated that elective termination of pregnancy was performed, cannot answer whether maternal mortality was prevented solely on the basis of the termination. In general, the vast majority of conditions in pregnancy are managed successfully. However, the scientific literature does note situations where elective termination was performed to protect the life of the mother.

1.29 With regard to suicide and maternal mortality, the epidemiological evidence suggests a protective effect against suicide from pregnancy. Clinicians are concerned, however, that it is difficult to predict situations where the mother actually commits suicide. Clinicians undertake a thorough assessment of the situation and together with other health care professionals offer the appropriate medical, psychiatric and social intervention which is usually successful in resolving most suicide ideation, however, cannot guarantee a successful outcome in all cases.

60 Appleby L. Suicide during pregnancy and in the first postnatal year. *British Medical Journal.* 1991; 302:137-40.

61 Greenblatt JF; Dannenberg AL; Johnson CJ. Incidence of hospitalized injuries among pregnant women in Maryland, 1979-1990. *American Journal of Preventive Medicine.* 1997 Sep-Oct; 13(5): 374-9.

62 Marzuk PM; Tardiff K; Leon AC; Hirsch CS; Portera L; Hartwell N; Iqbal MI. Lower risk of suicide during pregnancy. *American Journal of Psychiatry.* 1997 Jan; 154(1): 122-3.

63 Gissler M; Hemminki E; Lonnqvist J. Suicides after pregnancy in Finland, 1987-94: register linkage study. *British Medical Journal.* 1996 Dec 7; 313(7070): 1431-4.

64 Schorr SJ; Richardson D. Psychiatric emergencies. *Obstetrics and Gynaecology clinics in North America.* 1995 Jun; 22(2): 369-83.

CHAPTER 2
THE LEGAL CONTEXT

Introduction

2.01 This chapter sets out the legal provisions governing abortion in Ireland. It describes the statutory provisions and examines the constitutional position before and after the enactment of the Eighth Amendment. It also examines the implications of the case of *Attorney General v. X* (the *X* case) and subsequent amendments to the Constitution. It also refers to the report of the Constitution Review Group and the more recent case of *A and B v. Eastern Health Board, Mary Fahy, C and the Attorney General* (the *C* case). Finally, existing medical practice and the Medical Council's *Guide to Ethical Conduct and Behaviour* are considered.

Statutory provisions

2.02 Two sections of the Offences Against the Person Act, 1861* are relevant to the question of abortion. The first of these, section 58, states:

> Every woman being with child who with intent to procure her own miscarriage shall unlawfully administer to herself any poison or noxious thing or shall unlawfully use any instrument or other means whatsoever with the like intent and whosoever with intent to procure the miscarriage of any woman whether or not she be with child shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing or shall unlawfully use any instrument or other means with the like intent, shall be guilty of felony ...

Section 59 states:

> Whosoever shall unlawfully supply or procure any poison or other noxious thing or any instrument whatsoever knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or not be with child, shall be guilty of a misdemeanour ...

These provisions were confirmed by section 10 of the Health (Family Planning) Act, 1979.

2.03 It should be noted that the Offences Against the Person Act, 1861 did not make the destruction of

*The provisions of the Offences Against the Person Act, 1861 now fall to be interpreted in the light of the judgment of the Supreme Court in the *X* case (see paragraphs 2.14 and 2.15).

the life of a child in the process of being born a criminal offence. It has been argued that the law on homicide applies only to born persons and the law on abortion only to foetuses in the womb and that therefore a child could be vulnerable at the time of birth. In England and Wales the Infant Life (Preservation) Act, 1929 and in Northern Ireland section 25 of the Criminal Justice (Northern Ireland) Act, 1945 were passed in order to ensure protection for the life of a child in the process of being born. There is no equivalent legislative provision in Ireland.

2.04 The meaning of section 58 was considered in England and Wales in *R v. Bourne* [1939] 1 KB 687. This case involved a fourteen-year-old girl who had become pregnant as a result of multiple rape. An abortion was carried out by Dr Bourne, who was then tried under the section. In his ruling, Macnaghten J. accepted that abortion to preserve the life of a pregnant woman was not unlawful. Furthermore, he ruled that, where a doctor was of the opinion that the probable consequence of a pregnancy was to render a woman a mental and physical wreck, he could properly be said to be operating for the purpose of preserving the life of the mother.

2.05 The *Bourne* decision has been relied upon in many other jurisdictions including Northern Ireland, Australia, Canada, New Zealand and the United States. In Northern Ireland cases relating to the interpretation of section 58 and 59 of the Offences Against the Person Act, 1861 have come before the courts in recent years. Details of some of these cases are contained in Appendix 3.

2.06 However, no court in this jurisdiction has relied on the *Bourne* judgment. In *Society for the Protection of the Unborn Child v. Grogan and Ors* (Unrep. March 6 1997, p. 7) Keane J. expressed the opinion that 'the preponderance of judicial opinion in this country would suggest that the *Bourne* approach could not have been adopted in this country consistently with the Constitution prior to the Eighth Amendment'.

2.07 There is some evidence of abortions and infanticide occurring in Ireland and of prosecutions under the Offences Against the Person Act, 1861, in particular during the mid-1940s, when wartime restrictions on travel between Ireland and England were imposed. No prosecution under the Act has taken place since 1974.

Abortion and the Constitution

2.08 Prior to the insertion of the Eighth Amendment in 1983, Article 40.3 of the Constitution stated:

> 40.3.1 : The State guarantees in its laws to respect and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen.
>
> 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.

2.09 The courts' judgements in a number of cases, in reliance upon these and other articles of the Constitution, suggest that the Constitution implicitly prohibits abortion.; see, *McGee v. Attorney General* [1974] IR 284; *Gv. An Bord Uchtála* [1980] IR 32; *Finn v. Attorney General* [1983] I.R. 154 and *Norris v. Attorney General* [1984] IR 36.

2.10 Terminology used in these cases includes 'the offence of endangering or destroying human life', 'the right to life', 'the right to be guarded against all threats before or after birth', 'the right to privacy of a pregnant woman does not extend to a right in her to terminate a pregnancy', 'the right to life is a sacred trust to which all the organs of government must lend their support' and 'the unborn child has a right to life and it is protected by the Constitution.'

2.11 Notwithstanding the statutory provisions and the *dicta* referred to above, it had become clear by the early 1980s that many who were opposed to abortion did not regard the existing provisions as adequate. It was argued that it was necessary to insert a specific article into the Constitution which would prohibit abortion. This was to avoid a situation where, by virtue of judicial interpretation of the Constitution or statute, abortion could be deemed lawful. In this context, the case of *Roe v. Wade* (decided by the Supreme Court of the United States) was cited. In this case the Court had ruled that a Texas statute prohibiting abortion other than to save the life of a pregnant woman violated a woman's constitutional right to privacy.

2.12 In a referendum held in 1983, the electorate voted to insert the Eighth Amendment into the Constitution. This became Article 40.3.3. It provides:

> The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect and, as far as practicable, by its laws to defend *and vindicate that right.*

2.13 Following this amendment, a number of cases came before the courts concerning its interpretation. These dealt largely with the provision of information on or referral to abortion services available in other countries. In 1986, the Society for the Protection of the Unborn Child obtained an injunction restraining two organisations, Open Door Counselling and the Dublin Well Woman Centre, from furnishing women with information which encouraged or facilitated an abortion. On appeal in 1988 and in *SPUC v. Grogan* I.R. 753, the Supreme Court held that it was unlawful to disseminate information, including the address and telephone number of foreign abortion services, which had the effect of facilitating the commission of an abortion. In 1992 Open Door Counselling and Dublin Well Woman Centre took a successful case under the European Convention on Human Rights, challenging the injunction which prevented them from disseminating information about abortion clinics outside the State (see Chapter 3, paragraphs 3.06 and 3.07 for further details).

2.14 The interpretation of the amendment was further

considered in the *X* case, which arose in 1992. 'X' was a fourteen-year-old girl who became pregnant as a result of an alleged rape. Both the girl and her parents wished to travel abroad so that she could have an abortion. The issue of having scientific tests carried out on retrieved foetal tissue so as to determine paternity was raised with An Garda Síochána. The Director of Public Prosecutions was consulted and in turn informed the Attorney General. An injunction was obtained *ad interim* to restrain the girl from leaving the jurisdiction or from arranging or carrying out a termination of the pregnancy.

2.15 In the High Court, Costello J. granted an interlocutory injunction in broadly similar terms and the case was appealed to the Supreme Court. A majority of the members of the Supreme Court held that, if it were established, as a matter of probability, that there was a real and substantial risk to the life, as distinct from the health, of the mother and that this real and substantial risk could only be averted by the termination of her pregnancy, such a termination was lawful. The Court accepted the evidence that had been adduced in the High Court that the girl had threatened to commit suicide if compelled to carry her child to full term and deemed that this threat of suicide constituted a real and substantial risk to the life of the mother. On this basis, the injunction granted by the High Court was lifted.

2.16 Some of the *dicta* of the majority in the Supreme Court also indicated that the constitutional right to travel could be restrained so as to prevent an abortion taking place in circumstances where there was no threat to the life of the mother. The right to travel *simpliciter* did not take precedence over the right to life.

2.17 The decision in the *X* case gave rise to a number of different concerns. One concern was that the Supreme Court had found that under Article 40.3.3 abortion could be lawful where it was necessary to avert a real and substantial risk to the life of the mother. There were concerns also about the possible abuse of suicide risk as grounds for obtaining an abortion. There were other concerns about the apparent willingness of the Court to grant injunctions to restrain persons from travelling abroad for the purpose of having an abortion. In November 1992 constitutional amendments were proposed to deal with different aspects of the judgment.

2.18 The first of these related to what was described as the substantive issue, that is the circumstances in which an abortion would be permissible within the State. The following wording was proposed as the Twelfth Amendment of the Constitution, as an addition to the existing Article 40.3.3:

> It shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life, not being a risk of self-destruction.

The wording put forward by the Government of the day indicated that it considered that there could be circumstances where an abortion was necessary to save the life of the mother but that these circumstances do not include the risk of suicide. This amendment was rejected. (See paragraphs 7.32-7.36 for further discussion.)

2.19 The second proposal, the Thirteenth Amendment of the Constitution, related to the issue of travel. The following wording was proposed:

> This subsection shall not limit freedom to travel between the State and another state.

This amendment was passed.

2.20 The third proposal related to the provision of information. The case-law confirming that the provision of information relating to abortion services was illegal has been noted above. However, although the issue was not addressed directly in the *X* case, it seemed to follow from the terms of the judgment that the dissemination of information relating to abortion in the circumstances outlined in that judgment would be lawful. In addition, developments at a European level (see paragraph 2.13 above) had made it desirable for the Government to clarify the position. The following wording was proposed for this, the Fourteenth Amendment of the Constitution:

> This subsection shall not limit freedom to obtain or make available, in the State, subject to such conditions as may be laid down by law, information relating to services lawfully available in another state.

This amendment was also passed.

2.21 Legislation was introduced in the form of the Regulation of Information (Services outside the State for Termination of Pregnancies) Act, 1995 which laid down by law, as contemplated by the recent 'information' amendment of the Constitution, conditions under which information relating to services lawfully available in another State might be made available within the State. This Act permits a doctor or advice agency to provide abortion information to pregnant women in the context of full counselling as to all available options and without any advocacy of abortion. Abortion referral is specifically prohibited under the Act. This legislation was referred to the Supreme Court by the President and its constitutionality was upheld.

Constitution Review Group

2.22 A Constitution Review Group was established in April 1995 with the following terms of reference:

> To review the Constitution and, in the light of this review, to establish those areas where constitutional change may be necessary, with a view to assisting the All-Party Committee on the Constitution, to be established by the Oireachtas, in its work ...

In the course of its deliberations the Group considered Article 40.3.3. In its report, produced in 1996,

the group discussed a number of approaches which are referred to further in Chapter 7, 'Possible Constitutional and Legislative Approaches'. An extract from the Report of the Constitution Review Group appears at Appendix 5.

Recent developments

2.23 Aspects of the law relating to abortion were considered in *A and B v. Eastern Health Board, Mary Fahy, C and the Attorney General,* High Court, 28th November 1997. This case involved a thirteen-year-old girl who had been raped and was pregnant as a result. The Eastern Health Board, which had subsequently taken the girl into its care, became aware that she was pregnant and, in accordance with the girl's wishes, obtained orders from the District Court allowing it to take the girl abroad for an abortion and to make all necessary arrangements for same.

2.24 C's parents sought to challenge these orders by way of judicial review. However, Geoghegan J. accepted that, where evidence had been given to the effect that the pregnant young woman might commit suicide unless allowed to terminate her pregnancy, there was a real and substantial risk to her life and such termination was therefore a permissible medical treatment of her condition where abortion was the only means of avoiding such a risk. In other words, the test formulated in the *X* case was applied in the *C* case also.

2.25 Although the decision in the *C* case was decided substantially along the same lines as the *X* case, Mr. Justice Geoghegan, in giving judgment, included remarks in relation to arguments addressed to him concerning the right to travel. This issue was not one on which he was addressed either by counsel for the State or for the Health Board. His remarks remain what lawyers term *obiter dicta,* i.e. statements made in the course of giving judgment which are not part of the reasons supporting the binding judgment of the Court. He stated:

> This amendment is framed in negative terms and must, in my view be interpreted in the historical context in which it was inserted. There was, I think, a widespread feeling in the country that a repetition of the X Case should not occur in that nobody should be injuncted from actually travelling out of the country for the purpose of an abortion. It must be remembered that three out of the five judges of the Supreme Court took the view that in an appropriate case a travel injunction could be granted. It was in that context, therefore, that the amendment was made and I do not think it was ever intended to give some new substantial right. Rather, it was intended to prevent injunctions against travel or having an abortion abroad. A court of law, in considering the welfare of an Irish child in Ireland and considering whether on health grounds a termination of pregnancy was necessary, must, I believe be confined to considering the grounds for termination which would be lawful under the Irish Constitution and cannot make a direction authorising travel to another jurisdiction for a different kind of abortion. The amended Constitution does not now confer a right to abortion outside of Ireland. It merely prevents injunctions against travelling for that purpose.

2.26 These remarks are problematic. The logical implication is that proceedings could be issued, for example under the Guardianship of Infants Act, 1964, in a case in which parents are in dispute with their minor daughter over whether she should travel for an abortion (or the parents themselves disagree on this issue) and that in these circumstances a Court should determine the issue by reference to the right to life of the unborn guaranteed in Article 40.3.3 and not by reference to the constitutional freedom to travel. It may be argued in the alternative that in such a case the freedom to travel should determine the issue.

Medical practice and the law

2.27 In view of the statutory and constitutional provisions regarding abortion outlined above, it is useful to consider whether these may have implications for medical practice. The medical profession operates under ethical guidelines issued by the Medical Council, the medical profession's regulatory body established under the Medical Practitioners Act, 1978. Any doctor found to be in breach of these guidelines is guilty of professional misconduct.

2.28 The guidelines currently in operation were issued by the Medical Council on 26 November, 1998 and superseded the previous document, published in 1993. The following is the text relevant to abortion:

> The deliberate and intentional destruction of the unborn child is professional misconduct. 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. Refusal by a doctor to treat a woman with a serious illness because she is pregnant would be grounds for complaint and could be considered to be professional misconduct.

2.29 From this wording it would appear that the Medical Council is relying on the direct/indirect distinction which is discussed in Chapter 1, 'Pregnancy and Maternal Health' and in Chapter 7, 'Possible Constitutional and Legislative Approaches'. This raises a question as to the ethical status of any medical treatment which involves the destruction of the foetus to save the life of a pregnant woman (including suicide risk, as in circumstances such as those of the *X* case). It also raises a question as to the powers of the Medical Council to strike a doctor from its Register in the event of a complaint of serious professional misconduct for carrying out an abortion in circumstances equivalent to those of the *X* case. Any such decision, of course, would have to be ratified by the High Court and it would clearly be open to a doctor whom the Medical Council wished to strike off to challenge any such decision in that Court.

2.30 Certain of the constitutional and legislative approaches discussed in Chapter 7 would clearly conflict with

the ethical position on abortion enunciated by the Medical Council. Other approaches might require some adjustment in that position.

CHAPTER 3
THE STATE'S OBLIGATIONS UNDER INTERNATIONAL AND EUROPEAN UNION LAW

Introduction

3.01 In considering the constitutional and legal options in relation to abortion, it is necessary to take account of Ireland's obligations under international and European Union law and to ascertain whether any of the options would run counter to these obligations. Of particular relevance in this regard are the obligations which the State has assumed in relation to the promotion and protection of human rights, notably the right to life and the right to privacy. Protocol No. 17 to the Treaty on European Union is also relevant and is discussed in this chapter. The chapter deals only with the State's legal obligations. It does not include consideration of the position adopted by Ireland in relation to abortion in the context of other international discussions which do not entail the assumption of a legal obligation by the State.

The European Convention on Human Rights

3.02 Principal among the State's international obligations are those which it has assumed under the European Convention on Human Rights.[65] The Convention guarantees a number of civil and political rights, including the right to life and the right to respect for private and family life. It is of great significance to any discussion of the law relating to abortion for two reasons.

3.03 First, the Convention provided for the establishment of two international bodies, the European Commission and the European Court of Human Rights, before which complaints of alleged violations by a state party of the rights protected by the Convention could be brought. A complaint could be brought in the first instance before the Commission which decided whether it was admissible or not. If a complaint was admissible, the Commission could subsequently express an opinion on whether or not there had been a violation of the Convention. Although the Commission's opinion was not legally binding on the parties, its interpretation of the relevant provisions of the Convention was of some weight. The complaints procedure under the Convention has very recently been streamlined and a new European Court of Human Rights established to replace the Commission and the earlier Court. Decisions of the new Court will be legally binding on the parties as were decisions of the 'old' Court,[66] and the Court's interpretation of the Convention rights is therefore of great importance, as it is the Court's interpretation which would be binding on Ireland in any case brought against it.

3.04 Secondly, the Convention has acquired a special status in EU law. For years the European Court of Justice has drawn on the Convention as a source of Community rights, and this position was confirmed in 1992 by the Treaty on European Union (the Maastricht Treaty). Article F(2) of the Treaty provides that the Union shall respect fundamental rights, *inter alia*, as guaranteed by the Convention, as general principles of Community law.[67]

3.05 At the outset, it should be stressed that both the Commission and the 'old' Court never had to decide whether the right to life protected by the Convention extends to the unborn. Nor was the Court asked to consider the compatibility of a particular case of abortion or the abortion law of a particular country with the provisions of the Convention. The high level of protection accorded to the unborn under Irish law was however taken into account by the Court in interpreting the scope of the right to freedom of expression under the Convention.

3.06 In the case of *Open Door and Dublin Well Woman v. Ireland*,[68] the applicants contended that restraints under Irish law on their freedom to impart and receive information concerning abortion facilities outside the jurisdiction of Ireland breached their right to freedom of expression as guaranteed by Article 10 of the Convention. Restrictions on freedom of expression are permitted under the Convention on specific grounds and conditions. Two of the grounds pleaded by the Irish Government were the protection of the rights of others – in this instance of the unborn – and the protection of morals. The Court recognised that the protection afforded under Irish law to the right to life of the unborn is based on profound moral values concerning the nature of life which were reflected in the stance of the majority of the Irish people against abortion as expressed in the 1983 referendum, and accepted that the restrictions in issue in the case pursued the legitimate aim of the protection of morals, of which the protection in Ireland of the right to life of the unborn is one aspect. In the light of this conclusion, it did not think it necessary to decide whether the term 'others' in the phrase 'the protection of others' extends to the unborn.

3.07 Having accepted that the restraints in question pursued an aim which is legitimate under the Convention, the Court had then to decide whether they were 'necessary in a democratic society' for the protection of morals. In this context the Govern-

65 Ireland ratified the Convention on the 25 February 1953.

66 Under Article 46 of the new text of the Convention (previously Article 53), the High Contracting Parties undertake to abide by the final judgment of the Court in any case to which they are parties.

67 The basic nature of this obligation will be reflected in a new paragraph 1 of Article F when the Amsterdam Treaty enters into force. The new paragraph provides that the Union is founded on a number of principles which are common to the Member States, including the principle of respect for human rights and fundamental freedoms.

68 Judgment of the Court, 29 October 1992, (1993) 15 EHRR 244.

ment argued that the Court should have regard to Article 2 of the Convention which guarantees the right to life, which right, they contended, extends to the unborn. The Court however observed that it was not being called upon to examine whether a right to abortion is guaranteed under the Convention or whether the foetus is encompassed by the right to life as contained in Article 2. The only issue it had to address was whether the restrictions on the freedom of the applicants to impart and receive information about abortion facilities outside Ireland was necessary in a democratic society for the legitimate aim of the protection of morals. While acknowledging that national authorities enjoy a wide margin of discretion in matters of morals, particularly in an area which touches on matters of belief concerning the nature of human life, the Court did not find that the test of necessity was satisfied and held therefore that Ireland had breached the applicants' right to freedom of expression under the Convention. The Court awarded damages of IR£25,000 to Dublin Well Woman, and costs and expenses to both corporate applicants.

3.08 Although the Court has not so far been asked to consider the compatibility of a particular case of abortion or the abortion law of a particular country with the provisions of the Convention, there have been several individual applications to the European Commission of Human Rights which concerned the abortion law of a Contracting State. While the applicants in these cases sought to invoke a number of provisions of the Convention, their main complaints were that a particular abortion or the law relating thereto infringed the right to life of the unborn or the right to respect for their private or family life.

3.09 It is clear from these cases that States Parties to the Convention enjoy a very wide margin of discretion in regulating abortion. However, it is not clear what limitations there may be to this discretion at both the liberal and the restrictive ends of the spectrum.

3.10 The Commission found that an abortion carried out at ten weeks in order to avert a risk of injury to the physical or mental health of the pregnant woman did not contravene the Convention.[69] It also held that an abortion carried out at fourteen weeks and authorised by two doctors who took the view that the pregnancy, birth or care for the child might place the woman in a difficult situation of life fell within the area of discretion left to States Parties in this matter.[70] On the other hand, it rejected a claim that the right to respect for private life requires a State to permit the termination of pregnancy upon request during the first twelve weeks.[71]

3.11 While the Commission did not adopt a position on whether the right to life under the Convention extends to the unborn, it expressed the opinion that, if the right extends to the unborn, the right is not absolute. It stated that:

> If [the right to life] were held to cover the foetus and its protection were, in the absence of any express limitation, seen as absolute, an abortion would have to be considered as prohibited even where the continuance of the pregnancy would involve a serious risk to the life of the pregnant woman. This would mean that the 'unborn life' of the foetus would be regarded as being of a higher value than the life of the pregnant woman ....

Such an interpretation, it found, would be contrary to the object and purpose of the Convention.[72]

Other human rights agreements

3.12 Other human rights agreements to which Ireland is party and which are of potential relevance in this context are the International Covenant and Civil and Political Rights,[73] the Convention on the Rights of the Child[74] and the Convention on the Elimination of All Forms of Discrimination Against Women.[75] None of these agreements, as presently understood, appears to place any limits on the freedom of States Parties to adopt whatever abortion régime they wish.

3.13 One of the obligations assumed by States Parties to the International Covenant on Civil and Political Rights is to report periodically to the United Nations on the measures they have adopted to give effect to the rights recognised in the Covenant and on the progress made in the enjoyment of the rights. Reports are submitted for consideration by the Human Rights Committee, a body of independent human rights experts established under the Covenant. Ireland submitted its first Report to the Committee in 1992, and during the Committee's consideration of the Report some members raised the issue of abortion. One member expressed the opinion that the question of the right to life of the unborn should be kept under constant consideration until such time as the Committee was in a position to pronounce on the issue. Ireland submitted its Second Report to the Committee in 1998, and reference is made in this Report to the establishment and composition of the Cabinet Committee and the Interdepartmental Working Group on Abortion.

3.14 Similarly there has been established under the Convention on the Rights of the Child a Committee which examines reports from States parties on the measures they have adopted to give effect to the rights recognised in the Convention and on the progress they have made in ensuring the enjoyment of these rights. Ireland submitted its first Report to the Committee in 1996. While mention is made in the Report of the constitutional protection of the

69 Application No. 8416/79, *X* v *United Kingdom*, admissibility decision of 13 May 1980, 19 *Decisions and Reports of the European Commission of Human Rights* (D & R) 244.

70 Application No. 17004/90, *H v. Norway*, admissibility decision of 19 May 1992, unreported.

71 Application No. 6959/74, *Brggemann and Scheuten* v. *Federal Republic of Germany*, admissibility decision of 19 May 1976, 5 D&R 103, and Report of 12 July 1977, 10 D&R 100.

72 *X v. United Kingdom*.

73 Ireland ratified the Covenant on 8 December 1989.

74 Ireland ratified the Convention on 21 September 1992.

75 Ireland acceded to the Convention on 22 December 1985.

right to life, including the right to life of the unborn, no express link is drawn between this and the definition of childhood.[76] Indeed the Convention itself leaves open the question of when childhood begins, but recognises that some legal protection for the future child should exist prior to birth.[77]

3.15 A Committee has also been established under the Convention on the Elimination of All Forms of Discrimination Against Women; and States Parties have undertaken to submit at certain intervals to the Secretary-General of the United Nations, for consideration by this Committee, a report on the legislative, judicial, administrative or other measures which they have adopted to give effect to the provisions of the Convention and on the progress made in this respect. Ireland has submitted three Reports to the Committee, the first in 1987 and combined second and third reports in 1997.

3.16 As its title indicates, the Convention is concerned with the elimination of discrimination against women and with the promotion of equality between men and women. It contains several explicit references to procreation and pregnancy and includes an undertaking that women be provided with appropriate services in connection with pregnancy and that women enjoy the same rights as men to decide freely and responsibly on the number and spacing of their children. Ireland has referred in its Reports to the legislative and constitutional provisions relating to abortion and to the relevant legislation on family planning services.[78]

Law of the European Union

Protocol No. 17 to the Treaty on European Union

3.17 In September 1991, the European Court of Justice decided in the case of *SPUC v. Grogan*[79] that abortion could constitute a service within the meaning of Article 60 of the Treaty of Rome. The case concerned the right of certain student organisations to distribute information on the identity and location of abortion clinics abroad. In answering the question asked of the Court whether a Member State could prohibit the distribution of information about abortion services in another Member State, the Court found against the student organisations, as the information was not distributed on behalf of an economic operator established in another Member State. However, one clear implication of the decision was that, had the information been distributed 'on behalf of an economic operator established in another Member State' by agencies having a commercial relationship with foreign abortion clinics or by the clinics themselves, a Member State could not prohibit the distribution of information in such circumstances. Protocol No. 17 to the Treaty on European Union was adopted to avoid the possibility of Community law overriding Article 40.3.3º of the Constitution should a conflict arise between this constitutional provision and Community law.

3.18 **Protocol No. 17** states:

> Nothing in the Treaty on European Union, or in the Treaties establishing the European Communities, or in the Treaties or Acts modifying or supplementing those Treaties, shall affect the application in Ireland of Article 40.3.3 of the Constitution of Ireland.

It would appear that, by virtue of the Protocol, the European Court of Justice should defer to Irish law in so far as there is a conflict between Community law and the application in Ireland of Article 40.3.3º of the Constitution; that, in effect, the Protocol takes measures relating to the application in Ireland of Article 40.3.3º out of the remit of the Community legal order.

3.19 In relation to possible amendment of Article 40.3.3º, the Protocol would seem not to restrict the power to amend the Article, as it seeks only to exclude Community law from affecting the application in Ireland of this constitutional provision. Any amendment would therefore be a matter for domestic law. However, the question has been raised whether an amendment would automatically obtain the benefit of the immunity from Community law provided by the Protocol. This is because it is unclear from the wording of the Protocol whether the Article 40.3.3º referred to in the Protocol is that which existed at the time of ratification of the Treaty on European Union or could include any later amendment of it. On the one hand, legal certainty would seem to require that our Community partners should only be bound by that version of Article 40.3.3º which existed at the time of the ratification of the Treaty. On the other hand, it could be argued that the intention of the Protocol was to leave these matters entirely to Irish constitutional law and that therefore any later changes to Article 40.3.3º are covered by the Protocol.

3.20 On 1 May 1992 the Foreign Ministers of Member States adopted a Solemn Declaration relating to the Protocol. Following the *X* case, the Government sought to amend the Protocol to ensure that Community law rights to travel and information are not limited by the Protocol. However, other Member States were reluctant to agree to the amendment of the Protocol, as they feared that this might set a precedent for the renegotiation of other aspects of the Treaty on European Union. Instead they agreed to a Declaration giving their legal interpretation of the Protocol. The Declaration states, *inter alia*, that:

> It was and is their intention that the Protocol shall not limit freedom either to travel between member States or, in accordance with conditions which may be laid down in conformity with Community law,

76 See paras. 104-111 and Chapter III of the Report, published by the Government Publications Office, 1996.

77 Some states made a declaration upon signature or ratification of the Convention giving their understanding of the personal scope of the Convention. For example, the United Kingdom lodged a declaration along with its instrument of ratification stating, 'The United Kingdom interprets the Convention as applicable only following a live birth.'

78 Combined Second and Third Reports, 1997.

79 Case C-159/90 [1991] E.C.R. I-4685

> by Irish legislation, to obtain or make available in Ireland information relating to services lawfully available in member States.
>
> ... the High Contracting Parties solemnly declare that, in the event of a future constitutional amendment in Ireland which concerns the subject matter of Article 40.3.3 of the Constitution of Ireland and which does not conflict with the intention of the High Contracting Parties hereinbefore expressed, they will, following entry into force of the Treaty on European Union, be favourably disposed to amending the said Protocol so as to extend its application to such constitutional amendment if Ireland so requests.

3.21 Subsequently, in November 1992, Article 40.3.3º was amended in order to protect the freedom to travel to and from another State and the freedom to obtain or make available in Ireland information relating to services lawfully available in another State.

3.22 Two implications have been drawn from the Declaration. First, that an amendment to the Constitution will not be covered by the terms of the Protocol, and so will not be immune from the effect of Community law, unless the other Member States, at Ireland's request, agree to amend the Protocol. Secondly, that the approval will only be forthcoming for an amendment which does not conflict with freedom to travel or to receive and disseminate information under Community law.

3.23 It is therefore far from clear what the present position is in relation to the Protocol and the Solemn Declaration as a matter of Community or international law. If only the original version of Article 40.3.3º of the Constitution is protected by the Protocol from being overridden by Community law, then the latter will prevail over any amendment of Article 40.3.3º which conflicts with Community law.[80] Should however any amended version of Article 40.3.3º be protected, then Ireland is free to make whatever, if any, amendment it wishes to this provision.

CHAPTER 4
OTHER GROUNDS FOR ABORTION, SET IN AN INTERNATIONAL CONTEXT

4.01 The Supreme Court decided in 1992 in the *X* case that abortion is permissible in Ireland under the Constitution 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. The Supreme Court also accepted that the threat of suicide constituted a real and substantial risk to the life of the mother.

4.02 Many of the submissions received by the working group take issue with the Supreme Court's judgement and argue in favour of a referendum to secure a prohibition on abortion in all circumstances. However some other submissions seek that abortion be allowed in wider circumstances than those determined by the Supreme Court in the *X* case. In this chapter other possible grounds for abortion are examined and set where possible in an international context. It may be helpful therefore to read this chapter in conjunction with Appendix 3, 'The Law Relating to Abortion in Selected Other Jurisdictions' from which the examples quoted here are taken and which contains in summary form information on the law on abortion in other EU Member States and in Australia, Canada, Malta, New Zealand, Switzerland and the United States of America.

4.03 The grounds cited in the submissions which seek provision for abortion in certain circumstances, in addition to saving the life of the mother, include (a) to preserve the woman's physical and/or mental health, (b) cases of rape or incest, (c) cases of congenital malformation of the foetus, (d) social and economic grounds and (e) abortion on request. In this chapter each of these grounds is considered with reference to the approach in other countries. The constitutional and legal implications of permitting abortion in any of these circumstances are considered in Chapter 7, 'Possible Constitutional and Legislative Approaches'.

(a) Physical/mental health of the mother

4.04 Many countries allow abortion where it is considered necessary to preserve the physical health of the mother. In general, 'physical health' is broadly defined. In many cases, the law does not specify the aspects of health that are concerned but merely states that abortion is permitted when it averts a risk of injury to the pregnant woman's health. In some countries, such as Spain and Portugal, the definition is narrower and applies only if there is a risk of serious and lasting damage to the woman's health.

4.05 Many countries' abortion laws also permit abortion on mental health grounds. 'Mental health' is generally interpreted quite broadly and can include distress arising from pregnancy resulting from rape or incest or from carrying a foetus where an antenatal diagnosis suggests a congenital impairment. It may also include distress arising from social factors such as income, career, number and spacing of existing children or other domestic or personal circumstances.

4.06 It should be noted that the application of abortion laws can be more liberal than the legislation itself might suggest, especially when the indications involve risk to health. In Switzerland, for example, the Swiss Penal Code prohibits abortion except for therapeutic termination of pregnancy on medical grounds, i.e. in order to avoid a danger to the woman's life or in the case of a serious, otherwise unavoidable danger of severe or lasting injury to

80 Article 29.4.5º of the Constitution provides, *inter alia*, that no provision of the Constitution prevents laws enacted, acts done or measures adopted by the European Union or by the Communities or by institutions thereof from having the force of law in the State.

her health. However in practice it would appear that many Swiss cantons have quite liberal abortion practices and psychosocial grounds now account for more than 95% of abortions in that country. This serves to illustrate that the wording of the grounds on which abortion is permitted may not be a reliable indicator of how these are interpreted in practice. In the absence of the availability of abortion for social reasons or on demand, the experience of other countries would suggest that abortion is commonly permitted on grounds of health and that this can result in high abortion rates. Another example is England and Wales, with an abortion rate in 1996 of 13 (calculated by reference to the number of abortions per thousand women aged between 14 and 49). Ninety-five per cent of all abortions there are carried out on the grounds that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman.

4.07 Countries vary as to certification and time limits. Most countries, such as England and Wales, require certification by one or two doctors at an approved hospital or clinic. While abortion is generally available during the first twelve weeks of pregnancy, some countries permit abortion later than this on grounds of physical or mental health. However some restrict abortions after twelve weeks to cases where risk to health is substantial. For example, in Belgium an abortion can be carried out only if two doctors agree that the woman's health is in danger and in Denmark an abortion after twelve weeks is available when necessary to avert serious deterioration to the woman's physical or mental health.

4.08 There has been considerable debate in Ireland about permitting abortion on physical or mental health grounds, in particular during the campaigns leading up to the 1983 and 1992 constitutional amendments. Those in favour of having explicit constitutional protection for the unborn did not consider that this would constrain doctors from treating a pregnant woman for any medical condition. In 1983 concerns were expressed by some who opposed the amendment that the proposed amendment could result in preventing or delaying doctors from giving necessary treatment to a pregnant woman to safeguard her health because such treatment would be potentially life-threatening to the foetus. Mental health was also raised as an issue, particularly in relation to cases where the pregnancy arose from rape or incest. In 1992 the wording proposed as the Twelfth Amendment of the Constitution was criticised by some for making a distinction between life and health and also for excluding suicide risk. The approach of the then Government was that it was necessary to ensure that termination of the pregnancy be permitted only where necessary to save the life of the expectant mother, excluding the risk of suicide. Deletion of the phrase 'as distinct from the health' would also in its view have made it possible to terminate the pregnancy where there was no risk to the mother's life. It was also pointed out that in other countries allowing abortion on grounds of 'risk of damage to health' has made abortion more easily available.

4.09 Some submissions argue that no distinction should be made between a woman's life and her health and that the term 'health' should include mental health. The majority of submissions, however, strongly reject the idea of allowing abortion on physical or mental health grounds.

(b) Rape/incest

4.10 As stated in Chapter 5 (paragraph 5.28), a number of submissions raise as a cause of concern the situation of women who are pregnant as a result of rape or incest. The law in many countries permits abortion where pregnancy has resulted from rape or incest. While both the *X* and the *C* cases involved minors who were pregnant following sexual assault, each case was determined on the basis of risk to life of the mother and not with reference to the circumstances in which she became pregnant.

4.11 Statistics on rape collected by the Gardaí and the Dublin Rape Crisis Centre are available. However it is difficult to gauge the extent to which cases of rape and incest may be under-reported and the actual number may be rather higher than the official statistics indicate. Likewise no information is available on the extent to which such cases result in pregnancy or the outcome of the pregnancy.

4.12 In 1998, 292 cases of rape were reported or known to the Gardaí. In the same year 18 cases of incest were reported.

4.13 Evidence suggests that criminal proceedings ensue in only some of the cases of rape and incest reported to the Gardaí. In 1997 the Working Group on Violence against Women stated that, for many women, their experience of the criminal justice system in such cases is difficult, often traumatic, and that this situation is not helped by the general perception that sentencing in rape cases is both inconsistent and lenient. That Group made a number of recommendations designed to encourage more women to report cases of sexual violence to the Gardaí.

4.14 Medical treatment offered to a victim in the immediate aftermath of rape includes prescribing emergency contraception. No detailed or comprehensive information is available on the extent to which women at risk of pregnancy from rape/incest avail of this option.

4.15 Rape Crisis Centres provide a range of counselling and therapy for victims of rape, sexual assault and child sexual abuse. Statistics produced by the Dublin Rape Crisis Centre for the period July 1997 to June, 1998 show that based on its client group, 36% of adult rape and 17% of child sexual abuse is reported to the Gardaí. The Centre's statistics show that 118 clients were identified as being at risk of pregnancy. Of these 21 (18%) became pregnant. Eight women continued with the pregnancy and kept the baby, one woman opted for adoption, five women ter-

minated their pregnancies, two women miscarried and the outcome is unknown in the case of five women.

4.16 Provisions in other countries in relation to abortion for rape victims vary. In some cases rape/sexual assault is not specified among the grounds on which an abortion may be permitted, but abortion is available on grounds of a threat to a woman's physical or mental health. In England and Wales the majority of abortions are carried out on grounds of physical or mental health. Some countries do however specify rape and/or incest as grounds for abortion but apply specific time limits and other criteria. In Finland, for example, if pregnancy is the result of rape, an abortion can be performed only if legal action in respect of the crime has been taken or if evidence of the crime has been obtained by police inquiry. In Germany abortion is permitted on grounds of crime, which apply if there are serious grounds for the assumption that the pregnancy is the result of a sexual assault. In Spain, a rape must have been reported to the police in order for an abortion to be permitted on these grounds.

4.17 Because many countries require that the case be brought to court or be reported to the authorities before permission for abortion can be granted, some women may be discouraged from opting for an abortion on these grounds and may instead seek an abortion on grounds of mental health, where this is available.

4.18 Submissions which oppose abortion in cases of rape/incest assert that to permit an abortion would be to add a second traumatic event to that which had already occurred and would not be beneficial to the woman. The argument is also made that the foetus should not be denied the right to life on account of the circumstances in which it had been conceived. Instead, it is argued, the woman should be encouraged to carry the pregnancy to term and, if she did not wish to raise the child, to place it for adoption. Concern has also been expressed that if abortion were permissible for victims of sexual assault, some women could falsely claim that they had been the victim of such assaults in order to obtain an abortion. It has also been argued that social support, and not the availability of abortion, is the most important single factor influencing rehabilitation after sexual assault.

4.19 An alternative view has also been put forward that coerced pregnancy does not impose an obligation on a woman to carry her pregnancy to term and that children and adolescents in such a situation are particularly vulnerable.

(c) Congenital malformations

4.20 A number of submissions seek that abortion be permissible on grounds of foetal impairment in cases of extreme abnormality or where the condition of the foetus is incompatible with life. Many others, however, express strong opposition to any such provision**.**

4.21 Many countries permit abortion on grounds of foetal impairment. Foetal impairment is sometimes referred to specifically, for example in England and Wales 'where there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped'. In other countries there is no specific provision in this regard. However, in some of these an abortion may be obtained on the grounds of adverse effect on the mother's mental health.

4.22 Congenital malformations/anomalies are a major cause of stillbirth, neonatal death and of physical and mental defects and metabolic disorders. Approximately 2% of new-born infants have a major malformation. The incidence may be as high as 5% if malformations detected later in childhood, including abnormalities of the heart, kidneys, lungs and spine, are included. Malformations are also common among spontaneous abortions.

4.23 There are many causes of congenital malformations. Approximately half are due to genetic abnormalities. In about 40% the cause is unknown and the remaining cases are due to chromosomal abnormalities, teratogens (anything capable of disrupting foetal growth and producing malformation) and other factors. Major malformations are structural abnormalities that have serious medical, surgical or cosmetic consequences. Minor anomalies which have no serious consequences however are common and affect approximately 4% of children. Abnormalities may be inherited (a chromosome defect or a gene flaw) or acquired which means that the embryo was initially normal but was damaged during its development by an injurious agent e.g. drugs, infection, irradiation or maternal metabolic disorder.

4.24 Examples of genetic abnormalities include achondroplasia (a condition causing dwarfism and hydrocephalus), cystic fibrosis and haemophilia. Other malformations include neural tube defects. These are among the more common birth defects. In Western Europe the incidence is approximately 5 per 1,000 births. There is a spectrum of neural tube defects ranging from minor defects to anencephaly. In anencephaly the brain fails to develop and the death rate is 100%, with most infants dying during delivery. Chromosomal defects account for a small percentage of abnormalities (approximately 1%). Down's syndrome is the most common chromosomal abnormality and is responsible for 30% of all cases of severe mental handicap. Its frequency is approximately 1 in every 700 births.

4.25 The identification of pregnancies that are of greater risk is a fundamental concept of antenatal care. This is achieved through a process of history taking, physical examination and screening. The purpose is to detect and treat any condition that puts the mother and baby at risk. Prenatal screening is also used to detect and assess possible congenital malformation. There are a number of prenatal diagnostic tests available. Common indications for prenatal diagnosis are advanced maternal age and a previous

child with either Down's Syndrome or neural tube defect. Amniocentesis is frequently used in the detection of these conditions. Other prenatal diagnostic tests include ultrasound and the use of cellular and biochemical markers to detect potential foetal abnormalities.

4.26 Estimates of the incidence of congenital abnormalities in Europe, which include statistics on induced abortions, suggest that induced abortions as a result of foetal malformations represented 14.8% of all reported congenital abnormalities in 1994. Induced abortions among pre-natally diagnosed cases of malformation were the most frequent in anomalies of the nervous system (anencephaly) and in chromosomal anomalies (Down's syndrome).[81]

4.27 In 1996 in England and Wales a total of 1,929 abortions were carried out under ground E, i.e. where there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped. Of these, 882 were terminated because of congenital malformations, 561 were due to chromosomal abnormalities and 486 were due to other conditions. In total they account for slightly more than 1% of all abortions carried out in England and Wales.

4.28 Terminations where a congenital abnormality is suspected are usually performed before 20 weeks gestation with a number of exceptions (usually 24 weeks). Authorisation of abortions on these grounds is usually given by one, two or a panel of doctors. In Belgium and France after the first trimester two doctors must agree that the foetus is believed to be seriously impaired. In Denmark authorisation is made by a committee comprising a social worker and two doctors. In Finland an abortion on grounds of foetal impairment must be authorised by the State Medical Board. In England and Wales, in common with the other statutory grounds under which abortion is available, the abortion must be certified as justifiable by two registered medical practitioners, while in Spain authorisation involves two specialists of an approved public or private health centre neither of whom is the doctor performing the abortion or under whose direction the abortion is to be performed.

(d) Economic or social reasons

4.29 Some countries permit abortion under certain social or economic conditions. Most of these refer to social and economic stresses and environment in general, while some detail the social and economic conditions where abortion may be permitted. In France and Belgium the inclusion of social and economic grounds may be inferred in that abortion is permitted when a woman is 'in a state of distress because of her situation'. Abortion in such circumstances is permitted up to ten weeks in France and during the first trimester in Belgium. In other countries social conditions are closely related to mental health. The law in Luxembourg refers to the living conditions that may result from the birth of the child and considers them as grounds for abortion during the first twelve weeks when they are likely to endanger the physical or mental health of the pregnant woman. In Italy the law specifies that the economic, social and family situation must be taken into account in determining if continuation of the pregnancy or childbirth would seriously endanger the physical or mental health of the pregnant woman. Abortion is permissible on these grounds during the first trimester.

4.30 Different countries have different arrangements in this regard. Most provide for a procedure whereby the woman is informed of the risks attached to the procedure (Belgium and France) and the alternatives to abortion (Belgium and France and Italy). In Belgium the woman is the sole judge of whether she is in distress. In France, in addition to the consultation with the doctor, the woman must consult with a social worker or family counsellor about the abortion and if she still wishes to proceed she must renew her request in writing, not sooner than one week from the time of the first request. Belgium, Luxembourg and Italy also insist on a similar waiting period.

4.31 It would appear that, in general, where abortion is permitted on economic and social grounds the law tends to be interpreted in a liberal way. It may be worth noting, however, that other constraints may act to reduce access to abortion for some women. In Italy, for example, abortion is available during the first trimester on economic or social grounds. However in practice it would appear some women experience difficulties in accessing services, possibly because of conscientious objections by physicians and other health care professionals.

(e) Availability on request

4.32 The major difference between laws permitting abortion on social and economic grounds and those permitting abortion on request is that in the former a set procedure must be followed which includes certification and justification of the abortion, whereas in the latter a woman is granted an abortion if she requests it. In practice there may be little to choose between the two in terms of access and the difference may be purely in terms of the philosophical orientation of the law. Examples of countries in which abortion is available on request are Sweden (up to eighteen weeks), the Netherlands (up to thirteen weeks) and Denmark (up to twelve weeks). In Sweden, for pregnancies between twelve and eighteen weeks gestation the woman is required to discuss the situation with a social worker. In the Netherlands, a five-day waiting period is required between the initial consultation and the performance of the abortion while in Denmark the woman must submit an application and be informed of the risks involved in the procedure and of other alternatives to abortion.

81 Eurocat Report 7, *15 years of Surveillance of Anomalies in Europe 1980-1994*. Brussels 1997.

Summary

4.33 This chapter sets out other possible grounds for abortion and where possible in an international context. The grounds range from circumstances in which an abortion is permissible only to save the life of the mother to countries where abortion is available on demand. It appears that the numbers of women who seek abortions because of threat to life, rape/incest and foetal impairment are relatively small, with the vast majority of abortions taking place on grounds of risk to the mother's physical/mental health or social/economic grounds. In the Irish context recent research, including the 'Women and Crisis Pregnancy' study, has found that the majority of Irish women seek abortion for so-called 'social reasons'. These are discussed in Chapter 6, 'The Social Context'.

4.34 It is also worth noting that interpretations of laws can vary considerably. For example, a law which may appear on paper to be restrictive may in practice operate in a much more liberal way. The opposite may also occur. A country may have apparently liberal laws but other factors, for example the operation of a conscience clause for medical and other personnel, may limit women's access to the service.

4.35 Where abortion is available on a range of grounds, analysis is difficult, since a woman may seek an abortion on the most easily accessible ground. For example, if proof of a rape is required, it may be easier for a rape victim to obtain an abortion on grounds of physical or mental distress, if this is available.

CHAPTER 5
THE SUBMISSIONS TO THE INTERDEPARTMENTAL WORKING GROUP

Overview

5.01 As part of the process of preparation of the Green Paper, advertisements were placed in the national and provincial newspapers, inviting interested parties and organisations to submit their views on the matters referred to in the Working Group's Terms of Reference. The purpose of inviting submissions was to inform the process of preparation of the Green Paper on the range of issues surrounding the debate on abortion and to obtain the views of individuals and organisations thereon and not to conduct a plebiscite on the course of action the Government should take.

5.02 Approximately 10,000 submissions were received in response to the advertisements. A wide diversity of issues was raised in the submissions and this chapter sets out the main ones. Submissions were received from a wide range of organisations (these are listed in Appendix 4) and from individual members of the public. The vast majority of submissions expressed a wish for a referendum which would seek to achieve an absolute prohibition on abortion. While mindful of the weight of submissions which expressed a desire for a constitutional ban on abortion, the Government has been anxious to discuss the range of views and arguments contained in the submissions as a whole.

5.03 While it is difficult to provide in summary form the full flavour of the submissions received, every effort has been made accurately to reflect their thrust and content. In order to provide an overview, the analysis of the submissions has been grouped under five broad categories: Medical, Ethical/Moral, Social, Constitutional/Legal and Other Issues. It is hoped that every individual and body who made a submission will find that the points they made are reflected in this summary, even if it has not been possible to detail each and every argument made. **It should be understood that the inclusion of a particular argument or statement in this chapter does not indicate that the Cabinet Committee is in agreement with it.**

5.04 In addition to the submissions seeking the amendment of the Constitution to achieve an absolute prohibition on abortion, the Working Group also received petitions containing some 36,500 signatures, all of whom sought a total ban on abortion. The submissions dealt with a wide range of issues relating to abortion and showed that the debate about abortion is a complex one, with many people holding firm views on the issue. It is clear that many Irish people regard abortion with abhorrence, whatever the circumstances. This view is apparent from the submissions made to the Working Group, both from individuals and organisations. The main considerations underlying this view are:

There is no medical condition which would necessitate the termination of pregnancy in order to save the life of a pregnant woman with a life-threatening illness;

Once conception has occurred, a future human being is developing and any intervention to terminate this process is wrong;

Abortion is tantamount to murder;

Human life is sacred from the time of conception;

To permit abortion in certain defined circumstances would gradually lead to its ready availability.

5.05 There are others who are disposed to permitting abortion in certain circumstances. The main views advanced in this regard include:

Termination of pregnancy should be available in Ireland in accordance with the decision of the Supreme Court in the *X* case;

Termination of pregnancy where a woman's life or health is at risk is not wrong and should be available in Ireland;

Termination of pregnancy in cases of rape or incest or certain abnormalities of the foetus should be permissible;

> Each woman has the right to control her body and reproductive system and the State should not seek to limit this right;

Medical issues

5.06 The medical context of abortion as set out in the submissions includes the following:

- medical conditions which pose a risk to the life of the pregnant woman
- physical health
- mental health
- sexual assault (rape and incest)
- foetal abnormalities
- medical and psychiatric consequences of abortion
- methods of termination

Medical conditions which pose a risk to the life of the pregnant woman

5.07 Two very different schools of thought emerge from the submissions in relation to medical conditions which pose a risk to the life of the pregnant woman. It is argued in many submissions that direct abortion is **never** necessary to save the life of the mother. Some make a distinction between what they term 'direct' and 'indirect' abortion, 'indirect' abortion being where a woman receives medical treatment which results, as a secondary effect, in the death of the foetus. They point out that such medical treatment is not regarded as abortion under ethical guidelines of the Medical Council. (The concept of 'direct' and 'indirect' abortion is discussed in Chapter 1, paragraph 1.09, and is also adverted to in Chapter 7, paragraphs 7.17-7.24).

5.08 Submissions, including those from medical practitioners, which are totally opposed to any form of intentional abortion do not regard those procedures currently accepted under existing medical ethics as abortions. Others, however, are concerned that an absolute constitutional ban on abortion might be regarded as encompassing these procedures unless they are specifically exempted.

5.09 Other submissions, including some from individual medical professionals, indicate that, in their view, there are medical conditions where termination of a pregnancy may be necessary to save a woman's life – for example, where a pregnant woman suffers from certain cardiac diseases or severe pre-eclampsia in early pregnancy.

5.10 Submissions which express opposition to abortion quote statistics which show that Ireland has one of the lowest maternal mortality rates in the world. Examples of statements made are:

> In the most recent seven-year period for which figures are available, 1984-1990, the maternal mortality rate in Ireland has been consistently lower than that reported in England and Wales.
>
> In the National Maternity Hospital there have been in excess of 36,000 confinements during the five-year period ending in December, 1996 without a single maternal death.
>
> In 1982 a review of all maternal deaths in the National Maternity Hospital over a ten- year period revealed that there were 21 maternal deaths from a total of 74,317 births. Analysis of the cause of death in each case led the authors of the study to conclude that the availability of induced abortion would not, in any way, have reduced the number of maternal deaths over the study period. A more recently published 1996 countrywide study of maternal mortality in Ireland between 1989 and 1991 revealed five direct maternal deaths arising from 157,752 births giving a rate of 3.2 per 100,000.

5.11 Some submissions also refer to a statement issued in 1992 by a number of prominent obstetricians/gynaecologists, to the effect that there are no medical circumstances justifying direct abortion, that is, no circumstances in which the life of the mother may only be saved by directly terminating the life of her unborn child.

5.12 Many submissions quote the ethical guidelines issued by the Medical Council in 1993, which state '...that the necessity for abortion to preserve the life or health of the sick woman remains to be proved....' Some also note that this position was later endorsed by the Irish Medical Organisation. The most recent set of ethical guidelines, issued in November 1998, is adverted to in Chapter 1, 'Pregnancy and Maternal Health', Chapter 2, 'The Legal Context' and in Chapter 7, 'Possible Constitutional and Legislative Approaches'.

5.13 Other submissions cite a letter published in the press during the 1992 referendum campaign and signed by 31 consultant obstetricians/gynaecologists who opposed the then Government's proposed wording for a constitutional amendment on the substantive issue of abortion, on the grounds that it would ultimately allow termination of pregnancy for a wider range of conditions than that acknowledged by the Government. The letter cited cardiac and hypertension cases successfully treated in Dublin maternity hospitals without any maternal deaths.

5.14 Attention is drawn to the abortion statistics for England and Wales, which indicate that only a very small percentage of abortions are carried out to save the life of the mother or to prevent grave permanent injury to the physical or mental health of the woman.

5.15 On the other hand, other submissions state that continuation of pregnancy may in a small number of cases pose a grave risk to a woman's life. While acknowledging the excellent medical care available in Ireland and the low maternal mortality/morbidity rates, these submissions contend that these figures do not take account of the fact that a very small number of women with a life-threatening condition may in fact be travelling to England and Wales for abortions. The following conditions are mentioned as ones where induced abortion may be indicated in certain circumstances: cancers of the breast and female reproductive tract, leukaemia and lymphoma, heart disease, hypertension/pre-eclampsia and Eisenmenger's Complex. It is argued that direct abortion may be necessary in the treatment of the pregnant woman, particularly if a diagnosis of a

potential life-threatening condition such as severe cardiac disease or severe hypertension is made early in pregnancy. However submissions which take a contrary view, including submissions from medical professionals, quote from research which states that abortion does not play a role in the treatment of the above conditions.

5.16 The Report on Confidential Enquiries into Maternal Deaths in the United Kingdom is cited in submissions. These enquiries provide information into the causes of death in pregnancy and the puerperium (the period from the onset of labour to return of the womb to its normal state) and identify cases where a termination of pregnancy may have been considered a better option than allowing the pregnancy to continue. However it is acknowledged in several submissions that if life-threatening conditions are diagnosed in late pregnancy the goal will always be to combine optimum treatment for the mother with the delivery of a viable baby.

Physical health

5.17 The 'physical health' of the pregnant woman is referred to in submissions and in doing so argue that no distinction should be made between life and health. They argue that an abortion should be permissible if the health of the woman is seriously at risk. In general these submissions make no distinction between physical and mental health and, insofar as they refer to physical health, provide no elaboration as to how risk to physical health may be distinguished from risk to life.

Mental health

5.18 Many of the submissions which consider mental health hold the view that suicide in pregnancy is extremely rare and difficult to predict. They contend that the *X* case (see Chapter 2, paragraphs 2.14-2.16) and *C* case (paragraphs 2.23-2.26) judgments are faulty and should not form the basis for legislation. Another aspect of the suicide issue which is central to a significant number of submissions is the belief that to permit abortion on grounds of a risk of suicide would lead to its easy availability. The experience in England and Wales is cited in this regard.

5.19 Other submissions quote from correspondence from a consultant psychiatrist[82] in which he states that over a period of more than 30 years as a consultant psychiatrist to the National Maternity Hospital and the Coombe Women's Hospital, pregnant women who had psychiatric symptoms were referred to him for assessment and treatment. He is quoted as stating that he never saw a pregnant woman whom he considered required an abortion on psychiatric grounds. In his view other effective treatment options were and are available, it is said.

5.20 Some submissions cite a study[83] which found that in England and Wales during the 11-year period from 1973 to 1984, the total suicide rate in pregnant women was one-twentieth that of the expected rate of suicide in the non-pregnant population. The study found that in the post-natal period, the risk was one-sixth that expected in the non-post-natal group, while for women who had stillbirths the rate was the same as for the general female population. The authors concluded that 'motherhood seems to protect against suicide' and discounted the possibility that under-reporting of maternal suicides was likely to explain the finding.

5.21 Also quoted in several submissions is research from Finland which found that of all suicides in Finland over a period of years, the lowest number was among women who had recently given birth, whereas the greatest number was among women who had had an abortion.

5.22 The private commission of inquiry chaired by Lord Rawlinson in 1994 into the operation and consequences of the Abortion Act (in operation in England and Wales since 1967) is referred to. It concludes as follows:

> The Commission heard from witnesses representing the Royal College of Psychiatrists who stated that although the majority of abortions are carried out on the ground of danger to the mother's health, there is no psychiatric justification for abortion. Thus the Commission believes that to perform abortions on this ground is not only questionable in terms of compliance with the law but also puts women at risk of suffering a psychiatric disturbance after abortion without alleviating any psychiatric problems that already exist.

5.23 The difficulty of predicting suicide is also highlighted in submissions. Numerous studies quoted have attempted to assess the predictability of suicide in high-risk populations. One which is frequently cited concluded that the prediction of suicide using the standard risk factors which have been identified by previous work in psychiatry was wrong in 97% of instances examined.

5.24 One reference is made in a submission to an Irish psychiatrist who is quoted as stating that at present it is not possible to predict suicide with a modicum of certainty: 'Therefore if the law on termination of pregnancy within the Republic of Ireland is to be changed, then estimation of risk of suicide by clinicians would be an unreliable criterion for allowing for such termination.'

5.25 While acknowledging that suicide in pregnancy is rare, other submissions say that this is a fairly recent phenomenon and suggest that heretofore it has been more common. They refer to research which is said to have found that the suicide risk in pregnancy has been steadily falling. This, it is said, has led to the conclusion that the fall in suicide in pregnancy is due to a series of social changes that have greatly

82 John P. Malone, Emeritus Professor of Clinical Psychiatry, University College Dublin and the Mater Misericordiae Hospital, Dublin. Statement quoted in *Irish Times*, 29 June 1993.

83 Appleby L, *Suicide during Pregnancy and the First Postnatal Year*. BMJ7 1991: 302, 137-140.

reduced the number and the adverse social consequences of unwanted pregnancies. These social changes are identified as including access to legal abortion and increased availability of contraception.

5.26 The issues of the psychiatric consequences of unwanted pregnancy on adolescents and children is also raised in some submissions. These recognise that pregnancy as a result of sexual abuse is an extremely traumatic experience for a woman of any age, but particularly a child, and that such a pregnancy will affect all aspects of that adolescent's development, not just her sexual development. It is also stated that examination of data by age in the study referred to in paragraph 5.25 shows that the risk of suicide in pregnancy is very much higher in teenage mothers-to-be. On the other hand other submissions argue that the traumatic experience of the unwanted pregnancy is only compounded by an abortion.

5.27 The assessment of suicide risk in adolescents and children is also identified as a cause of concern in some submissions. The point is made that, ideally, assessments should be carried out by a Child and Adolescent Psychiatrist but that it could be difficult to find a child psychiatrist to carry out such assessments in Ireland, in view of the fact that doctors are aware of the Medical Council's opposition to abortion. One submission concludes that children who are pregnant as a result of sexual abuse should be permitted to have an abortion and that psychiatry should not be involved in this matter, on the grounds that psychiatrists could be influenced by their own personal views and moral beliefs.

Sexual assault (rape and incest)

5.28 A number of submissions express concern about the appropriate response to the situation of women who are pregnant as a result of rape or incest. Some of these express the view that morally a victim of rape or incest should not have to continue with the pregnancy if they do not wish to do so. Others, while acknowledging that rape is an extremely serious offence, express the view that abortion should never be an option and that the unborn child conceived as a result of rape has the same right to life as any other.

5.29 Submissions were received from the main churches in Ireland. Roman Catholic Church teaching acknowledges that the victim of incest or rape has a right to seek medical help with a view to preventing conception. However, the Church's position is that where pregnancy results, a human life has come into existence and to end this life by abortion is considered a further violation of the woman's body which may in fact increase her distress. The Church of Ireland and the Presbyterian Church take a somewhat different view and consider that exceptional cases may arise where abortion may be an option.

5.30 Submissions point out that in countries where abortion is available for victims of sexual assault, many women who are pregnant as a result of rape do not choose this option. They refer to research which has found that issues relating to the rape experience, not the pregnancy, are the primary concern of the majority of rape victims and that social support is the most important single factor influencing rehabilitation.

5.31 Concern is expressed in some submissions that to permit abortion on grounds of rape/incest could be open to abuse. There is great difference of opinion when discussing how such cases should be assessed. At one end of the spectrum is the view that the woman's claim should be taken at face value, while at the other is that there should be a requirement of proof of sexual assault. It is also argued by some that in cases of alleged incest, a blood relationship would have to be proved. Those opposed to such requirements of proof argue that they would effectively rule out abortion as an option, in view of the time required to provide the necessary evidence.

Foetal abnormalities

5.32 The issue of the termination of pregnancy where a foetal abnormality is diagnosed is addressed in submissions. Many of these categorically reject the notion of termination in circumstances where there is severe foetal abnormality, and express fear that permissibility of abortion for severe foetal abnormality would lead to demand for abortion for less serious conditions. Some submissions however argue the case that abortion should be permitted in cases of extreme abnormality or where the condition of the foetus is incompatible with life, e.g. anencephaly.

5.33 This area is a very complex one and examples are provided in submissions where parents opt for terminations in very difficult circumstances. One example refers to conditions with a high chance of recurrence in families and, while not advocating abortion, recommends that adequate and non-directive counselling should be provided by genetic counsellors who have an insight and knowledge of the difficulties both prior to and during pregnancy.

5.34 Submissions refer to amniocentesis and CVS (Chorionic Villus Sampling, which involves the taking of samples of protein before the placenta forms), which can be used to indicate the possible presence of certain foetal abnormalities, and argue that these procedures should be available on demand. Others, however, object to the availability of such screening, on the grounds that abortion should never be an option, whatever the results of such testing may suggest.

Physical and mental consequences of abortion

5.35 The medical and psychological sequelae of abortion is considered in submissions. The majority of these submissions focus on the psychiatric aspects. According to research quoted, up to 10% of women can suffer severe psychiatric consequences and up to 50% can suffer psychological effects as a result

of having an abortion. On the other hand, research is cited which has found that abortion does not pose a psychological hazard for women.

5.36 Others approach this issue in a different manner and set out what they consider to be the medical and psychiatric consequences for Irish women arising from the unavailability of abortion in Ireland. In short, they express concern that many women travel for abortion without receiving any counselling, that many do not receive post-abortion counselling or contraceptive advice and that few, if any, receive a gynaecological assessment or a health check prior to travelling, or a post-abortion medical check-up.

5.37 Submissions refer to research which found that Irish women who have abortions in England and Wales are more likely to have a termination at a later gestational stage than their English or Welsh counterparts (and that consequently they face increased physical and mental health risks). It is stated that 60% of Irish women attending clinics in England and Wales had their abortions in the first trimester, compared to 89% for women resident in England and Wales. Another study put the percentage of abortions performed on Irish women in the first trimester at closer to 70%, still considerably lower than for women resident in England and Wales.

5.38 The additional stress involved in having to travel to another country, the financial costs involved and the moral climate in Ireland, which is strongly opposed to abortion, are also raised as issues.

Methods of termination

5.39 Other submissions, some including video material, received from organisations opposed to abortion describe in detail different methods of abortion and how the procedure is carried out. Some submissions drew attention to new methods of medical abortion, primarily the abortifacient drug RU486, and expressed strong opposition to these. Concern was also expressed for the pain felt by the foetus during the carrying out of an abortion and research referred to which states that foetal responses may begin within a number of weeks of conception.

Ethical and moral context

5.40 Submissions dealing with ethical or moral considerations were received from representatives of the main churches, along with contributions from a number of theologians and philosophers.

5.41 The question of when human life begins is central to many of these. The majority defined human life as beginning at the moment of conception, i.e. fertilisation of the ovum. Others define human life as commencing at implantation, two to three weeks after fertilisation. Others again enter into a discussion of the development of the embryo and foetus to try to pinpoint the milestones of human personhood.

5.42 Submissions from representatives of the Roman Catholic Church state that the right to life is the most fundamental of all rights because it is the foundation of all other rights. The violation of this right is stated to be an injustice. The Roman Catholic Church teaches that the direct and intentional killing of innocent human life at any stage from conception to natural death is gravely and morally wrong. Human life is at its most defenceless in the womb and has the right to receive the protection of the law. From the moment a human life begins to exist at conception, it is entitled to the same respect and protection as any other human life.

5.43 The Roman Catholic Church also states that destruction of a human life when it is at its most defenceless – for instance in the first or last stages of its existence – overturns the moral order. It is argued that these are the times when individuals have the most pressing claim to be protected from harm. Each life is precious. It is stated that the life of the child in the mother's womb is sacred and inviolable, just as the life of the mother is sacred and inviolable. Both lives are of equal value. The Church states that an expectant mother with a life-threatening illness must receive the urgent medical treatment which is indispensable for the saving of her life, even when the treatment puts the life of the child at risk. It is argued that recourse to abortion is not necessary to save the life of the mother and that the absence of abortion does not endanger the lives of women.

5.44 The Roman Catholic Church's position is that the principle that neither the mother's life nor the unborn baby's life may be deliberately and directly terminated for any cause remains true whatever the law of the state or international law may say.

5.45 Some submissions discuss the concept of the 'consistent life ethic', which demands equitable treatment of human beings. This ethic objects to any balancing of the value of life which automatically gives precedence to some over others. On this basis a mother's life cannot be given precedence over that of the foetus, or *vice versa*. It is argued that the common good cannot be promoted through the violation of basic rights, such as the right to life, and that the common good requires the restriction of individual rights in some respects.

5.46 A submission representing a broader Catholic tradition (outside Ireland) introduces a number of new dimensions to the ethical arguments concerning abortion and points to aspects of Catholic theology which, it argues, would allow for the acceptance of policies that favour access to a wide range of options, including contraception and abortion.

5.47 Arguments in support of pluralism and the separation of Church and State are also advanced in several submissions.

5.48 The Church of Ireland affirms the sanctity of life both before and after birth. While teaching that the deliberate termination of an intrauterine life cannot be right, many in the Church of Ireland believe that exceptional cases may arise where abortion may be an option and may even be a necessity in a few very rare cases. It is stated in the Church of Ireland's

submission that no abortion is ever desirable and that at most it can be described as the lesser of two evils.

5.49 The Presbyterian Church states that as a general principle the membership of the Presbyterian Church upholds the sanctity of human life from conception and that the termination of life within the womb should not be considered except under the most extreme circumstances. There is diversity of opinion in the Presbyterian Church as to what constitute exceptional cases. There is agreement that termination should be permissible if there is a real physical risk to the mother's life. There is less agreement among the membership on other possible grounds, i.e. rape, risk of injury to physical or mental health of the mother, or extreme abnormality detected in the foetus. It considers that the legal position as it pertains in Northern Ireland is adequate so as to ensure that abortion is carried out only in the most extreme circumstances and that to change Irish law to accord with the situation in Northern Ireland would be acceptable.

5.50 Submissions refer to the ethical principle of an act of double effect, i.e. the harm caused unintentionally or indirectly to one for the benefit of another. This principle, it is stated, is understood in medical ethics to cover the loss of the foetus to save the mother's life in cases such as ectopic pregnancy or cancer of the uterus.

5.51 Submissions refer to statements from the Medical Council, the Irish Medical Organisation and an Bord Altranais, in which these bodies publicly expressed their ethical opposition to abortion. These bodies did not make submissions to the Working Group.

5.52 Some submissions argue that there is a need to respect the moral diversity which exists among people of sincerity and good conscience and to respect a pregnant woman's moral viewpoint.

Social context

5.53 The social context of abortion is a central theme in submissions. These identify a need to address the social issues surrounding abortion and to put in place policies to provide more assistance to women with crisis pregnancies. Several submissions draw on the findings of the research commissioned by the Department of Health and Children from Trinity College. In general, these submissions are sympathetic to the plight of women with crisis pregnancies but are anxious that everything possible be done to reduce the numbers of such pregnancies. Paragraphs 5.54 to 5.65 summarise the main points raised:

Educational approach to sexuality and modern moral responsibility

5.54 The view is expressed that the new Relationships and Sexuality Education (RSE) Programme introduced in schools should embrace comprehensive education on sexuality and reproduction. It is argued that it should incorporate a module on methods of contraception and that educational programmes should also cover issues such as assertiveness and respect in relationships.

5.55 Attention is drawn to the role of men and the need to educate men to behave responsibly in relationships. The reluctance of many men to accept responsibility for contraception is identified as a critical factor in this regard.

Contraception education programme

5.56 Some submissions seek a national contraception education programme, to include the provision of widespread and accurate information campaigns on contraception, offer widespread access to contraception through health schemes and private outlets at low cost or no cost as appropriate, and provide emergency contraception in pharmacies. They say that shortcomings in services currently provided should be identified and that where general practitioners do not provide a full range of family planning services, the deficit should be made good by appropriate agencies.

5.57 On the other hand, other submissions express opposition to the provision of contraception for young people and view an increased reliance on contraception and any plans to make such services more widely available as likely to lead to more unwanted pregnancies and hence increased demand for abortion.

Adoption as an alternative to abortion

5.58 Some submissions express the view that it would be preferable for women who have abortions to instead carry their baby to term and to place the baby for adoption. Adoption is seen as providing an option for women who cannot or do not wish to take on the burden of motherhood and the point is made that the placing of a child for adoption is a little-used option nowadays. The promotion of adoption by counselling agencies, the introduction of more open forms of adoption, greater support for women who choose adoption and greater recognition of the rights of women who give up their children and the rights of adopted children are amongst the issues raised.

Role of alcohol

5.59 The significant contributory role of alcohol consumption to the occurrence of unwanted pregnancies is adverted to in several submissions. More effective health promotion strategies are sought in this regard.

Social stigma

5.60 Several submissions identify society's attitudes towards and treatment of lone mothers as major contributory factors to the number of Irish women opting for abortion. The view is expressed that women who find themselves with a crisis pregnancy need social support and that often this is not forthcoming. As a consequence, they argue that the

secrecy and shame attaching to a crisis pregnancy often makes abortion seem to be the only option for the women concerned.

Economic factors

5.61 Submissions which refer to the social context of abortion identify single motherhood with economic hardship. It is argued that more financial support is required in the form of a guaranteed minimum income, better housing, changes to the taxation system, affordable childcare for women who wish to work or continue education, improved child income support and free medical care for children.

5.62 A few submissions put forward the view that some single women become pregnant in order to qualify for State welfare and housing.

5.63 Students are identified in some submissions as a particularly vulnerable group insofar as having a baby interrupts their studies and the costs involved in providing for a baby and the cost of childcare often make it impossible for the women in question to resume their studies. The consequent lack of qualifications often leads to poorly-paid employment. In such a situation many women leave the labour market and become dependent on income support. For those women who continue to work, it is suggested that improvements in work structures such as wider availability of job-sharing, flexitime and longer periods of maternity leave are important.

Pregnancy counselling services

5.64 The current counselling services are considered to be inadequate and this is cited as contributing to the numbers seeking abortion abroad. A national network of non-directional crisis pregnancy counselling services, which should be free and available on request (without delays) is sought. Proper training for all staff involved in counselling is also identified as a priority. Several submissions draw attention to the fact that a significant number of women seek abortion information without counselling and that at present many women travel abroad to have an abortion without having undergone any counselling in Ireland.

5.65 Some submissions perceive a lack of clarity about the position of General Practitioners and of some agencies who do not provide counselling on all of the options (i.e. including the option of abortion). They suggest that such doctors and agencies should refer a patient to another doctor for information, notwithstanding their conscientious objection to abortion. On the other hand, some others argue that public funding should be provided only to agencies which do not provide information on accessing abortion services.

Constitutional/legal issues

Legal background

5.66 Some submissions refer to the Offences Against the Person Act, 1861 and raise the issue of abortions which would be regarded as 'lawful' under the Act, e.g. acts done in the course of proper treatment in the interest of the life or health of the mother. Others, however, interpret the Act as providing a total ban on direct intentional abortion and draw attention to what they regard as a conflict between the Act and the Supreme Court's judgment in the *X* case (see paragraphs 2.14-2.16).

5.67 While the purpose of the 1983 constitutional amendment was generally seen as 'copperfastening', rather than changing, the existing law on abortion, some argue that it should have been accompanied by specific legislation prohibiting abortion. In their view, the *X* and *C* case judgements were a consequence of the non-enactment of such legislation.

5.68 On the other hand, a number of submissions are critical of the fact that the Constitution was amended in 1983. Others, while agreeing with the objective of the constitutional amendment, consider the wording adopted to be flawed. A number call for legislation to regularise the position following the judgment in the *X* case.

The X *case*

5.69 The judgment in the *X* case is criticised in many submissions. There is criticism that the test in the *X* case contemplates that there are circumstances where direct abortion is required to protect the life of the mother and that such intervention is lawful within the State. It is also argued that a threat of suicide as a life-threatening risk should not have been allowed. It is also stated that the decision in the *X* case cannot be reconciled with the constitutional provision of an equal right to life to both mother and foetus. Other criticisms include reliance on the evidence of a clinical psychologist, the fact that the opinion was not challenged and that a gestational time limit for termination was not specified. Some submissions are critical of the fact that counsel for the Attorney General in the *X* case conceded that Article 40.3.3 envisaged lawful abortion in the jurisdiction in certain circumstances.

The C *case*

5.70 The judgment in the *C* case is also criticised in submissions. As in the *X* case, the criterion of suicide risk is unacceptable to many, as is the description of abortion as 'medical treatment'. It is argued that in this case the threat of suicide was not imminent, the evidence of the psychiatrists was not tested and that no opportunity was given to any party opposing abortion to introduce competent expert medical evidence which could have put forward alternatives to abortion. In the event, the *C* case followed the test formulated by the Supreme Court in the *X* case. Nonetheless, the Attorney General is criticised in some submissions for not directing counsel appointed by him to defend the interests of the unborn child to appeal the judgement to the Supreme Court.

5.71 Another concern expressed in relation to the *C* case concerns the 'right to travel' issue. It is argued that the *C* case has demonstrated that minors, adult women with intellectual disability or women who

are wards of court would have particular difficulties with access to abortion. They argue that if there is a conflict between parents/guardians as to whether a minor can travel for an abortion in circumstances where there is not a real and substantial risk to her life, then the court cannot authorise or direct that a minor can travel abroad. The situation of a minor in the care of a health board is also viewed by some as a cause for concern.

5.72 All the submissions which refer to this issue argue for an absolute legal guarantee for women to exercise their right to travel and refer back to the 1992 constitutional amendment in relation to travel, which at the time was generally understood to mean that a woman's right to travel would not be subject to any restriction. Other submissions refer also to travel rights under EU law.

Calls for referendum

5.73 Submissions seek a new referendum to achieve their understanding of the Constitutional amendment passed in 1983, i.e. an absolute ban on abortion. Wordings are suggested for a referendum which, it is argued, would not impinge in any way on existing medical practice in relation to the treatment of pregnant women with life-threatening conditions, even where such treatment may involve adverse effects on the foetus.

5.74 Many of these submissions acknowledge the difficulty in formulating a wording. Solutions suggested vary from referring any proposed wording to a panel of legal experts, who would argue for and against, to referral to the Supreme Court in order that a proposed wording might be tested in advance of a referendum.

5.75 Examples of some of the proposed wordings are:

> (1) Add to 40.3.3 '... Nothing in the Constitution would render lawful the deliberate, intentional destruction of the unborn or its deliberate, intentional removal from its mother's womb before it is viable.'
>
> (2) 'No new law shall be enacted, and no provision of the Constitution shall be interpreted, to render induced abortion lawful in the State.'

or

> It shall be unlawful to terminate the life of an unborn unless such termination is the unsought side-effect of medical treatment necessary to save the life of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life.
>
> (3) Then in addition to any of the above add 'the unborn child shall, from the moment of conception, have the same right to life as the child born alive.

Proposals for legislation

5.76 It is argued in a number of submissions that abortion issues should be regulated by legislation. In some of these it is argued that the Constitution is not an appropriate place to deal with such a complex medical, ethical and social issue and they envisage that to proceed by a legislative route the removal of Article 40.3.3 by referendum and the repeal of Sections 58 and 59 of the Offences against the Person Act, 1861 would firstly be required. The scope of the legislation sought in submissions ranges from legislation to cover the *X* case as a minimum measure to legislation providing for abortion in various other wider circumstances.

5.77 The legislative approach, as set out in submissions, therefore covers a wide spectrum. Most who favour this approach are of the view that no distinction should be drawn between the life and the health of the pregnant woman. Pregnancy resulting from rape and incest and cases where the foetus cannot survive the pregnancy (e.g. anencephaly) are also cited in a very small number of submissions as possible grounds for an abortion.

5.78 The problem of definitions has also led some to favour the legislative route, particularly as the crucial term 'unborn' has not itself been defined. Views vary widely, with the majority of those who made submissions being of the view that human life begins at conception, while others propose that 'unborn' should be defined as applying only to those foetuses which have achieved viability (that is, which would be capable of being maintained alive if delivered). It is also suggested that 'unlawfully', as used in the Offences Against the Person Act, 1861 should also be defined, so that doctors can be certain as to when they can lawfully terminate a pregnancy. Other suggestions are that legislation should provide for protection for doctors who carry out abortions and for sanctions against those who may target, harass or intimidate doctors, support staff and patients involved.

5.79 There is however a different view that if legislation were to be enacted, medical professionals would interpret the provisions very broadly. It is argued that this was the experience in England and Wales and that this has led to relatively easy access to abortion, and that every effort should be made to prevent such a development in Ireland.

Information legislation

5.80 Several submissions call for the repeal of the Regulation of Information (Services Outside the State for Termination of Pregnancies) Act, 1995, arguing that it has led to an increase in the numbers of Irish women who have abortions abroad. Others argue that it should not be a requirement that information is made available only in the context of non-directive counselling on the full range of options for a woman with an unplanned pregnancy. Rather, they say, information should be made available on request separately from counselling agencies.

5.81 A number query whether section 6 of the Act, which prohibits persons supplying information on abortion from having any 'interest, direct or indirect' in any clinic offering abortion services outside the State, may be in breach of EU law, thus making the prohibition invalid.

5.82 It is also argued that counselling agencies should be legally obliged to clarify the scope of the information they provide. It is argued that if they do not provide abortion information they should be legally required to make a referral to an agency which does (see Section 5.65 above).

5.83 Submissions which refer to Protocol No. 17 to the Treaty on European Union and the Solemn Declaration made thereunder (see Chapter 3, paragraphs 3.17 to 3.23, for a discussion of these matters) reflect considerable confusion as to whether the Protocol is effective in the light of the Solemn Declaration and the amendments to Article 40.3.3 made in 1992. Some argue in favour of having in place some protection against EU law in the area of abortion, while others object in principle to the seeking of any derogation in this matter. However, given the general uncertainty as to the precise meaning of the Protocol, there is general agreement in these submissions that clarification is required. There was practically no reference to Ireland's obligations under other international instruments.

Other issues

Rights issue

5.84 Some submissions approach abortion as a rights issue for women. They argue that because abortion is not permitted in Ireland, women are denied a right to bodily integrity, to travel and to freedom of conscience, unless their life is at stake and that this constitutes a denial of their civil rights. It is also argued that women are denied their moral integrity, that is recognition of their capacity to make good, rational and moral decisions about their lives. It is claimed that in treating women in this way the State fails to trust half of its citizens to make decisions about their health and this is an indicator of 'the central patriarchy of the State'.

5.85 On the other hand, as indicated earlier, the view is expressed in many other submissions that the unborn have an equal right to life and that a woman should not therefore be allowed discretion in relation to the continuation of her pregnancy.

Socio-economic issues

5.86 Some see access to abortion as a socio-economic or a class issue. Of central concern in these submissions is the fact that travel abroad imposes financial burdens on women, who must bear the cost of travel and accommodation as well as the cost of accessing the service in private clinics. They conclude therefore that women from the lower socio-economic groups are disadvantaged in terms of access to abortion services.

Research

5.87 There is support for more research into aspects of the abortion issue. The recommendations received include that there should be a comprehensive review of international research on abortion by an interdisciplinary panel, long-term studies of the physical and mental effects of abortion on women and research on improving the uptake of contraception in women at risk of an unwanted pregnancy. Another suggestion advanced is that a task force should be set up to consider the options which arise from the Green Paper. Membership should include a cross-section of representatives from Government, women's organisations, the social partners, youth organisations and medical and health professionals.

CHAPTER 6
THE SOCIAL CONTEXT

Introduction

6.01 In Ireland public debate on abortion has frequently focused on the circumstances of the *X* case in 1992 and the *C* case in 1997, where the girls concerned were minors who became pregnant as a result of unlawful sexual intercourse and where continuation of the pregnancy was deemed to pose a risk to their lives. While, since the *X* case, abortion is permissible on grounds of risk to theá mother's life (see Chapter 2, paragraph 2.15), the evidence is that the numbers of women for whom pregnancy poses such a risk are small and, some would claim, non-existent. Nonetheless almost 6,000 Irish women had abortions in England and Wales in 1998 and this is the subject of concern to many people. Research has shown that the majority of these abortions take place for reasons which could be broadly classified as social/economic. These include factors which contribute to the incidence of unwanted pregnancy such as inadequate education and information, and failure to use or incorrect use of contraception. They also include factors which influence the woman's decision to have an abortion, such as her age, her perceived inability to cope with lone motherhood, social stigma, impact on education and career, and financial or domestic considerations. While the majority of women who have abortions are single, some are married and for these women factors such as age, health, number of existing children and financial worries all contribute to the decision- making process involved in choosing abortion.

6.02 This chapter discusses the social context of abortion under three main headings: (i) factors which contribute to the incidence of unwanted pregnancy; (ii) factors which influence a woman's decision to have an abortion and (iii) possible strategies to reduce the numbers of women seeking abortions. The chapter draws from the submissions received on the Green Paper and on research carried out with Irish women who have had abortions, primarily the 'Women and Crisis Pregnancy Study' commissioned by the Department of Health in 1995 and carried out by a team from Trinity College, Dublin.

Pregnancy, parenthood and marriage

6.03 In discussing the social context of abortion it is useful to look at the changes in Irish society in recent

years where pregnancy, parenthood and marriage are concerned. First, the large decline in the birth rate over the last two decades and the fall in the size of families, indicate the extent to which women are controlling their fertility. The birth-rate, which was considerably higher than in other European countries, fell from 21.9 births per 1,000 population in 1980 to 13.5 per 1,000 population in 1995. The figures for 1996 and 1997 show a slight reversal of this trend, with the birth-rate rising to 14.3 per 1,000 population by 1997. In parallel with this, the average age of marriage has increased, and women have chosen to remain part of the workforce for longer before starting a family. There is some evidence that the marriage rate is declining, but it is too early to draw definite conclusions in this regard, because of the higher average age of marriage than was the norm in the 1960s and 1970s.

6.04 Although up to 1995 the overall birth-rate declined, the number of non-marital births as a proportion of the total increased steadily, most notably in the 1980s and 1990s. In 1980, of 59,825 births, 3,691 or 5.0% were classified as 'illegitimate'. By 1997, of 52,311 births, 13,892 or 26.6% were non-marital births (the concept of illegitimacy having been abolished). Of the non-marital births in 1997, 2,747 (19.8%) were to women under 20 years of age, and 5,338 (38.4%) were to women aged 20-24. Whereas in the past many unmarried women who gave birth had their children adopted, changes in society's attitudes and the provision of social supports such as the single mothers' allowance (introduced in 1973) have resulted in the great majority of unmarried mothers keeping their child. In 1961, 56% of children from non-marital births were put up for adoption. In 1991 this figure had fallen to 6.7%. In this discussion it should be noted that information on the proportion of non-marital births which are to women with long-term partners, as opposed to lone mothers, is not known.

6.05 However, while pregnancy and motherhood outside marriage have become more common and more acceptable, such acceptance is by no means widespread or unqualified. For many women there continues to be a social stigma associated with pregnancy outside marriage or a long-term stable relationship. There continues to be public debate about the growing proportion of births to unmarried mothers and whether it is in children's best interests to be brought up in a single-parent family. For a significant number of women with unplanned pregnancies, having a baby outside a marital or a long-term stable relationship is problematic, because of family, social, educational or career considerations.

Studies of Irish women who have had abortions

6.06 In 1991 4,154 women who had abortions in England and Wales gave Irish addresses, giving Ireland an abortion rate of 5.2 (the number of abortions per thousand women aged between 15 and 44). By 1997 this had increased to 5,336 women with an abortion rate of 6.4. The provisional figure for 1998 is 5,892. The majority of these women were single and in their twenties. (More detailed information is contained in Appendix 2.)

6.07 A number of small-scale studies were undertaken in the 1980s and 1990s into Irish women's experiences of abortion. These consistently found that although all age-groups were represented, women in the 20-24 age-group were most likely to have abortions. A significant number had no experience of contraception. Most of the women studied became pregnant because of failure to use contraception or from incorrect use of contraception. The majority of women having abortions were single – four out of five had never been married. The studies found that those from the middle social classes represented the highest proportion of women concerned. Housewives and students were also represented to a significant degree. Two studies noted that 8% to 10% of women studied had previously had an abortion. Difficulties with accessing counselling services were identified, and the continued existence of a stigma surrounding non-marital pregnancy was cited as a major factor in women choosing to have an abortion.

Trinity College 'Women and Crisis Pregnancy' study

6.08 In 1995, as part of a package of measures associated with the enactment of the Regulation of Information (Services outside the State for Termination of Pregnancies) Act, 1995 the Department of Health commissioned from the Department of Sociology, Trinity College Dublin, research into the factors which lead women with a crisis pregnancy to choose the option of abortion. It was hoped that with a better understanding of the factors which result in women choosing the option of abortion, effective and properly-targeted programmes could be developed to help reduce the incidence of unwanted pregnancy. The study was published in March 1998.[84]

6.09 The study examined abortion rates among Irish women and its authors calculate an abortion rate of 5.6 in 1995. It also uses an alternative method of calculating the abortion rate as a percentage of conceptions ending in abortion – conceptions being defined as the number of births, still-births and abortions to Irish women in the year concerned. This approach shows that in 1995 8.5% of conceptions resulted in abortion. Of these, 25% of non-marital conceptions and over 2% of marital conceptions were aborted. The study found that women with crisis pregnancies are likely to be in their late teens or early twenties, single and less likely to be in an ongoing supportive relationship. However they do not differ from other pregnant women by occupation or educational level. For the majority of women, the pregnancy was likely to be their first. Some of those who participated in the study were married women in their forties or were mothers who were separated and already had children. The women had identified their pregnancy as prob-

84 Mahon, E., Conlon, C. & Dillon, L. 1998. *Women and Crisis Pregnancy*, Government Publications, Dublin.

lematic in the context of their overall social and personal circumstances or, in some cases, their overall state of health.

6.10 The study examined three groups of women with crisis pregnancies: one group who had chosen abortion, a group who planned to keep their babies and a group who planned to give their babies up for adoption. It examined contraceptive practices of women with crisis pregnancies and their use of pregnancy counselling and information services. It also examined the factors which influence a woman's decision to opt for abortion, lone motherhood or adoption. On completion of the study the authors submitted a package of recommendations arising from the research to the Inter-Departmental Group for consideration in the context of this Green Paper.

Factors which contribute to the incidence of unwanted pregnancy

6.11 The main factors identified in submissions and in research as contributing to the incidence of unwanted pregnancy can be categorised under two main headings, education and contraception.

(i) Education

6.12 A number of submissions are critical of existing relationships and sexuality education for young people, insofar as it is clear that many young people lack basic knowledge about their bodies and how to control their fertility. They also criticise the lack of assertiveness training and consider that there is a need to encourage greater respect within relationships. Many highlight men's apparent lack of appreciation of their responsibilities and the need to provide suitable educational programmes for them. Several submissions draw attention to the role played by alcohol in the occurrence of many unplanned pregnancies and see a need to put in place policies aimed at encouraging more responsible attitudes to alcohol.

6.13 Submissions recommend a more comprehensive relationships and sexuality education which would ensure that women and men have fuller knowledge of fertility and contraception. They suggest that this training should also include assertiveness and respect in relationships with a particular emphasis on the need to educate men; education should cover the use of contraception, including emergency contraception.

6.14 The 'Women and Crisis Pregnancy' study confirms that there is considerable ignorance of fertility cycles and a lack of knowledge about how to ensure effective contraception. It highlights a lack of assertiveness amongst women in terms of their relationships and a reluctance on the part of men to take responsibility for contraception. It also highlights a gap between parental knowledge or acknowledgement of their children's sexual activity and the actual level of sexual activity among young people. The existence of this gap meant that many parents did not broach the issues of sexual relationships and contraception to any serious degree with their children.

6.15 The authors of the study also recommend a comprehensive health education strategy around sexuality which would equip women with the skills necessary to articulate and express their needs with regard to safe sex with their partners. This strategy should, they say, be employed at three levels: within the formal educational system; in localised community-based initiatives and through media-based educational campaigns. They propose that education on contraception should include how to access and effectively use each available form of contraception.

6.16 With regard to the role of parents, the authors of the study recommend that health educators encourage and promote increased openness and honesty between parents and their young daughters or sons about their sexual activity and contraceptive use.

(ii) Contraception

6.17 Submissions which deal with contraception express concern at regional gaps in service provision and factors such as cost, which may restrict access. They recommend more widespread availability of contraception, including emergency contraception, at little or no cost. They consider that shortcomings in services currently provided should be identified and the deficit made good by appropriate agencies.

6.18 The 'Women and Crisis Pregnancy' study confirmed findings of earlier research that many women who have abortions did not use contraception or used it incorrectly.

6.19 The study found that social and personal factors militated against consistent use of contraception. The fact that young women were sexually active was not generally disclosed to their parents and many believed that their parents would disapprove or be shocked if they found this out. This included a fear of contraceptive pills being discovered by parents, concern over how their doctor might respond to a request for the pill, and a fear that being on the pill would result in women being perceived as sexually available. Many women were therefore reluctant to use the pill unless in a long-term relationship.

6.20 The study also found that women also felt that to carry condoms was to compromise their reputation. However, the principal impediment to the effective use of condoms was found to be the failure of men to assume responsibility for contraception. In the face of objections from their partner, some women were not assertive about condom use, fearing that insistence would threaten their relationship. As a result, effective contraception was compromised.

6.21 The authors of the 'Women and Crisis Pregnancy' study make a wide range of recommendations about contraceptive use and availability. These include the extension of the present Maternity and Infant Care Scheme to include family planning services to ensure that all women have access to family planning services free of charge, incorporating the provision of contraceptive services into the terms of contract of general practitioners (including the

availability of additional resources and training) and improved access and information on all contraceptive services, including the pill, condoms, sterilisation and emergency contraception.

Issues surrounding a woman's decision whether or not to have an abortion

6.22 The previous section has dealt with factors which can affect the incidence of unwanted pregnancy, primarily education and contraception. This section examines factors which can influence women in their decision whether or not to have an abortion. These are counselling and information, attitudes to adoption and lone motherhood. The issue of post-abortion counselling is also discussed.

(i) Counselling and information

6.23 Since the enactment of the Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995, women have been entitled to receive counselling and information on abortion services available abroad. The Act stipulates that counselling must be non-directive and, where abortion is discussed, must also include a discussion of the options of adoption and lone motherhood. A range of agencies provide pregnancy counselling and receive financial assistance from the Department of Health and Children towards the provision of such a service. Not all of these agencies will provide women with information on how to obtain an abortion.

6.24 The Irish College of General Practitioners produced an information booklet for General Practitioners in 1995. This explains the legal position on the provision of abortion information. It gives comprehensive guidelines to doctors in relation to pregnancy counselling and also provides a list of services available in Ireland and the United Kingdom for women with crisis pregnancies. General Practitioners are not obliged to provide women with information on how to obtain an abortion and, for reasons of conscience, some GPs do not give this information.

6.25 A number of submissions cite inadequate provision of current counselling services as contributing to the numbers having abortions. They say that many women receive no counselling before making a decision to have an abortion. There also appears to be a lack of clarity about the position of General Practitioners and agencies who do not provide counselling on all of the options. A small number of submissions are critical of the legal requirement that information on abortion may be obtained only in the context of counselling. They seek that the law be changed in this regard.

6.26 Submissions seek the provision of a national network of non-directional crisis pregnancy counselling services which would be free of charge and available on request. Appropriate training of all staff involved in counselling is also considered a priority. It is argued by some that doctors and agencies who do not provide counselling on all of the options on grounds of conscientious objection should be obliged to refer the patient to another doctor or agency. The authors of the 'Women and Crisis Pregnancy' study reiterate these recommendations.

6.27 The 'Women and Crisis Pregnancy' study found that 33% of women who had an abortion obtained information about the clinic which they attended from a source other than a doctor or agency in Ireland - in other words they did not use the counselling route at all. Another group attended their general practitioner, but not all doctors were willing to provide counselling, and some did not provide information on abortion as an option. The study found that charges and waiting periods for appointments with some counselling agencies acted as a disincentive. Women's expectations and requirements of the counselling agencies varied, ranging from seeking information only to seeking a full discussion on their pregnancy and all of the options which they should consider.

6.28 The study concluded that a significant number of women lacked information on the availability of counselling services and that many women decide on abortion without receiving any counselling. Many are unclear about the availability of counselling and the legal situation on information and there was some dissatisfaction at having to undergo counselling as a prerequisite to information.

6.29 The authors recommend that consideration be given to changes in the legislation whereby basic information on abortion could be given simultaneously with information on adoption and lone motherhood in the form of a booklet which would be widely available. This information, which would include names and addresses of clinics in England and Wales, should stress the importance of non-directive counselling. This, in the authors' view, would improve the level of uptake of counselling as it would give the woman more time to think about her options rather than having to focus her attention on accessing information.

6.30 The authors also recommend the regulation of pregnancy counselling providers by the Department of Health and Children. Agencies and GPs should also be explicit as to whether they provide information on all options, including abortion and if not, whether they will refer women to another agency or doctor. Patients should also be assured of confidentiality, they stress.

6.31 Other research carried out on the impact of the Regulation of Information (Services outside the State for Termination of Pregnancies) Act, 1995 highlights a number of ways in which the position of women with crisis pregnancies has changed since the enactment of the legislation.[85] For example women are now seeking counselling at a much earlier stage in their pregnancy and they are more likely to have discussed their pregnancies with partners and/or

85 O'Brien, T., de Burgh, S. & Kiernan, K. 1998. *Assessing the Impact of the 1995 Abortion Information Legislation for Women who seek Pregnancy Counselling in Ireland.* Irish Family Planning Association, Dublin.

relatives and friends. The percentage who had not told anyone of their pregnancy was considerably lower than in a 1992/1993 study (7.3% compared to 36%). These findings suggest greater openness and willingness to talk about crisis pregnancy. However this research highlighted the fact that many women still travel to England and Wales for abortions without receiving any counselling.

Decision to have an abortion

6.32 Submissions which address the social dimension of abortion strongly associate the decision to have an abortion with social stigma, i.e. society's attitudes towards and treatment of lone mothers. For some women the secrecy and shame attaching to a crisis pregnancy can make abortion seem like the only option. This is also borne out by research.

6.33 The 'Women and Crisis Pregnancy' study examined the decision-making processes of women who decide to have abortions. It found that a wide range of factors influenced a woman's decision to have an abortion and considered that these were related to the many roles a woman occupies. These roles included her role as a daughter, whereby she feels that she must live up to her parents' expectations that she will not become pregnant until she is in the appropriate social circumstances. The study found that she seeks to complete her education or training and establish her career; difficulties regarding availability of maternity leave or childcare facilities may mean that the woman feels that she must choose between her career and staying at home.

6.34 Women also saw motherhood as a social role with responsibilities to care for a child emotionally, socially and financially. They feared that lone motherhood would prove to be a very difficult, unsupported alternative. The impact of her pregnancy on a woman's relationship with the father and, where she was already a mother, with her other children, was also a consideration. Women who decided to have an abortion also wished to raise a child in the most favourable circumstances and asserted that giving birth to this child now was not in the child's interests.

Post-abortion counselling

6.35 The vital issue of post-abortion counselling was also raised in submissions and in research. There is much secrecy in relation to the experiences of the women who travel from Ireland to have an abortion abroad and from the evidence available it is clear that many of them never receive post-abortion counselling or a medical check-up. This is a major cause of concern and there is general agreement that these issues need to be addressed. The pregnancy counselling agencies which receive funding from the Department of Health and Children provide post-abortion counselling as part of their service and it is desirable that women who have had an abortion avail themselves of this, so that they receive such support and assistance as they may require.

6.36 Post-abortion medical check-ups are also important, because of the possible risks to women's health, particularly their reproductive health, should any complications go undiagnosed. Such a check-up also provides the opportunity for women to obtain advice on appropriate contraception for the future and thereby reduce the incidence of further unwanted pregnancies.

(ii) Adoption

6.37 The Adoption Act 1952, sets out the legal procedure governing adoption in Ireland. Before the early 1970s, when an allowance for 'unmarried mothers' was first introduced, the State offered little or no help to women with a crisis pregnancy. Women who found themselves in this position had little option but to turn to the various religious orders who ran maternity hospitals, mother and baby homes and orphanages. Many of these were supported by State grants.

6.38 Since the early 1970s, the number and percentage of non-marital children placed for adoption has fallen considerably. In 1984, for example, there were 898 children placed for adoption by health boards and registered adoption societies, while in 1997 the number had fallen to 108 children.

6.39 There is no specific research available on the reasons why fewer women choose to place their babies for adoption nowadays. However it would appear that a combination of factors has led to the majority of unmarried mothers now keeping their babies. These include more enlightened attitudes to births outside marriage, greater family acceptance and support, greater State supports, improved opportunities for combining career with single motherhood, some negative media coverage of adoption. The availability of abortion outside Ireland means that women who do not want to continue with a pregnancy may decide to have an abortion and this of course has also affected the number of babies being placed for adoption. It should be noted that while attitudes have changed and social conditions for single mothers have improved, the submissions received indicate that many people feel that further change is needed in these areas.

6.40 Many submissions whose authors express opposition to abortion urge that women with unplanned pregnancies give strong consideration to continuing their pregnancy to term and putting the child forward for adoption; they want every effort to be made to facilitate the choice by the women of adoption rather than abortion in such cases. A number of submissions recommended more promotion of adoption by counselling agencies, the introduction of more open forms of adoption, greater support for women who choose adoption and greater recognition of the rights of natural mothers and adopted children.

6.41 One of the negative factors for a woman considering placing her baby for adoption is that she must carry the baby for nine months, give birth and then face the trauma of being parted from her baby. As there is no statutory provision for 'open adoption' in this

country, the birth mother must resign herself to the possibility that she may never see her child again.

6.42 Also, the 'Women and Crisis Pregnancy' study found that women who intended to have their baby adopted viewed the issue in terms of their own circumstances rather than those of potential adoptive parents. These women tended, on moral grounds, to have rejected abortion from the outset. They had also rejected lone motherhood at this stage of their lives, because of the unfavourable view they had of such a situation, which they considered would have entailed dependence either on their family or on social welfare. They also felt that they would have to forgo future educational and employment opportunities and that they were not in a position to cater for their child's emotional and financial needs at this stage of their lives. These women wanted to maintain secrecy about their pregnancy, as they felt that if their pregnancy was disclosed they and their families would be stigmatised. Secrecy would also allow them to make a decision about adoption without being influenced by others. They were therefore being accommodated by agencies which care for women in this situation and after the pregnancy were able to return to their community without any substantial change in their identity.

6.43 The study concluded that there was a lack of information available to women about adoption and the availability of services which facilitate adoption, including residential homes. It also indicated that once women moved into a residential home setting they were usually unable to continue with work or training. The study found that there was a need for better counselling for the women and their families. It also found that the women had no specific knowledge about their rights or those of the putative father in relation to their children.

(iii) Lone motherhood

6.44 Submissions which discuss lone motherhood tend to associate it with economic hardship. Issues seen as having a bearing in this regard include difficulties in combining employment and parental responsibilities and in obtaining affordable housing.

6.45 The majority of the women interviewed during the 'Women and Crisis Pregnancy' study who planned to become single mothers stated that they had never considered abortion as a solution to their situation. A number of them had considered adoption but rejected it because they felt that they could not cope with giving up their baby after giving birth.

6.46 The study found that, as expectant single mothers are especially vulnerable socially, financially and emotionally, they are heavily dependent on the support systems of partners and parents. Unlike women seeking abortion or adoption, many in this group did not find support agencies with services to match their needs as they prepared to become single mothers. The support of family and partner was crucial, however. Some women also found that they had to cope with the stigma attaching to non-marital pregnancy. Work or education arrangements had to be revised to take account of the pregnancy. The degree to which parental or partners' assistance with childcare arrangements was forthcoming had a bearing on the continuation of education plans. Those who remained in their jobs while pregnant were in better-paid, skilled positions, with maternity benefits and these women anticipated being able to afford private childcare.

6.47 The 'Women and Crisis Pregnancy' study makes a number of recommendations regarding single motherhood and adoption, as follows:

- To reduce social stigma, the authors of the study recommend the use of positive images of lone mothers. The negative stereotype of lone motherhood should be counteracted by positive images of women who have successfully managed to raise children on their own. Parents need to be made aware of how crucial their response is to their daughter's decision-making process and of the need for care and understanding.
- The authors of the study also consider that steps should be taken to reduce the opportunity costs of pregnancy and childrearing, thereby minimising the social factors which lead to abortion. These include changes in fiscal and social policies which would be supportive of children, childcare and child-rearing, for example, the present taxation system should be altered to assist women with the costs of children and childcare. Children's allowance should be increased and mother/child-friendly initiatives in places of education, training and work should be introduced. All work, training and employment places should have State-supported crèche and childcare facilities as recommended in the 'Second Report of the Commission on the Status of Women'.
- In addition, ongoing support and counselling should be available to alleviate demands and anxieties created by the pregnancy and anticipated motherhood, including support for the parents of the pregnant girl if required.
- Educational and training institutions should support young pregnant women by encouraging them and facilitating in every possible way to continue with their education. With specific regard to women who choose adoption, women in voluntary mother and baby homes should be assisted in continuing their education and training during their pregnancy.
- More counselling should be provided for women who choose adoption. Agencies should provide the option of family counselling, especially post-adoption experiences to help facilitate an easier return to the family home after the adoption has taken place. Peer counselling should also be available. Each woman should also be made aware of all the legalities of adoption.

Strategies to reduce recourse to abortion

6.48 The 'Women and Crisis Pregnancy' study, along with earlier research and the submissions received, pro-

vides very valuable insights into the social context of abortion. Its publication has also stimulated public debate on possible ways in which the number of Irish women having abortions might be reduced. On receipt of the study the Department of Health and Children circulated it widely to health boards, relevant Government Departments and other agencies. Health boards were asked to review the adequacy of the family planning and counselling services in their areas, having regard to the study's findings, and to consider what service developments might be required. Additional funding has been provided to the health boards in 1999 for developments aimed at reducing recourse to abortion, especially among the 15-34 age-group.

6.49 This section identifies issues for discussion in the areas of education, contraception, and services for women experiencing crisis pregnancies with a view to highlighting possible strategies to reduce recourse to abortion. As a number of developments have taken place in recent years this section also summarises action to date under each heading.

Education

6.50 In 1997 the Department of Education and Science began a process of introducing Relationships and Sexuality Education (RSE) in both primary and second level schools. The intention is that this will be incorporated into the Social and Personal Health Education (SPHE) which will become core curriculum before 2000**.** The following objectives are incorporated in the programme:

- to educate and inform women fully about their bodies and reproductive systems, including the physiological knowledge of how pregnancy occurs and methods of contraception;
- to ensure that boys and young men receive education in relationships and sexuality;
- to give young people a language they can use to discuss relationships and sexuality;
- to empower young people to take responsibility for their sexuality and fertility;
- to empower them to evaluate the likelihood of becoming pregnant according to their sexual activity;
- to promote changed social attitudes to female sexuality;
- to promote male responsibility towards contraception;
- to facilitate the development of communication, assertiveness and decision-making skills.

Teachers have been trained, schools are developing policies on RSE and materials have been produced in order to provide effective relationships and sexuality education for all Irish young people.

6.51 From the perspective of the Department of Education and Science, provision has been made through the RSE curriculum and guidelines for the educational issues raised in the 'Women and Crisis Pregnancy' study to be addressed. In furthering this initiative the Department continues to work in close co-operation with the partners in education and the Department of Health and Children at national level, and promotes a collaborative approach to the introduction of RSE among teachers, parents and school management at local level.

6.52 Health Boards have also had an important role in establishing services to promote the sexual health behaviour of young people at risk, outside of the school setting. One example is the Eastern Health Board's Teenage Health Initiative. This programme is specifically targeted at young people in disadvantaged areas who have been identified as being at risk.

6.53 The following issues need to be considered and debated:

- Education on use of contraception is not currently included in the RSE curriculum. Further consideration needs to be given to how best to ensure that young people have access to full information in this regard;
- The need for approaches other than a school-based one, e.g. community-based 'outreach' programmes, media-based educational campaigns. Teenage health initiatives on the lines of those developed by the Eastern Health Board could be extended to other boards;
- Educational campaigns designed to cultivate more responsible attitudes to alcohol, with particular regard to alcohol and sexual activity and the risks involved;
- Educational programmes targeted at parents to encourage the open discussion of sexuality in the home.

Contraception

6.54 A range of family planning and health services is currently provided by the eight health boards, general practitioners and other agencies such as the Irish Family Planning Association and the Well Woman Centres. The Eastern Health Board has also set up a number of pilot projects to provide a range of women's health services, including family planning. New proposals include the establishment of a health centre specifically designed and targeted at marginalised young people.

6.55 The following issues are identified for further debate:

- the availability of the widest possible choice of service for women seeking advice on and services for contraception
- The production of an information booklet or leaflets which would be widely available regarding the correct and safe use of contraceptives;
- Improved access to contraception, including identification of and extension of services to meet current unmet need;
- The availability of contraception at little or no cost to everyone who needs it;
- Improved access to emergency contraception, especially outside the major urban areas;
- More widespread availability of sterilisation and vasectomies as part of the public health service;

- An examination of the role of GPs in the provision of family planning services.

Services for women with crisis pregnancies

Counselling and information

6.56 Since 1995 the Department of Health and Children has provided funding for agencies and health boards to provide pregnancy counselling. While this service has been of benefit to some women it appears that there is a lack of information as to what is available. There are some gaps in service provision and waiting times also affect access. The following measures are identified for further consideration:

- Publication of an information booklet which lists the pregnancy counselling services which provide information on (i) lone motherhood, (ii) abortion and (iii) adoption, to be made widely available in GPs' surgeries, clinics, pharmacies, hospitals etc.
- Counselling and information services should be available on a drop in basis/without any waiting period and the widest possible choice of service provider should be available;
- Counselling should be provided without charge to clients;
- Post-abortion counselling and post-abortion medical check-ups should be widely available and their availability advertised.

Adoption and lone motherhood

6.57 Much discussion has taken place on how the options of adoption and lone motherhood can be made more attractive to women considering abortion.

6.58 Adoption is a very complex issue. Central to any promotion of adoption as an option in the context of dealing with an unplanned pregnancy are the needs and wishes of the pregnant woman and the need to ensure that she is not subject to pressure or exploitation of any kind. The first consideration to be overcome relates to the manner in which contact is made with the pregnant woman early enough in her pregnancy in order to outline the benefits of adoption in a non-pressurised way.

6.59 In the 'Women and Crisis Pregnancy' study women who opt for adoption appeared to rule out abortion at the outset. As far as they were concerned adoption represented an alternative to lone motherhood as distinct from an alternative to abortion. It would appear from the research that adoption agencies were very much to the fore in promoting adoption as a real solution to crisis pregnancy and that this option continued to be reinforced throughout the counselling sessions.

6.60 One theme to emerge during the preparation of the Green Paper is the increased promotion of adoption and a number of suggestions have been put forward as to how women with crisis pregnancies might be made more aware of the nature of adoption practice nowadays and encouraged, if possible, to choose adoption in preference to abortion. The recently published 'Adoption Handbook' outlines the fact that there is much greater openness surrounding adoption nowadays. Irish adoption agencies go to great lengths to ensure that the birth mother has a say in choosing the type of family that the child will be placed with. Letters and photographs may be exchanged from time to time via the adoption agency but personal details will not be passed on while the child is under the age of 18 years.

6.61 Legal adoption is permanent and, traditionally, involves the severing of all ties between a child and its birth mother. Birth mothers who choose to give their baby up for adoption today have a reasonable prospect of being reunited with their child in future years should the child wish to do so. The great secrecy which attached to adoption in the past has been replaced by a more open and compassionate approach to the birth mother's need to know that the child had a happy life and the child's need to know its identity. However there is no statutory basis in Irish law for this more open approach to adoption and this limited openness does not necessarily compare with that in other countries.

6.62 Open adoption in its broadest sense is being practised in recent years in a number of cases in the United Kingdom and the USA. This type of adoption may include the sharing of information and sometimes contact between the birth parents and the adoptive parents before the birth of the child, at the time of placement and possibly through the child's life. Commentators identify a number of arguments for and against greater openness and contact in adoption. However the history of open adoption is too short to provide much research evidence in support of either viewpoint.

6.63 The Department of Health and Children's recently-established Child Care Legislation Unit has been researching the issue of a Contact Register and the broader issue of post-adoption contact generally as a preliminary to preparing legislative proposals. It is evident that there are very complex legal issues to be considered in the context of legislating in this area. The putting in place of a comprehensive post-adoption contact service may or may not serve to make adoption a more attractive option to a woman with a crisis pregnancy. For example the prospect of the child being able to trace her at a future date may not appeal to her, given the need for secrecy in the decision-making process of many women who opt for adoption. However on the other hand there may be women who would view adoption in a more attractive light if a post-adoption contact service was put in place. However it should be noted, as stated in paragraph 6.42, that the research indicates that women who opted for adoption do so in terms of their own circumstances rather than those of the adoptive parents. It must of course be remembered that the interests of the child must always be paramount where adoption is concerned, and that adoption is first and foremost a service for the benefit of the children involved, rather than any of the other parties.

6.64 Lone motherhood as an option has increased in popularity over the years, often for reasons which are identified as contributing to the fall in the number of babies available for adoption. These include a more enlightened and compassionate attitude to births outside marriage, greater family acceptance and support, improved allowances and housing, increased opportunities of combining education, career and single motherhood. While in the minority, the role of single father also merits consideration. While attitudes have changed and social provisions for single mothers have improved, the submissions received indicate that many people feel that further change is needed in these areas. However it would appear that there is considerable room for improvement. For example, there is still evidence of social stigma. The 'Women and Crisis Pregnancy' study refers to a small number of women who intended keeping their babies and who received no support from their families. There is also evidence that lone mothers miss out on education and career opportunities and that they are more likely to be in the lower economic categories.

6.65 In this context it is also relevant to recall the factors referred to by women who decided to have abortions. In most instances the reasons behind the woman's decision to have an abortion are very similar to those given by women who decide on lone motherhood. It would appear therefore that there is considerable variation in either the perception women have of the availability of supports and services or the actual availability of these supports and services. The influence of perceived social stigma, while significant, would also appear to vary depending on the circumstances of the woman concerned.

6.66 Health boards and voluntary agencies operate a number of initiatives to provide social support for young mothers. There are also a number of employment programmes targeted specifically at young mothers funded from national and EU sources.

6.67 The following measures are identified for further consideration:

- Examination of measures which might increase the acceptability of adoption including the promotion of more 'open' forms of adoption;
- Provision of improved counselling for women who choose adoption;
- Provision of more support for pregnant women by educational and training institutions to enable them to continue with their education, including the provision of services for women in mother and baby homes;
- An examination of income support structures and ancillary services, such as housing, for mothers who are unemployed;
- Availability of more flexible work patterns, such as job sharing/part-time work to facilitate working mothers;
- Improve provision of affordable childcare for working mothers;
- Provision of ongoing social support and counselling for lone mothers and their immediate families.

CHAPTER 7
POSSIBLE CONSTITUTIONAL AND LEGISLATIVE APPROACHES

Introduction

7.01 As indicated in Chapter 2, 'The Legal Context', several issues have been raised by the judicial interpretation of the constitutional and statutory provisions regarding abortion. This chapter sets out possible constitutional and legislative approaches to this issue. These range from an absolute constitutional ban on abortion to constitutional amendment and legislation permitting abortion on grounds beyond those specified in the *X* case. In considering these options the Government drew in part on the work of the Constitution Review Group. However, the views expressed in submissions received from the public and interested groups have also been central to formulating the options discussed.

7.02 Before dealing with these matters in detail however there is a number of background issues which may have a bearing on most if not all of the options dealt with in this chapter. The first of these is the Constitution Review Group and its work. Secondly, possible problems of definition relating to Article 40.3.3 of the Constitution are discussed. Thirdly, reference is made to the Medical Council's ethical guidelines, which are relevant to any possible approaches to the issue of abortion.

Constitution Review Group

7.03 A Constitution Review Group was established in April 1995 with the following terms of reference:

> To review the Constitution and, in the light of this review, to establish those areas where constitutional change may be desirable or necessary, with a view to assisting the all-Party Committee on the Constitution, to be established by the Oireachtas, in its work ...

In the course of its deliberations, the Group considered Article 40.3.3. In its report, produced in 1996, the Group discussed five possible approaches for addressing the issue of abortion generally. These are:

(a) introduce an absolute ban on abortion
(b) redraft the constitutional provisions to restrict the application of the *X* case decision
(c) amend Article 40.3.3 so as to legalise abortion in constitutionally defined circumstances
(d) revert, if possible, to the pre-1983 situation
(e) regulate by legislation the application of Article 40.3.3.

An extract from the report is contained in Appendix 5. The above classification of possible approaches has been adopted in part in considering the options available.

Possible problems of definition

7.04 In 1983, when the text proposed for Article 40.3.3 of the Constitution was being debated, some commentators were critical of the use of certain terminology which it was felt might give rise to problems of interpretation in the future. Article 40.3.3 reads as follows:

> 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.

Primarily the criticisms centred on the absence of a definition of the term 'unborn', and possible problems of interpretation concerning the phrases 'with due regard to the equal right to life of the mother', and 'as far as practicable'.

7.05 The Constitution Review Group Report devoted considerable discussion to possible problems associated with the absence of a definition of the term 'unborn'. The Group's view was that '… in the context of abortion law, which deals with the termination of pregnancy, a definition is essential as to when pregnancy is considered to begin; the law should also specify in what circumstances a pregnancy may legitimately be terminated and by whom'.

7.06 The Constitution Review Group went on to suggest that the term the 'unborn' could be defined either (a) by making definitions by legislation in the expectation that, if challenged, they may be held by the Supreme Court to be in conformity or not with the Constitution itself or (b) in the Constitution itself (or alternatively to authorise expressly by a constitutional provision the making of all necessary definitions by legislation).

7.07 The issue of whether the term 'unborn' should be or can be defined may again arise in any option involving the retention of Article 40.3.3 or in any amendment of the article which uses the term. If it is decided therefore that 'the unborn' should be defined, at least four types of definition are possible, as follows: (i) the time of fertilisation, (ii) implantation, (iii) some other specified time after fertilisation, or (iv) viability.

7.08 From an analysis of the campaign surrounding the 1983 amendment it would appear that supporters of the amendment were satisfied that the term 'unborn' provided constitutional protection from the time of conception/fertilisation, although the actual timing of this cannot be precisely defined. Although the issue has never directly arisen for consideration by the Courts there is some judicial support for this interpretation (*Attorney General (SPUC) v. Open Door Counselling* [1988] IR 583 at 588). Were such an interpretation to be formally confirmed, it would appear to cast some doubt over the legality of the use of post-coital contraception (the 'morning after' pill and post-coital IUD) but neither have been subjected to legal challenge since the passing of the 1983 constitutional amendment and do not appear currently to cause any difficulties for the medical profession. However, a formal definition of the 'unborn' in the Constitution or in legislation might alter this situation.

7.09 While not of direct relevance to this Green Paper the implications of defining the term 'unborn' in this way for *in vitro* fertilisation (IVF) and the freezing of embryos must be considered. If it were specified within a definition that the protection of Article 40.3.3 extended to *in vitro* fertilisation, legal problems could arise in relation to some practices in this area. If, as an alternative, it was decided to specifically exclude *in vitro* fertilisation from the protection of Article 40.3.3, the result could appear anomalous.

7.10 The second approach, i.e. defining the term 'unborn' as commencing from 'implantation' could be imprecise and would probably require some further definition. If a definition of 'implantation' was considered feasible, the difficulties regarding post-coital contraception and IVF treatment would not arise, although legislative regulation of the latter would still be required.

7.11 The third approach, i.e. defining the term 'unborn' as commencing from a specified time after fertilisation (for example 'ten days after fertilisation') would not interfere with current practice regarding the use of post-coital contraception (provided the specified time chosen was not so early as to render such a practice unconstitutional). However it could be expected that there would be significant opposition to a definition along these lines.

7.12 With regard to the final approach, 'viability', it must be said that this definition does not reflect current medical practice or the accepted current constitutional and legal position, nor was it proposed in any of the submissions received. It would permit abortion on grounds wider than those specified in the *X* case judgement. Such a definition would require a constitutional amendment.

7.13 Finally, the option of continuing to operate without a definition of the 'unborn' must also be given consideration. Although the difficulties associated with the term 'unborn' cannot be dismissed, they have not troubled the Courts or the medical profession to date. It is significant that in the debate over an amendment to the Constitution in 1992 the issue of defining the term 'unborn ' did not feature to a significant extent. It is arguable that much of the difficulty relates to the implications of possible definitions for the whole area of IVF treatment, which, in itself, is not of direct relevance to the Green Paper.

Medical Council Ethical Guidelines

7.14 The Medical Council's ethical guidelines have been referred to in Chapter 2, 'The Legal Context'. In the discussion in that chapter the issue as to whether or not these guidelines accord with the current constitutional position was raised. In this chapter the guidelines are significant not just insofar as they

do or do not reflect the current legal position but insofar as they are relevant to the constitutional and legislative options being proposed. A central consideration to any discussion of options is the position of doctors whose decision to perform an abortion could result in a decision by the Medical Council to strike them off the register.

Approaches for discussion

7.15 As stated earlier, some submissions received by the Working Group were in favour of a new constitutional amendment to achieve what they referred to as a total ban on abortion. Other submissions represented a less restrictive approach (for example, to permit abortion in the circumstances of the *X* case but excluding the risk of suicide), while some favoured the availability of abortion in the circumstances outlined in the *X* case. Some other submissions favoured the availability of abortion in circumstances which were broader than those set down in the *X* case – for example, in cases where pregnancy has resulted from sexual assault, where serious foetal abnormality has been detected, or where the mother's physical or mental health is at risk. A small number of submissions described abortion as a rights/class issue and advocated the availability of abortion with few restrictions (see Chapter 5, 'The Submissions to the Interdepartmental Working Group', paragraphs 5.84 and 5.86).

7.16 On this basis, the following approaches are discussed below:

(i) An absolute constitutional ban on abortion;
(ii) An amendment of the constitutional provisions so as to restrict the application of the *X* case;
(iii) The retention of the *status quo*;
(iv) The retention of the constitutional *status quo* with legislative restatement of the prohibition on abortion;
(v) Legislation to regulate abortion in circumstances defined by the *X* case;
(vi) A reversion to the position as it pertained prior to 1983;
(vii) Permitting abortion on grounds beyond those specified in the *X* case.

(i) Absolute constitutional ban on abortion

7.17 While this option is referred to in submissions as an absolute ban on abortion, the intention appears to be to retain existing medical practice and to permit treatment where the loss of the foetus is the indirect consequence of treatment necessary to save the life of the mother. Advocates of this option do not accept that direct abortion is ever necessary to save the mother's life.

Discussion

7.18 There are a number of dimensions to this option which require careful consideration. The discussion in Chapter 1, 'Pregnancy and Maternal Health', indicates that although some doctors maintain that direct termination of pregnancy is never necessary, others, in their clinical judgment, maintain that there can be situations where a direct termination is required to save the life of a woman. While the vast majority of conditions in pregnancy are managed successfully, international scientific literature documents situations where elective termination was performed to protect the life of the mother. Some studies, however, conclude that clinical conditions can be treated successfully by medical or surgical management without recourse to termination of pregnancy.

7.19 Any wording designed to achieve a complete constitutional ban would therefore bring the medical treatment of expectant mothers into sharp focus. If an absolute ban on direct abortion were put in place, there would be implications for cases where any doctor considered that certain treatment involving the removal of the foetus was necessary in order to save a woman's life, including the types of cases discussed in Chapter 1. There might also be implications in relation to the laparoscopic treatment of ectopic pregnancies frequently carried out in Ireland, where the foetus is directly removed from the fallopian tube. In cases such as the laparoscopic treatment of an ectopic pregnancy, or the termination of a pregnancy in cases of severe eclampsia, Eisenmenger's syndrome or the conditions mentioned in paragraph 1.22, it is difficult to see how the destruction of the embryo can be described as an unintended side-effect.

7.20 It would also appear that in its ethical guidelines the Medical Council has added to the concept of direct/indirect abortion, a reference to the state of mind of the person carrying out the procedure ('deliberate or intentional'). The question arises as to whether the use of such words in a constitutional amendment would allow doctors to maintain their practice of undertaking a medical intervention in appropriate circumstances, even though this may result in the termination of the pregnancy. (The question of a distinction, from a medical perspective, between direct and indirect abortion is discussed in Chapter 1, paragraph 1.09.)

7.21 The manner in which the Courts might interpret such concepts in a constitutional context is an entirely open question. It cannot be stated with certainty whether the law would or would not make a distinction between the direct or the deliberate and intentional abortion of an unborn child, as referred to in the Medical Council Guidelines, and unintentional foetal loss which comes about as a side-effect of medical treatment. The issue was not addressed by the Supreme Court in *Attorney General v. X*, although Hederman J did, in the course of his dissenting judgement refer to the 'indirect but foreseeable result of an operation undertaken for other reasons' and stated that he did not think any operation of which the sole purpose was saving the mother could be a direct killing of the foetus.

7.22 It should also be borne in mind that Article 40.3.3 of the Constitution is framed in terms of the right to life of the unborn and does not refer at all to abortion, direct or indirect. Legal difficulties which may arise in relation to the concept of direct and

indirect abortion do not therefore exist at present. They may arise, depending on the wording of an explicit constitutional prohibition on abortion. The approach taken by the then Government in the 1992 referendum campaign indicates that it had considerable concerns over attempts to make a distinction between direct and indirect abortion. The wording put forward in the 1992 referendum on the substantive issue of abortion reflected the Government's view that, however remote, the possibility of an abortion being necessary in order to save the life of a pregnant woman could not be ruled out and that a distinction as between direct and indirect abortion could not therefore serve as the basis for a constitutional provision.

7.23 In its consideration of the option of introducing an absolute constitutional ban on abortion, the Constitution Review Group concluded that reliance on the understanding of indirect abortion put forward by certain of the interest groups is unsafe.

7.24 An absolute ban on abortion may therefore have the effect of compromising current medical procedures accepted under the ethical guidelines, unless a way can be found to incorporate appropriate definitions into the Constitution. The extent to which proposed wordings successfully make the distinction between direct and indirect abortion, or indeed whether it is possible to make such a distinction, are matters for further consideration. An absolute ban would also seem to accept the contention that a 'direct' abortion is never necessary to save the life of a mother, although the evidence on this point is not conclusive and that contention remains controversial.

7.25 It is possible that the ethical guidelines currently in force may be changed in the future, for example to reflect a different, more liberal, ethical approach or to take account of developments in medical practice. An explicit constitutional prohibition on direct termination of pregnancy would circumscribe the Medical Council's freedom to draw up guidelines as it considered appropriate, if it sought to adopt a more liberal approach.

7.26 The difficulty of arriving at an acceptable wording to provide for a constitutional prohibition on abortion should not be underestimated. Considerable debate and effort preceded the formulation of the 1983 amendment, which later proved not to afford the protection to the unborn which many believed it to confer. In 1992, the Government of the day put forward a formula which was judged to be the best possible in the circumstances, yet this was rejected by the electorate.

7.27 Finally, consideration would be required as to whether this option would be compatible with the State's obligations under the European Convention on Human Rights, as it would allow for the deliberate termination of pregnancy only where this is an indirect consequence of medical treatment intended to save the life of the mother. There is case law of the European Commission of Human Rights which suggests that such an absolute ban on abortion may not accord with the State's obligations under the Convention (see Chapter 3, paragraph 3.11). However case law of the European Court of Human Rights indicates that States Parties to the Convention enjoy a very wide margin of discretion in regulating abortion. The limitations to this discretion are not clear.

(ii) Amendment of the constitutional provisions so as to restrict the application of the *X* case

7.28 This option proposes that the Supreme Court's decision in the *X* case be modified by the removal of a risk or threat of self-destruction as a ground for establishing that a real and substantial risk to the life of the mother exists. As such it would meet the *X* case test except that it excludes the risk of suicide.

7.29 After the *X* case in 1992 the Oireachtas passed three Bills proposing amendments to the Constitution. The aim of the first Bill was to remove risk of suicide as grounds for permitting abortion. The second Bill dealt with the question of freedom to travel abroad and the third dealt with the issue of information on services lawfully available in other states. These Bills have been discussed in Chapter 2, 'The Legal Context'.

7.30 The first Bill proposed to amend the Constitution for the twelfth time by appending the following provision to Article 40.3.3:

> It shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life, not being a risk of self-destruction.

The proposed amendment was defeated.

Discussion

7.31 The wording used in 1992 sought to meet the concerns of those who wished to safeguard the provision of medical treatment to pregnant women, whilst removing suicide risk as a ground for abortion. In 1992 however many rejected what was perceived to be an explicit acknowledgement that direct, intentional interference with the right to life of the unborn could ever be justified. It is useful to recall the position of many of those opposed to abortion, i.e. that a direct abortion is *never* necessary to save the life of the mother.

7.32 The proposed amendment was also opposed by groups who wished at a minimum to ensure that abortion was permissible in circumstances equivalent to those of the *X* case, including suicide. Concern was also expressed by some groups about the distinction made in the wording between life and health of the woman.

7.33 This option can therefore be described as adopting the same general approach as the proposed Twelfth Amendment in 1992. While the question of a wording to achieve the purpose of the amendment

would of course be examined afresh, in view of the amount of effort which went into the formulation of the draft proposed in 1992, the difficulty in arriving at an acceptable wording is considerable. It is also possible that while definition of the 'unborn' did not feature to any great extent in the debate surrounding the proposed Twelfth Amendment in 1992, a new debate could result in the need for such a definition being placed on the agenda.

7.34 Consideration may also be given to whether a proposal of this sort would require accompanying legislation. In 1992, such accompanying legislation was considered unnecessary by the Government. If legislation was proposed under this option it would, in line with the proposed constitutional amendment, exclude suicide as grounds for abortion. The publication of draft legislative proposals in the context of this approach might serve to reassure some of those concerned about this approach on the grounds that it might be open to abuse.

7.35 Prior to a referendum designed to exclude the risk of suicide, it would be possible to publish draft legislation setting out provisions specifically related to the suicide risk, including a certification process in relation to this, which would be enacted if the amendment were not to succeed. If the electorate voted to remove 'the suicide risk' then the Bill would be enacted without those provisions relating to suicide risk. If they voted to retain suicide risk, then the Bill would be enacted with relevant provisions. The legislation would of course be subject to amendment by the Oireachtas, either during its passage through the House or, subsequently, by way of amending legislation

7.36 It may also be speculated that those opposed to the 1992 wording on the grounds that it was not liberal enough will continue to maintain this opposition. The *C* case of 1997, which is described in Chapter 3, 'The Legal Context', again brought to the fore the issues surrounding suicide risk.

(iii) Retention of the *status quo*

7.37 If it is not possible to reach consensus on constitutional and/or legislative reform, the existing situation will continue, with further cases which may arise being decided on an individual basis by the courts under Article 40.3.3, as interpreted by the *X* case. This means that the courts will refer to the judgement of the Supreme Court in that case, i.e. that a termination is lawful, if it is established, as a matter of probability, that there is a real and substantial risk to the life, as distinct from the health, of the mother and that this real and substantial risk could only be averted by the termination of her pregnancy. The Supreme Court also found that 'a real and substantial risk' includes the risk of suicide, unless on some future occasion the Supreme Court reverses its decision in the *X* case.

Discussion

7.38 While it can be argued that the retention of the *status quo* strikes a balance between those who argue for a return to the law as they thought it to be before the *X* case and the wishes of those who would like to see abortion available in circumstances other than those laid down in the *X* case, a number of issues would remain unresolved, including the possible problems of definition mentioned in paragraph 7.04. Retention of the status quo without legislation also has the disadvantage that the courts would become the ordinary forum for resolving issues relating to medical treatment and abortion.

7.39 It is not possible to predict what the nature of any future cases might be, nor their outcome. It is also possible that on some future occasion the Supreme Court may not arrive at the decision in the *X* case and could indeed potentially alter the test set out in the *X* case. It is impossible to predict the outcome of such future cases. In the current situation there are aspects about which the legal position is uncertain. For example, none of the judges in the Supreme Court adverted to time limits.

7.40 It is also noted that the judgments in the *X* case offer no direct guidance as to the liability of medical personnel who might consider a direct termination of pregnancy necessary in circumstances in which it is not absolutely clear that the mother's life is at risk or alternatively, if a decision not to perform an abortion resulted in the death of the mother.

7.41 Issues which also remain unaddressed are the question of guidance as to the evidence which would be necessary to justify an abortion and some statutory protection for the rights of those personnel who did not wish, for conscientious reasons, to assist in or be associated with the termination of the pregnancy.

(iv) Retention of the constitutional *status quo* with legislative restatement of the prohibition on abortion

7.42 The constitutional *status quo* could also be retained in combination with the introduction of statutory law which addresses the ambiguities and uncertainties in the present situation. One such option is to leave the Constitution in its present form and to re-enact the criminal prohibition on abortion in Ireland in the form of a new Act to replace the relevant provisions of the Offences Against the Person Act, 1861.

7.43 Such legislation would provide for a general criminal prohibition on abortion in the form of a criminal offence prosecutable on indictment. The legislation would provide that it would be a defence in any prosecution to establish that the actions in respect of which the prosecution was brought were taken by a doctor who was a registered medical practitioner and that the doctor in question had reasonable grounds to believe and did believe in good faith that the actions taken by him were necessary to avoid a real and substantial risk to the life, as

distinct from the health, of the mother. The effect of such legislation would be to restate in strong terms the general criminal prohibition on abortion in Ireland, while at the same time leaving room for existing medical procedures subject to tightly controlled legal circumstances.

7.44 The present constitutional provisions, as interpreted by the Courts in the *X* and *C* cases, allow for termination of pregnancy to avoid a real and substantial suicide risk to the life of the mother. Under this option the suicide risk could be dealt with by including a mechanism to restrict any claim based on suicide risk to cases where the medical practitioner clearly proved any such risk in advance to an appropriate expert committee and authorisation would have to be obtained from the committee. Such a provision would act as a 'double lock' against the possibility feared by many people that 'suicide risk' justification could provide a back door to 'abortion on demand'.

7.45 Another possible approach to the suicide risk could be to exclude any defence based on psychological or psychiatric grounds (including suicide). This approach would, however, be vulnerable to constitutional challenge in the light of the *X* and *C* case judgments.

7.46 Legislation of the type outlined above would have the advantage of permitting existing medical practice to continue in relation to certain established medical procedures. Whichever approach was taken in such legislation to suicide risk-related termination of pregnancy, the legislation would guarantee that it did not become a 'back door' to the availability of abortion on demand in Ireland.

7.47 This approach would seek to meet the criticisms made in the Supreme Court and elsewhere that the State had failed to provide any laws on foot of the constitutional amendment in 1983 to protect the life of the unborn in Ireland. In addition, it can be argued that legislation is capable of being more comprehensive and detailed than general provisions set out in the Constitution, and more capable of discriminating between desired and undesired consequences.

(v) Legislation to regulate Abortion in circumstances defined in the *X* case

7.48 The objective of this approach would be to implement the *X* case decision by means of legislation, i.e. to introduce legislation providing that a termination of pregnancy is lawful '… if it is established as a matter of probability that there is a real and substantial risk to the life, as distinct from the health, of the mother and that that risk can only be avoided by the termination of pregnancy.' This approach assumes that there would be no change in the existing wording of Article 40.3.3.

7.49 In formulating such legislation a possible approach may be not to restate the prohibition on abortion, which is already contained in section 58 of the Offences Against the Person Act, 1861, but instead to provide that a termination carried out in accordance with the legislation would not be an offence.

7.50 The detail of such legislation would require careful consideration but it could be along the lines of that discussed under the previous option (retention of the constitutional *status quo* with legislative restatement of the prohibition on abortion.).

Discussion

7.51 Since this option does not provide for a regime more liberal than the *X* case formulation, no constitutional amendment would be required. This option would, however, provide for abortion in defined circumstances and as such, would be certain to encounter criticism from those who are opposed to abortion on any grounds and who disagreed with the decision in the *X* case. Central to the criticism would be the inclusion of the threat of suicide as a ground and the difficulties inherent in assessing same.

7.52 The main advantage of this approach is that it would provide a framework within which the need for an abortion could be assessed, rather than resolving the question on a case-by-case basis before the courts, with all the attendant publicity and debate. It would allow pregnant women who establish that there is a real and substantial risk to the their life to have an abortion in Ireland rather than travelling out of the jurisdiction and would provide legal protection for medical and other personnel, such as nurses, involved in the procedure to terminate the pregnancy. The current medical ethical guidelines would not be consistent with such legislation.

7.53 It must be pointed out however that the problems of definition in the text of Article 40.3.3 would remain. A decision would be necessary on whether the proposed legislation would provide the definitions necessary to remove the current ambiguity surrounding the text of that Article. There is however a limit to what legislation can achieve by way of definitions as ultimately the interpretation of Article 40.3.3 is a matter for the Courts.

(vi) Reversion to the pre-1983 position

7.54 This option envisages reverting back to the pre-1983 position by deleting Article 40.3.3 which was interpreted in *Attorney General v. X* as permitting abortion if there is a real and substantial risk to the life, as distinct from the health, of the mother, including a risk of suicide. It would, as a consequence, involve reliance on the provisions of the Offences against the Person Act, 1861 and implied constitutional protection for the unborn referred to in the cases cited in Chapter 2, 'The Legal Context'.

Discussion

7.55 As with all the options dealt with in this chapter it is important to be clear as to what the effects of the option would be, if implemented. It would appear that some who favour this option believe that deletion of Article 40.3.3 would negate the effect of

the judgment in the *X* case and restore a simple prohibition on abortion as provided for in the Offences against the Person Act, 1861 and in *obiter dicta* in a number of cases up to 1984 (see Chapter 2, paragraph 2.09). However, the removal of the provision which was inserted in the Constitution in 1983 would not of itself negate the decision in the *X* case. The decision in the *X* case was arrived at in order to protect the right to life of the mother. The right to life of a mother, as with that of any other born person, was fully protected in the Constitution before the 1983 amendment was passed. In this respect, the only change effected by the 1983 amendment was to equate the mother's right to life with that of the unborn. Even in that situation, however, the court held in the *X* case that the mother's right to life must be protected, if necessary by the destruction of the unborn child. The removal of the 1983 amendment would not change this and if a future case arose, on the same facts as the *X* case, the court would still be constrained, if it followed the decision it arrived at in the *X* case, to hold that the mother's right to life entitled her to obtain an abortion.

7.56 The provisions of the 1861 Act are discussed in Chapter 2. It is useful however at this point to repeat some of the detail. The most notable interpretation of section 58 is contained in the English case *R v. Bourne* where the Court, accepting that abortion to preserve the life of the pregnant woman is not unlawful for the purposes of section 58, ruled that, where a doctor was of the opinion that the probable consequence of a pregnancy was to render a woman a mental and physical wreck, he could properly be said to be operating for the purpose of preserving the life of the mother.

7.57 The *Bourne* decision has been followed in many other jurisdictions including Northern Ireland, Australia, Canada, New Zealand and the United States. In subsequent cases it has been suggested, e.g.. in *R v. Newton and Stungo* (United Kingdom) in 1958 that section 58 may be interpreted in a wider sense so as to permit abortion on grounds of physical and mental health.

7.58 The *Bourne* decision has not been specifically followed in any decision in the Irish courts. Furthermore, as stated in Chapter 2, in *Society for the Protection of the Unborn Child v. Grogan and Ors*, 1997 Keane J expressed the opinion *obiter dicta* that 'the preponderance of judicial opinion in this country would suggest that the Bourne approach could not have been adopted in this country consistently with the Constitution prior to the Eighth Amendment.'

7.59 Prior to the Eighth Amendment in 1983 the Irish Constitution did not contain any specific provision aimed at prohibiting abortion. However *obiter dicta* in a number of cases suggested that the Constitution implicitly prohibited abortion and it is clear that the right to privacy under the Constitution has never been interpreted by the Courts in any case as encompassing a right to abortion.

7.60 The question arises as to whether the insertion of Article 40.3.3 achieved additional safeguards against the introduction of abortion. It became clear in the early 1980s and before that many who were opposed to abortion did not regard the existing provisions as adequate. It was argued that it was necessary to insert a specific article into the Constitution which would prohibit abortion. This was to avoid a situation where, by virtue of judicial interpretation of the right to privacy guaranteed in the Constitution, abortion was deemed to be lawful. The *X* case ruling therefore ran contrary to the intention of those who proposed the amendment.

7.61 It can be seen from the foregoing that the Offences against the Person Act, 1861 has been interpreted in other jurisdictions as permitting abortion in certain circumstances. While *obiter dicta* in cases prior to 1983 would indicate a constitutional prohibition on abortion, there is little guidance on how that prohibition would be reconciled with a threat to the life or the health of the mother, given that the mother's constitutional rights also require protection.

7.62 An alternative motivation for the deletion of Article 40.3.3 is the view that the insertion of provisions in the Constitution in relation to the unborn should not have occurred in the first place. Indeed some commentators have expressed the view that the Constitution is not the appropriate vehicle through which to deal with the complex issue of abortion.

7.63 If it was decided to attempt to revert to the pre-1983 position, the Constitution Review Group also raised the point that doctors would in that event have to be afforded legislative protection for appropriate medical intervention, on the basis that it could not be said how far, if at all, the 1861 Act's presumed protection for doctors would be effective in Ireland.

7.64 If this option were to be adopted and Article 40.3.3 deleted, at the very least the travel and information provisions of the Article could not be maintained in their present form. It could be anticipated that there would be a desire among many people to retain them in the Constitution as independent entitlements.

(vii) Permitting abortion on grounds beyond those specified in the *X* case

7.65 In Chapter 4, other possible grounds for abortion are examined and set where possible in an international context. As indicated earlier, a number of submissions also sought the introduction of abortion on some or all of these grounds. Each of the possible types of provision identified has been considered separately. This does not rule out consideration of a combination of some or all of these options if this approach were to be pursued. Were this to be done, some of the difficulties identified when options are considered separately might not arise.

7.66 In all of the cases discussed in this section, abortion would be permissible only if Article 40.3.3 of the Constitution were amended. Sections 58 and 59 of the Offences Against the Person Act, 1861 may also

need to be reviewed and new legislation to regulate any new arrangement would be necessary. The type of legislative model referred to in the discussion on the option of retention of the constitutional *status quo* with legislative restatement of the prohibition on abortion (see paragraphs 7.42-7.47) might, with appropriate adaptations, serve as a basis for regulation in other circumstances also. Issues such as criteria under which an abortion would be permissible, gestational limits, certification and counselling requirements, and possibly a waiting period after counselling, would be among the matters which legislation might address. The provisions in force in some other countries are also discussed in Chapter 4.

Discussion

(a) Risk to physical/mental health of mother

7.67 This option would provide for abortion on grounds of risk to a woman's physical and/or mental health.

7.68 In 1992 the proposed Twelfth Amendment to the Constitution was the subject of some criticism on the grounds that it specifically excluded risk to health as grounds for termination of a pregnancy. The English *Bourne* case of 1938 involved interpretation of the Offences Against the Person Act, 1861 to permit termination of a pregnancy where a doctor thought that the probable consequence of continuing a pregnancy would be to make the woman a physical or mental wreck.

7.69 As stated earlier, this case has not been specifically followed in any decision of the Irish courts. Article 40.3.3 of the Constitution would rule out an interpretation of the Offences Against the Person Act, 1861 in the manner of the *Bourne* judgement. Therefore any proposal to permit abortion on the grounds of danger to a woman's health would require amendment of this Article and possibly a review of the Sections 58 and 59 of the Offences Against the Person Act, 1861. A legislative framework to regulate the operation of such arrangements would also be required.

7.70 As discussed in Chapter 4, 'Wider Grounds for Abortion, Set in an International Context', the concept of physical health used in other countries for the purposes of abortion law tends not to be very specific. If it were intended to permit abortion on grounds of risk to a woman's health, but to confine the operation of such a provision to cases where there was a grave risk of serious and permanent damage, it would be necessary to circumscribe the provisions in an appropriate manner. The usual practice in other countries is for the issue to be treated as a medical matter. It could be anticipated that it might be difficult to arrive at provisions which would allow clinical independence and at the same time be guaranteed to operate in a very strict manner so as not to permit abortion other than on a very limited basis.

(b) Abortion for Women Pregnant as a result of Rape or Incest

7.71 This option would permit abortion where a woman was pregnant as a result of rape or incest.

7.72 Some countries permit abortion where the woman is pregnant as a result of sexual assault. It should be noted that these countries tend to permit abortion on other grounds as well, which may enable some women who have been sexually assaulted to obtain an abortion on these grounds rather than the sexual assault provisions. These countries do not lay down a requirement that the sexual assault be verified. The reporting of the assault to the police is the principal requirement.

7.73 Legislative arrangements to permit abortion in circumstances where a woman had become pregnant as a result of sexual assault might consist of a requirement that the assault be reported to the Gardaí. As indicated in Chapter 4, however, the evidence is that many rapes are not reported to the Gardaí. There may be many reasons for this. However the fact that this is so suggests that to permit an abortion only if a rape had been reported to the Gardaí would in effect make it available only if a woman was prepared to subject herself to the process which could follow if proceedings against any alleged rapist were instituted by the authorities. There is also the question of legal proof with regard to rape outside the jurisdiction, for example a case where a woman became pregnant after being allegedly raped while on holiday abroad.

7.74 In the case of a pregnant female under 17, since sexual intercourse with a person in this age category of itself constitutes a criminal offence, it could be argued that no further evidence of the circumstances in which the pregnancy occurred might be required in order for an abortion to be permissible.

7.75 As regards physical proof of rape, a woman might at the time of an assault have gone to a sexual assault treatment unit, but pregnancy, should it ensue, might not be confirmed for a number of weeks afterwards. The records made by a sexual assault treatment unit might, subject to considerations of confidentiality, provide a means of assessing a woman's claim to have been raped. However such records would not in themselves amount to proof that a rape had occurred.

7.76 Practical difficulties could arise if it were a requirement that a prosecution be secured or even commenced in respect of the rape. The time factor is also a consideration in this regard, as a case would probably take months or even years to come before a court and in any event might not result in a prosecution.

7.77 The particular circumstances of many incest cases would also render problematical the operation of strict tests of proof, because of the ongoing and coercive nature of many such relationships.

7.78 Another option therefore would be to accept a woman's word that she had been the victim of sexual

assault, with the option of this being corroborated insofar as possible but that such corroboration not be made an essential requirement.

7.79 Concern has been expressed that if abortion were permitted on the grounds of sexual assault, it might not be possible to confine it to genuine cases and that women who wished to have an abortion for other reasons could do so under such a provision.

(c) Congenital malformations

7.80 This option would permit abortion where a congenital malformation of the foetus had been diagnosed ante-natally.

7.81 The relevant provisions in other countries do not seem to include detailed specification of the conditions covered by such arrangements. Diagnosis that the foetus is impaired and the question of an abortion are matters between the woman and the medical personnel treating her.

7.82 This option is one of the most complex, were it to be considered. It could be expected that the question would arise as to what types of condition would be covered and how it could be ensured that the provisions would not be open to abuse, particularly if a tightly circumscribed arrangement were considered desirable.

7.83 It would not be practical to include in the Constitution a detailed specification of the types of conditions for which abortion would be permissible. It would be difficult even to do so in legislation, given the very lengthy list of conditions which might be involved. The desired parameters of any provision would also need to be considered, for example, would only conditions incompatible with survival after birth be at issue, or would a category such as 'severe handicap' be admitted? The discussion in Chapter 4 has already described the difficulty of neatly defining conditions incompatible with life and has shown that there is a wide spectrum of congenital malformations which cause greatly differing degrees of incapacitation or handicap. While pre-natal testing may indicate the likely presence of a handicapping condition, with many conditions the severity of a child's handicap is often apparent only after birth or during the child's developmental period. This could present a difficulty for any arrangement the intention of which was to permit abortion only in circumstances where a severe malformation of the foetus was diagnosed. Indeed, the difficulty of accurately diagnosing abnormalities *in utero* could result in the abortion of a foetus which was in fact healthy.

7.84 The chances of a child with some of the conditions considered surviving after birth vary according to the condition involved and the circumstances of each individual case. Therefore it would probably not be practical to have a category of 'incompatibility with life', as the period of survival after birth can vary from nil to some hours, several days, weeks or even months. For example, with anencephaly, where the brain fails to develop, most infants die during delivery but some may survive for a matter of hours. With some of the conditions involving chromosomal defects many children die in the early months of life, but some may live for considerably longer, even into adulthood.

7.85 Where gene defects are concerned, the hereditary nature of the conditions involved means that that chance of the condition being inherited by a carrier's children may be relatively high and there is a body of opinion which considers that termination should be available where pre-natal testing indicates the presence of the condition in the foetus. A contrary view is that abortion should not be permissible, even in such circumstances.

7.86 The issues identified above would require detailed examination if abortion on grounds of foetal impairment were to be considered. While other countries have legislation permitting abortion in these circumstances, it would appear that they specify in general rather than specific terms what types of condition are covered.

(d) Abortion for economic or social reasons

7.87 Under this option abortion would be permitted where certain specified criteria regarding a woman's social or family circumstances were met.

7.88 The statistics and research indicate that the great majority of abortions carried out in Britain on Irish women are performed for social reasons. The nature of these reasons is discussed in Chapter 6, 'The Social Context'.

7.89 In practical terms it would not be possible to put a provision of this type in place and at the same time to confine its application to only a small number of cases. Therefore it must be seen as putting in place a relatively liberal regime in relation to abortion. The experience of other countries indicates that because of the general way in which provisions of this type are expressed, they tend to enable women to obtain an abortion without undue difficulty. By their very nature such provisions are usually intended to have this effect.

(e) Abortion on request

7.90 This option would permit abortion where a woman requested it.

7.91 Where an arrangement of this type exists in other countries it is usually subject to a gestational time limit and consultation or counselling requirements, (e.g. in Austria or Denmark, up to the twelfth week of pregnancy). However in effect no other constraint would be in place to prevent a woman obtaining an abortion.

Discussion of options

7.92 The purpose of this chapter has been to set out a range of possible constitutional and legislative approaches for consideration. In doing this it draws on the work of the Constitution Review Group.

Reference has also been made to possible problems of definition associated with the text of Article 40.3.3 of the Constitution and the ethical guidelines issued by the Medical Council.

7.93 The discussion has identified advantages and disadvantages with each of the options. The question as to which, if any, of the approaches discussed in the foregoing is feasible and would find majority support is one for further debate. The Government is conscious that when these issues have previously been discussed publicly, prior to the 1983 and 1992 referenda, the debate became bitter and polarised, and it is anxious if possible to avoid a repetition of the type of debate which characterised those campaigns. It is hoped that by setting out the options in this Green Paper that the debate this time around will not be characterised with the previous acrimony.

7.94 An underlying feature which arises in the context of further debate is that there are major differences between those who hold the view that the Constitution should contain a provision which has the effect of prohibiting abortion and those who consider that the Constitution is not the appropriate vehicle to address the complex issues involved. On the one hand, those seeking a prohibition consider that the Constitution is the appropriate means of ensuring that human life is protected from its earliest stages and that such a fundamental issue as the right to life is not left in the hands of the legislature. On the other, it can be argued that such an approach seeks to circumscribe unnecessarily the elected representatives of the people in the discharge of their functions as legislators. It is accepted however that widely different approaches exist in many countries as to the issues which are appropriate to parliamentary decision and which are referred to the people in referenda.

7.95 An issue which will require further attention, if further constitutional change is under consideration, is what type of wording for an amendment will accurately provide what is intended and would have majority support. While a range of suggested wordings has been put forward for either additions to the current Article 40.3.3 or replacement of it, it is not considered that this Green Paper should attempt to weigh up the effects which any of these wordings, if adopted, would have. If further constitutional change is proposed, the merit or demerit of such a proposal depends exclusively on the wording suggested for such an amendment. Any amendment will have legal effects depending on its wording. Each and every possible legal effect of any amendment must be considered very carefully. It is also worth bearing in mind that the current article has been interpreted by the Supreme Court in a manner which many people would not have considered possible, when the wording for it was being debated in the early 1980s. For the people to judge wisely between arguments for and against an amendment of the Constitution, the debate must focus on the details of the amendment rather than its principle.

7.96 The desire of many people to ensure that there can be no abortion in Ireland in any circumstances, while appearing at first sight to be simple to achieve, encounters difficulties when the medical issues are discussed. While there are considerable differences of opinion in the medical profession as to whether there are any circumstances, even very rare ones, where a pregnancy may have to be terminated so as to save a mother's life, the international scientific literature documents situations where elective termination was performed to protect the life of the mother. In 1992 the then Government took the approach that, if there is even a very slight chance that such a termination might be necessary, the Constitution should not prohibit it.

7.97 The Government is also conscious that the debate on the constitutional and legal issues which will take place arises against the background of very significant numbers of Irish women having abortions in England and Wales each year. It is firmly of the view that this issue must be addressed and that every effort must be made to offer women with crisis pregnancies realistic and practical options along the lines discussed in Chapter 6, so that they will feel that they have real alternatives to abortion.

GLOSSARY OF MEDICAL TERMS

Amniocentesis – the sampling of amniotic fluid usually by percutaneous puncture under the guidance of ultrasound. It is performed early in the second trimester of pregnancy and may be used to screen mothers at high risk of producing an offspring with a congenital abnormality such as Down's Syndrome or Spina Bifida.

Amniotic fluid – the contained within the amnion that surrounds the foetus in the womb and protects it from external pressure.

Amniotic fluid embolism – the blockage of blood vessels by amniotic fluid in the maternal circulation.

Anencephaly – a congenital abnormality where the roof of the skull is defective and the underlying cerebral hemispheres (brain tissue) are underdeveloped or absent.

Aneurysm – a dilation of an artery due to weakness of the vessel wall and a gradual stretching by the pressure of the blood.

Chemotherapy – the treatment of diseases by chemical substances.

Chromosome – the bodies found in the nucleus of every cell in the body and which contain the genes (hereditary elements) which establish the characteristics of an individual.

Circulatory system – the vessels that allow circulation of the blood.

Cystic fibrosis – a severe genetic disorder characterised by abnormal mucous production and involve the lungs, pancreas and gastrointestinal tract.

Cytotoxic drugs – cytotoxic means destructive to cells. In cancer cytotoxic drugs are given with the aim of curing the disease; however, drug-related toxicity may occur.

Dissociative disorders – a defence mechanism where a group of mental processes are segregated from the rest of a person's mental activity so as to avoid emotional distress.

Eclampsia – repeated convulsions arising in pregnancy, associated with pre-eclampsia which is hypertension, protein in the urine and/or oedema (collection of fluid in the intercellular tissues spaces of the body, resulting in swelling of the feet).

Ectopic pregnancy – a pregnancy that occurs out of the usual place.

Eisenmenger's syndrome – a form of congenital heart disease in which pulmonary hypertension is present from early life causing reversed shunting of blood in the heart. It accounts for approximately 7% of adult congenital heart disease.

Embryo – the developing organism from the end of the second week after fertilisation to the end of the eighth week. Before this period the embryo is known as a fertilised ovum (zygote) and afterwards a foetus.

Fallopian tube – the uterine tubes which lead from the upper part of the uterus to the region of each ovary.

Haematological system – the blood and blood forming system which includes the peripheral blood, the bone marrow and the lymph node system.

Haemophilia – a genetically determined bleeding disorder due to a deficiency of a coagulation factor.

Haemorrhage – escape of blood from the vessels which naturally contain it.

Hyperemesis gravidarum – a rare condition of pregnancy where there is severe vomiting and which may result in severe dehydration, electrolyte imbalances and liver damage.

Hysterectomy – the surgical removal of the uterus.

Ischaemic heart disease – insufficient blood supply to the heart due to obstruction or functional constriction of one or more of the coronary arteries.

Laparoscopy – the use of an endoscope which permits examination of the interior of the abdomen by means of an endoscope.

Laparotomy – a surgical incision involving the abdomen whereby the abdominal cavity is opened.

Leukaemia – a disease where the number of white blood cells in the blood is permanently increased.

Lymphoma – a tumour of the lymphoid tissue.

Meningioma – a tumour arising from the meninges (membranes) enveloping neural tissue of the brain or spinal cord.

Metabolic disorder – a disorder of the chemical processes that occur within a living organism.

Myocarditis – inflammation of the muscle wall of the heart.

Neonatal period – the time pertaining to the first month of life.

Neoplasm – another word for tumour.

Neural tube defect – a congenital abnormality resulting from defective development of part of the wall of the spinal canal or the vault of the skull.

Neurosis – a group of psychological disorders which may be regarded as a quantitative exaggeration of normal reactions to events and situations however is distinguished from the psychoses by retention of insight, contact with the environment and sense of reality.

Obsessional disorder – a situation where there is pathologically persistent or recurrent ideas, which may be emotionally generated and which can lead to irrational action.

Ovum – the female reproductive cell.

Psychosis – a term for serious mental disorders where there is loss of contact with reality and derangement of the personality.

Puerperum – the period after childbirth which lasts until the mother's pelvic organs and tissues have returned to their normal condition.

Pulmonary embolus – the blockage of the pulmonary artery or one of its branches by a clot and which may be associated with lung damage.

Pulmonary hypertension – the increase in pulmonary artery pressure and in the pressure in the right side of the heart and the veins bringing blood to the heart which is often due to lung disease. There is increased resistance to the blood flow through the lungs.

Radiotherapy – treatment by radium or other radioactive matter including x-rays.

Rheumatic heart disease – cardiac disease involving cardiac valve abnormalities which may develop after rheumatic fever (an illness caused by streptococcal infection).

APPENDICES

APPENDIX 1
EXTRACTS FROM DOCUMENTS REFERRED TO IN TERMS OF REFERENCE

Section 58 of the Offences against the Person Act, 1861 states:

> Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony...

Section 59 of the Offences against the Person Act, 1861 states:

> Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanour ...

Article 40. 3.3 of Bunreacht na hÉireann 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.
>
> This subsection shall not limit freedom to travel between the State and another state.
>
> This subsection shall not limit freedom to obtain or make available, in the State, subject to such conditions as may be laid down by law, information relating to services lawfully available in another State.

The proposed Twelfth Amendment of the Constitution rejected by the people in the Referendum of 25 November 1992 stated:

> It shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life, not being a risk of self-destruction.

Protocol No. 17 to the Maastricht Treaty on European Union signed in February 1992 states:

> THE HIGH CONTRACTING PARTIES
>
> HAVE AGREED upon the following provision, which shall be annexed to the Treaty on European Union and to the Treaties establishing the European Communities:
>
> > Nothing in the Treaty on European Union, or in the Treaties establishing the European Communities, or in the Treaties or Acts modifying or supplementing those Treaties, shall affect the application in Ireland of Article 40.3.3 of the Constitution of Ireland.

and the **Solemn Declaration of 1 May 1992** on that Protocol states:

> The High Contracting Parties to the Treaty on European Union signed at Maastricht on the seventh day of February 1992,
>
> Having considered the terms of Protocol No. 17 to the Treaty on European Union which is annexed to that Treaty and to the Treaties establishing the European Communities,
>
> Hereby give the following legal interpretation:
>
> > That it was and is their intention that the Protocol shall not limit freedom to travel between Member States or, in accordance with conditions which may be laid down, in conformity with Community law, by Irish legislation, to obtain or make available in Ireland information relating to services lawfully available in Member States.
>
> At the same time the High Contracting Parties solemnly declare that, in the event of a future constitutional amendment in Ireland which concerns the subject matter of Article 40.3.3 of the Constitution of Ireland and which does not conflict with the intention of the High Contracting Parties hereinbefore expressed, they will, following the entry into force of the Treaty on European Union, be favourably disposed to amending the said Protocol so as to extend its application to such constitutional amendment if Ireland so requests.

APPENDIX 2
STATISTICS ON IRISH WOMEN WHO HAVE HAD ABORTIONS IN ENGLAND AND WALES

1 There is evidence that Irish women have for many years travelled abroad for abortions. However with the introduction in England and Wales of the Abortion Act, 1967, Irish women have been travelling there in increasing numbers. From 1970 to 1998 almost 95,000 women who had abortions in England and Wales gave Irish addresses. However it is often speculated that the real figure may be higher insofar as some Irish women may give British addresses for reasons of confidentiality.

2 Table 1 shows the abortion rate in England and Wales for Irish women normally resident in the Republic of Ireland in 1971, 1979, 1981 and 1991 onwards. (The abortion rate is calculated in this table as the number of abortions per 1,000 women aged between 15-44.)

Table 1

Year	Number	Female population 15-44	Abortion rate
1971	578	545,953	1
1979	2,804	675,085	4.1
1981	3,603	705,926	5.1
1991	4,154	791,800	5.2
1992	4,254	783,700	5.4
1993	4,402	787,600	5.6
1994	4,590	792,200	5.8
1995	4,532	805,200	5.6
1996	4,894	822,586	5.9
1997	5,336	836,200*	6.4
1998	5,892	850,000*	6.9

* Estimated

From Table 1 it is clear that the number of abortions performed on Irish women is steadily increasing (with an increase of 10.5% in 1998 compared to 1997). The abortion rate has increased from 5.2 in 1981 to 6.9 in 1998.

3 The Office for National Statistics in England and Wales compiles statistics on the number of Irish women who have abortions in England and Wales each year. While total figures are available for 1997 and 1998, the latest year for which detailed information is available is 1996.

Table 2

	All ages	Under 16	16-19	20-24	25-29	30-34	35-39	40-44	45 & over	N/K
All Legal Abortions	4,894	28	738	1,871	1,107	608	351	171	19	1
Single	3,906	28	706	1,777	928	342	88	32	4	1
Married	559	-	4	24	102	149	170	101	9	-
Separated	201	-	1	12	43	76	47	20	2	-
Divorced	25	-	-	-	3	7	10	4	1	-
Widowed	18	-	-	-	1	5	7	5	-	-
Not Stated/ Known	185	-	27	58	30	29	29	9	3	-

4 The Abortion Act, 1967, permits the termination of pregnancy on one or more of the following grounds:

A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy was terminated;
B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;
C the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman;
D the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) of the family of the pregnant woman;
E there is a substantial risk that if a child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped

or in emergency, certified by the operating practitioner as immediately necessary

F to save the life of the pregnant woman; or
G to prevent grave permanent injury to the physical or mental health of the pregnant woman.

Statutory grounds A, B and E are without time limit, but there is a time limit of 24 weeks for abortions under statutory grounds C and D.

5 As with all abortions performed in England and Wales the vast majority of abortions obtained by Irish women are carried out on Grounds C and D (99.7%). A very small number are performed under Grounds A + B (0.1%). 80% of Irish women seeking abortions have their pregnancy terminated by 12 weeks' gestation. 67% of women have not had a previous live/still birth. 15% have had at least one previous live/still birth with 18% of women recorded as having had two or more previous live or still births.

6 Table 2 provides a breakdown by age and marital status of Irish women who had abortions in 1996.

As can be seen from Table 2, 80% of women who have abortions are single. Most of these women are in their twenties. Twenty-three per cent of women are aged thirty or more and 4% are aged over 40.

APPENDIX 3
THE LAW RELATING TO ABORTION IN SELECTED OTHER JURISDICTIONS

The law relating to abortion in a number of other jurisdictions is briefly described in this Appendix.[86] The jurisdictions chosen are those with which Ireland may be said to have a particular association or affinity of a cultural, historical, political or social kind. First, the law in the other Member States of the European Union is outlined and the grounds on which abortion is permitted in these jurisdictions is presented in tabulated form for the purpose of comparison. Then, the law in Australia, Canada, New Zealand, Switzerland and the United States of America is reviewed. Brief mention is also made of the law in Malta.

Only the formal legal position is described here. No account is taken of how the law operates in practice.

The European Union

Austria Abortion was decriminalised in Austria in 1974. An abortion is available on request during the first twelve weeks after a medical consultation. After the first twelve weeks, an abortion is permitted only when necessary to preserve the pregnant woman's physical or mental health, in case of foetal impairment or if the pregnant woman is under fourteen years of age. An abortion must be performed by a doctor with the pregnant woman's consent.

The 1974 legislation was contested on the grounds that it violated provisions protecting life under the Austrian Constitution. However, the Austrian Constitutional Court dismissed the complaint on the grounds that the provisions protecting life do not apply to the foetus.

Belgium The abortion laws were liberalised in Belgium in 1990. Abortion is permitted in the first trimester when a woman who is 'in a state of distress as a result of her situation' requests a doctor to terminate her pregnancy. The woman is the sole judge of whether she is in distress. The doctor must inform the woman of the risks attached to the procedure and of the alternatives to abortion. The doctor must also be convinced of the pregnant woman's

86 This account is based on information contained in the U.N. publication, *Abortion Policies: A Global Review*, Vol. I (1992), Vol II (1993) and Vol. III (1995), updated to May 1998, and on information supplied by the Irish Embassies in the countries concerned.

determination to terminate her pregnancy.

After the first trimester, abortion is legal only if two doctors agree that the woman's health is in danger or if the foetus is believed to be seriously impaired.

All abortions must be performed by a doctor under good medical conditions in an establishment that is able to provide the woman seeking the abortion with relevant information. After counselling, the woman must be given six days to reach a decision. She must certify in writing, on the date of the procedure, that she is determined to terminate her pregnancy.

Denmark The 1973 legislation which regulates abortion provides that a woman domiciled in Denmark is entitled to abortion on demand during the first twelve weeks of pregnancy after the submission of an application for abortion and after being informed of the risks involved and of alternatives to abortion.

After the first twelve weeks, abortion is available without special authorisation only when necessary to avert a risk to her life or of serious deterioration to her physical or mental health, and this risk is based solely or principally on circumstances of a medical character. It is also available when authorised by a committee, composed of a social worker and two doctors. The committee may grant such authorisation when pregnancy, childbirth or child care entails a risk of deterioration of the woman's health on account of an existing or potential physical or mental illness or infirmity or as a consequence of the conditions under which she is living; when the pregnancy resulted from a criminal act; when foetal impairment is suspected; if the woman is incapable of giving proper care to the child; or if it can be assumed that pregnancy, childbirth or care of a child constitute a serious burden to the woman, which cannot otherwise be averted.

Abortion must be performed by a doctor in a state or communal hospital or in a clinic attached to a hospital.

Finland The 1970 Abortion Act permits abortion at the request of the pregnant woman, on the written recommendation of two doctors, in the following circumstances: if the pregnancy or delivery would endanger her life or health on account of a disease, physical defect or weakness in the woman; if delivery and care of the child would place a strain on her, given her living conditions; if the pregnancy is the result of an act committed in gross violation of the woman's freedom of action; or if, due to disease or mental disturbance, the parents are unable to care for the child. When the pregnancy is the result of rape, an abortion can only be performed on this ground if legal action in respect of the crime has been taken or if clear evidence of the crime has been obtained by police inquiry.

An abortion is also permitted if the woman is under seventeen or over forty years of age or already has four children. In such cases, the recommendation of the doctor performing the procedure is sufficient to approve the abortion.

The law also permits an abortion where there is reason to believe that the foetus will be seriously impaired. In such cases, the abortion must be authorised by the State Medical Board.

Under amending legislation of 1978, an abortion must in general be performed during the first trimester, except where a disease or physical defect in the woman might endanger her health. However, it is permitted up to the twentieth week if the woman is under 17 years of age or where there are other special reasons. 'Special reasons' may include the economic and social circumstances of the woman. Moreover, further legislation of 1985 permits abortion up to the twenty-fourth week if amniocentesis or ultrasonic examination has established that the foetus is seriously impaired.

An abortion must be performed by a licensed doctor in a hospital approved by the State Medical Board. The woman herself should apply for the procedure. Information on the risks of the procedure is to be provided prior to the termination and information on contraception is to be given to the woman after the procedure has taken place.

France Legislation enacted in 1975 liberalised abortion laws in France. This legislation, as subsequently amended, provides that abortion is considered lawful if the termination is performed before the end of the tenth week of pregnancy by a doctor in an approved hospital. A woman who is 'in a situation of distress' may request an abortion from her doctor who must inform her about the risks involved and provide her with a guide to family rights and assistance should she decide not to terminate the pregnancy. The woman must consult with a social worker or family counsellor about the termination, and if she still wishes to have an abortion, she must renew her request in writing, not sooner than one week from the time of the first request. She should also be informed about the prevention of pregnancy and alternatives to abortion.

If the pregnancy poses a grave danger to the woman's health or there is a strong possibility that the foetus may be severely impaired, abortion is permitted at any time during pregnancy, provided two doctors certify, after an examination, that the health of the mother or foetus is at risk.

Germany Abortion legislation passed by the German Parliament in 1992 to deal with the new post-unification régime was submitted to the Federal Constitutional Court to examine its compatibility with the Basic Law and to decide if the counselling provided for in the legislation offered adequate protection to the foetus. In a decision of 28 May 1993, the Court ruled that the proposed new abortion law was unconstitutional because it did not protect the life of the unborn. It held that an abortion may be performed only in exceptional circumstances and the compulsory counselling must be an active effort to dissuade the woman from terminating her pregnancy.
The German Parliament subsequently enacted the Pregnant Women's and Family Aid (Amendment) Act 1995 which inserts new sections on abortion into the Penal Code. The Code retains the principle that abortion should, as a general rule, be regarded as a criminal offence. The legislation re-enacts a provision from an earlier 1976 Act which permits abortion on medical grounds and on grounds of crime. The medical grounds apply if the termination of the pregnancy is necessary to save the life of a woman or to avert a danger of serious physical or mental damage to the pregnant woman, taking into account her current and future life conditions. There is

no time limit in respect of these grounds. The grounds based on crime apply if there are serious grounds for the assumption that the pregnancy is the consequence of a sexual assault (sexual abuse of children, rape, sexual coercion, or sexual abuse of helpless people). These grounds are only available within twelve weeks of conception. Counselling is not mandatory in these circumstances but the doctor performing the abortion must inform the woman of the medical implications of the procedure and discuss her decision with her. The doctor must also receive a certificate from another doctor stating that these grounds exist.

The Code further provides that an abortion performed by a doctor with the consent of the pregnant woman within the first twelve weeks after conception will not be punished, provided the pregnant woman receives anti-abortion counselling from someone other than the doctor performing the procedure at least three days prior to the operation and provides a certificate to this effect to the doctor. This counselling must encourage the woman to continue her pregnancy. She must be told that the unborn has a right to life at all stages of pregnancy and that the law may only regard abortion as acceptable if the continuation of the pregnancy would be an extraordinary burden exceeding that which can reasonably be expected of her. The Pregnancy Conflict Act 1995 sets out in more detail the rules governing counselling of pregnant women seeking abortions.

The legislation does not provide for abortion on eugenic grounds. However, in its decision of 28 May 1993, the Federal Constitutional Court held that abortion could only be regarded as lawful if necessary to protect the life or health of the pregnant woman, or where there exist other serious reasons justifying the termination of the pregnancy, and it indicated that one such reason could be that there were eugenic grounds justifying the termination.

Nor does the legislation provide for abortion on economic or social grounds but, in its decision of 28 May 1993, the Federal Constitutional Court held that, if the existence of a social indication could be satisfactorily proved, abortion on this ground could be regarded as lawful.

Greece Abortion is regulated by legislation of 1978 and 1986. It is available on request during the first twelve weeks. In cases where the pregnancy is the result of a criminal act such as rape, incest or the seduction of a minor under fifteen years of age, it is permitted during the first nineteen weeks. Where there is indication of serious foetal abnormality, it is allowed if the pregnancy has not exceeded twenty-four weeks. It is also allowed when necessary to avert an otherwise unavoidable danger to the life of the pregnant woman or a serious danger to her physical or mental health. In such cases, the necessity of the abortion must be certified by a specialist medical doctor.

The abortion must be carried out in a hospital by competent doctors.

Italy Legislation liberalising abortion law was enacted in Italy in 1978. This law provides that abortion is legal in the first ninety days of the pregnancy when the continuation of the pregnancy, childbirth or motherhood would seriously endanger the physical or mental health of the woman, taking into account her state of health, her economic, social or family situation, the circumstances under which conception occurred or the likelihood that the child would be born with abnormalities or malformations. A woman who wishes to have her pregnancy terminated on any of these grounds must apply to a doctor, who, after a medical examination, must inform her of possible alternatives and of the availability of social welfare benefits. The woman herself attests to her situation, and if she persists with the request to terminate her pregnancy, the doctor must issue a certificate, signed by himself and by the woman, attesting to her pregnancy and her request. Following a reflection period of seven days, the woman may present herself with the certificate to an authorised medical facility to obtain the abortion. The reflection period is not required in urgent cases such as those involving a threat to the woman's life.

After the first trimester, abortion is permitted only to save the woman's life or to preserve her physical or mental health.

An abortion must be performed in a public hospital or authorised private facility.

Luxembourg Abortion was liberalised in Luxembourg in 1978 by an amendment to the Penal Code.

Abortion is permitted during the first twelve weeks when the continuation of the pregnancy is likely to endanger the physical or mental health of the pregnant woman; when there is a strong likelihood that the child will be born with a serious disease, serious malformation or considerable mental defects; when the pregnancy resulted from rape; and when the living conditions that may result from the birth of the child are likely to endanger the physical or mental health of the pregnant woman.

The woman is required to consult a gynaecologist or an obstetrician and to give her consent in writing to the abortion, except where her life is in danger, she is a minor or she is not able to manifest her will. In these cases, ad hoc legal representative is required to give consent. Additional requirements are a one-week waiting period in order to allow the pregnant woman to reflect on her decision and a doctor's certificate concerning the existence of circumstances under which abortion is permitted. Certification by a doctor other than the one performing the abortion is required.

After the first twelve weeks, abortion is permitted only on therapeutic grounds or when the child may be born with a serious malformation or mental defects. In such cases, two doctors are required to attest that a serious threat exists to the woman or the child.

An abortion must be performed in a hospital or other approved facility.

The Netherlands The Termination of Pregnancy Act 1981 repealed the nineteenth century statutes that severely restricted abortion. It permits abortion on request up to thirteen weeks of pregnancy. The Act does not identify indications for abortion because it is deemed impossible to provide strict criteria. Abortion is allowed after thirteen weeks if the pregnant woman attests to a state of distress. The Act only applies however to termination of pregnancy if the foetus is not viable. Termination of pregnancy in the case of an independently viable foetus is a criminal offence.

Except in case of emergency, a five-day waiting period

between the initial consultation and the termination of the pregnancy is required, during which the woman must be counselled on alternative means of coping with her pregnancy. If the woman decides to proceed with the termination, she must be provided with after-care services that include methods of preventing unwanted pregnancy. The five-day waiting period may be waived if the woman's life is threatened.

An abortion must be performed in a licensed hospital or clinic.

Portugal The Portuguese law on abortion was liberalised in 1984. Abortion is permitted during the first trimester if there are significant indications that the pregnancy resulted from rape or incest, or if it would avert a risk of death or serious damage to the physical or mental health of the woman. If there are substantial grounds for believing that the child would be born with a serious or incurable disease or malformation, abortion is permitted during the first sixteen weeks. Abortion is permitted at any time if it is the only means of eliminating a risk of death or serious permanent damage to the physical or mental health of the pregnant woman.

Prior to the abortion, a doctor other than the one performing the procedure must sign a medical certificate attesting to the existence of the circumstances that render an abortion permissible. The abortion must be performed with the consent of the pregnant woman who must sign a document to this effect not less than three days prior to the date of the procedure. In case of emergency, if it is imperative that the abortion be performed immediately to save the life of the mother or to avert a serious threat to her life or lasting damage to her physical or mental health, the prescribed time-limit may be waived, as well as the required consent of the woman if she is unable to express her consent and it may reasonably be assumed that she would normally have granted it.

In January 1998 the Portuguese Parliament voted in favour of liberalising the law on abortion so as to permit unrestricted access to abortion up to ten weeks. However, because of the importance and sensitivity of the matter, the political parties agreed to put it to a referendum. In the referendum on 28 June 1998, the people voted, by a narrow majority, against such a change in the law.

Spain New abortion legislation was adopted in Spain in 1985. Abortion is permitted by or under the direction of a doctor provided that the woman gives her express consent to the procedure and one of the conditions provided for in the legislation is fulfilled. Abortion is permitted where it is necessary to avert a serious risk to the physical or mental health of the pregnant woman, in accordance with an opinion expressed prior to the abortion by a doctor, other than the one performing the abortion or under whose direction the abortion is to be performed, who holds an appropriate specialist qualification. It is permitted during the first trimester if the pregnancy is the result of rape, provided that the rape has been reported to the police. Where the foetus, if carried to term, would suffer from severe physical or mental defects, an abortion may be performed within the first twenty-two weeks provided that the medical opinion, communicated prior to the abortion, was expressed by two specialists of an approved public or private health centre, neither of whom is the doctor performing the abortion or under whose direction the abortion is to be performed. In the case of an emergency involving a risk to the life of the pregnant woman an abortion may be performed without the expressed opinion of a physician and without the consent of the woman.

In 1991, the Supreme Court of Spain sanctioned abortion for the first time on social grounds. There have subsequently been several unsuccessful attempts to adopt legislation on these grounds.

Abortion must be performed in an approved public or private health centre.

Sweden Abortion is regulated in Sweden by a law of 1974. This law permits the termination of pregnancy on request up to the eighteenth week of pregnancy, provided that the procedure will not seriously endanger the woman's life or health. For pregnancies between twelve and eighteen weeks, the pregnant woman is required to discuss the abortion with a social worker.

Abortion after eighteen weeks of pregnancy is legal only if the National Board of Health and Welfare authorises the procedure on substantive grounds. A threat to the life or health of the mother or eugenic, juridical, socio-economic and other grounds may justify the authorisation of an abortion if they can be determined on substantive grounds. In cases of emergency, a doctor may perform the abortion without authorisation. However, the authorisation may not be granted if there are grounds for assuming that the foetus is viable.

Except in emergency, abortion must be performed in a general hospital or other health-care establishment approved by the National Board of Health and Welfare.

United Kingdom

(i) Great Britain Abortion is regulated in England, Scotland and Wales by the Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990. Abortion with the woman's consent is allowed if two doctors certify that a ground for abortion exists. Where the continuance of the pregnancy would involve a risk to the life of the woman, greater than if the pregnancy were terminated, abortion is permitted without any time limit. It is also permitted where the pregnancy has not exceeded twenty-four weeks and the continuance of the pregnancy would involve a risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing child of her family. In assessing the risk to the health of the woman and her existing children, doctors may take into account the woman's 'actual or reasonably foreseeable environment.' Furthermore, if there is a substantial risk that, if the child is born, it will suffer from such physical or mental abnormalities as to be seriously handicapped, abortion is permissible within the first twenty-four weeks.

Except in cases of emergency, an abortion must be obtained in National Health Service hospitals or in approved institutions operating as private abortion clinics.

(ii) Northern Ireland The British Abortion Act 1967 does not apply to Northern Ireland. Under sections 58 and 59 of the Offences Against the Person Act 1861, it is an offence unlawfully to procure a miscarriage, punishable by a maximum sentence of life imprisonment. However, on

the basis of a 1930s court decision, *R v. Bourne*,[87] abortion is regarded as permissible in order to avoid serious harm to the mother's physical or mental health.

In recent years, cases relating to the interpretation of sections 58 and 59 of the Offences Against the Person Act 1861 have come before the Northern Irish Courts. The 1993 case of *Re K*[88] concerned a fourteen year old minor who was a ward of court. The Northern Health and Social Services Board sought an order permitting a termination of the pregnancy on the basis of the minor's statements that she would commit suicide if the pregnancy was not terminated. Having heard medical evidence that '... to allow the pregnancy to continue to full term would result in her being a physical and mental wreck', the judge found that a termination in such circumstances would be lawful.

In the 1994 case of *Re A.M.N.H.*,[89] the pregnant woman was severely mentally handicapped and a ward of court. There was medical evidence that the continuation of the pregnancy would adversely affect the woman's mental health. The judge held that abortion is lawful where the continuation of the pregnancy would adversely affect the mental or physical health of the mother. However, he said that the adverse effects must be real and serious. He found in the case that the termination of the woman's pregnancy would be lawful.

The 1995 case of *Re S.J.B.*[90] involved a seventeen-year-old severely handicapped girl who was made a ward of court. On the basis of medical evidence presented to the court, the judge held that a termination of the pregnancy would be lawful.

The case of *Re C.H.*,[91] also decided in 1995, concerned a sixteen year old girl who was a ward of court. She stated that she wished to have her pregnancy terminated and threatened to commit suicide if she was forced to continue with her pregnancy. On the basis of medical evidence, the judge held that it would be lawful for the pregnancy to be terminated.

In Northern Ireland, the decision to terminate a pregnancy is based on professional judgement following consultation with two doctors and with the informed consent of the woman. No clear time-limit is laid down by the law.

Other jurisdictions

Australia Restrictions on abortion vary by state and territory in Australia. In Victoria, the Australian Capital Territory and New South Wales, abortion comes under common law, while in the other states it is regulated under the Criminal Code. Only the laws of South Australia and the Northern Territory define lawful abortion. In other states and territories, the grounds are derived from judicial interpretations.

All states permit abortion to save the life of the pregnant woman. All states except Tasmania and Western Australia permit abortion on physical and mental health grounds, although there is proposed legislation in Western Australia to liberalise the abortion laws there. In Queensland, abortion is permitted only when necessary to preserve the life of the pregnant woman but the courts there apply the English case of *R v. Bourne* in the acquittal of defendants, indirectly permitting abortion on the grounds of preserving the woman's physical and mental health.

In the Capital Territory and New South Wales, abortion is permitted to preserve the physical and mental health of the pregnant woman, where social and economic stresses may be taken into account in the determination of risk to physical and mental health. Interpretation of the law in these states would also allow eugenic and juridical grounds. South Australia permits abortion to preserve the physical and mental health of the pregnant woman or if the foetus has the possibility of being seriously handicapped. The law also takes account of the pregnant woman's actual or reasonably foreseeable environment.

The Northern Territory permits abortion on eugenic grounds as well as on broad health grounds. In Victoria, the law permits abortion on broad physical and mental health grounds, and the courts there have invoked the *Bourne* case to give health grounds a very liberal interpretation. No state has made specific provision for cases where pregnancy results from rape or incest.

Specifications as to whether a doctor has to perform the abortion and the maximum period of pregnancy allowed for abortion also vary from one state to another. Authorisation by two doctors is required in South Australia and the Northern Territory. South Australia allows abortion up to twenty-eight weeks of pregnancy. In the Northern Territory, abortions may be performed up to the twenty-third week of pregnancy in emergencies, but only up to fourteen weeks if the treatment is not immediately necessary. In South Australia and the Capital Territory, the abortion must be performed in a prescribed hospital. Other states have no legal requirements as to where abortions are to be performed.

Canada Abortion has been regulated at federal level under the Criminal Code. A law of 1969 (Section 287 of the Criminal Code) legalised abortion in certain circumstances by exempting doctors from criminal liability if a hospital abortion committee was prepared to sign a statement to the effect the continuation of the pregnancy would or would be likely to endanger the pregnant woman's life or health.

This law was challenged in the courts and, in 1988, the Canadian Supreme Court held that Section 287 of the Criminal Code infringed the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice, as guaranteed by Section 7 of the Canadian Charter of Rights and Freedoms.[92] In his judgment, the Chief Justice stated that forcing a woman by threat of criminal sanction to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of her security of person.

As a result of this court decision, there is no law as such regulating abortion. Attempts by Parliament to enact a replacement law have been unsuccessful.

87 [1939] 1 K.B. 687.
88 Unreported, High Court (Family Division), Sheil J., 14 October 1993.
89 Unreported, High Court (Family Division), Mac Dermott L.J., 21 January 1994.
90 Unreported, High Court (Family Division), Pringle J., 28 September 1995.
91 Unreported, High Court (Family Division), Sheil J., 18 October 1995.
92 *Morgenthaler, Smoling and Scott v. The Queen* [1988] 44 D.L.R. (4th) 385.

Main Legal Grounds for the Termination of Pregnancy in Other EU Member States: Comparative Table

	To save the life of the woman	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	Available on request (no specific ground required)
Austria	Yes	Yes	Yes	No[1]	Yes	No[1]	Yes, during first trimester
Belgium	Yes	Yes	Yes	Yes, during first trimester[2]	Yes	Yes, during first trimester[2]	No
Denmark	Yes	Yes	Yes	Yes	Yes	Yes	Yes, during first trimester
Finland	Yes	Yes	Yes	Yes[3]	Yes, up to twenty-four weeks	Yes, up to twenty weeks	No
France	Yes	Yes	Yes	Yes, up to ten weeks	Yes	Yes, up to ten weeks, provided the woman is 'in a situation of distress'	No[4]
Germany	Yes	Yes	Yes	Yes, during first trimester	Yes	No	No
Greece	Yes	Yes	Yes	Yes, up to nineteen weeks	Yes, up to twenty-four weeks	No	Yes, during first trimester
Italy	Yes	Yes	Yes	Yes, during first trimester	Yes	No[5]	No
Luxembourg	Yes	Yes	Yes	Yes, during first trimester	Yes	No	No
Netherlands[6]	Yes	Yes	Yes	Yes	Yes	Yes	Yes, up to thirteen weeks
Portugal[7]	Yes	Yes	Yes	Yes, during first trimester	Yes, up to sixteen weeks	No	No
Spain	Yes	Yes	Yes	Yes, during first trimester	Yes, up to twenty-two weeks	Unclear	No
Sweden	Yes	Yes	Yes	Yes	Yes	Yes	Yes, up to eighteen weeks[8]
United Kingdom							
(i) Great Britain	Yes	Yes, up to twenty-four weeks	Yes, up to twenty-four weeks	No	Yes, up to twenty-four weeks	Yes, up to twenty-four weeks	No
(ii) Northern Ireland	Yes	Yes	Yes	No	No	No	No

1 Not a specific ground. However, since abortion is available on request during the first trimester, it is permitted in these circumstances during that period.
2 Provided the pregnant woman is 'in a state of distress as a result of her situation'.
3 Under Finnish law, where the pregnancy is the result of rape, an abortion may only be performed if legal action in respect of the crime has been taken or if clear evidence of the crime has been obtained by police inquiry.
4 An abortion may be performed during the first ten weeks at the woman's request if she is in a situation of distress
5 Not a specific ground. However, during the first ninety days, the economic and social situation of the pregnant woman may be taken into account in determining whether the continuation of the pregnancy or childbirth would seriously endanger her physical or mental health.
6 The Dutch legislation regulating abortion does not identify indications for abortion because it is deemed impossible to provide strict criteria. If the woman attests to a state of distress, abortion is allowed after thirteen weeks in a hospital or in an approved clinic.
7 In January 1998 the Portuguese Parliament voted in favour of liberalising the law on abortion so as to permit unrestricted access to abortion up to ten weeks. However, because of the importance and sensitivity of the matter, the political parties agreed to put it to a referendum. In the Referendum on 28 June 1998, the people voted, by a narrow majority, against such a change in the law.
8 If the pregnancy is between twelve and eighteen weeks, the pregnant woman is required to discuss the intended abortion with a social worker. However, statistics show that 95% of abortions are carried out in the first trimester.

Malta Abortion is prohibited in all circumstances in Malta.

New Zealand The Crimes Act 1961 was amended in 1977 and 1978 to provide a clearer definition of the grounds for legal abortion. Sections 182 - 187A of the Crimes Act permit abortion during the first twenty weeks of pregnancy on medical grounds if the pregnancy imposes serious danger to the life or to the physical or mental health of the woman, if there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped, or if the pregnant woman is mentally 'subnormal.' In addition, the fact that the woman is near the beginning or the end of the usual child-bearing years or that there are reasonable grounds for believing that the pregnancy is a result of rape, while not in themselves grounds, may be taken into account in determining whether the continuance of the pregnancy would result in serious danger to the woman's life or to her physical or mental health.

After twenty weeks, abortion is permitted only when necessary to save the life of the woman or to prevent serious permanent injury to her physical or mental health. The first medical contact for a woman wishing to have an abortion is her own doctor. If the woman's own doctor considers that an abortion may be permitted under the legal criteria, the doctor refers the case to an operating surgeon for authorisation by two certifying consultants, one of whom must be an obstetrician or gynaecologist. An abortion may only be performed in an institution licensed under the Contraception, Sterilisation and Abortion Act 1977. A woman must receive counselling from a trained counsellor before the abortion is performed.

Switzerland The Swiss Penal Code prohibits abortion except for therapeutic termination of pregnancy on medical grounds. Under Article 120 of the Code, a pregnancy may be terminated by a licensed physician, with the woman's written consent, in order to avoid a danger to her life or a serious danger of severe or lasting injury to her health which may not be otherwise avoided. If the pregnant woman is incapable of giving consent, consent must be given by her legal representative. Except in case of emergency, the physician carrying out the abortion must obtain the written approval of a second physician who is familiar with the woman's condition and who is designated by the authorities in the canton where the woman resides or where the abortion is to be performed. In cases of emergency, the approval of a second physician is not required, but the cantonal authorities must be notified of the abortion within twenty-four hours.

In 1981, two laws were passed obliging cantons to introduce counselling services for pregnant women and requiring health insurance to reimburse the cost of legal abortion.

New legislation is under consideration which would decriminalise abortion during the first twelve weeks of pregnancy.

United States of America In 1973, the Federal Supreme Court legalised abortion throughout the United States in the case of *Roe v. Wade*.[93] The Court held that, in the first trimester, the woman's decision to have an abortion should be exclusively between herself and her doctor but that in the second trimester, individual states could regulate abortion in order to preserve and protect the woman's health. In the third trimester or after foetal viability, the states could prohibit abortion except where it was necessary to preserve the life or health of the woman. The Court held that a foetus was not *per se* a person and was therefore not entitled to protection guaranteed by the United States Constitution until it reached the point of viability.

In recent years, both the U.S. Supreme Court and the Congress have begun to allow greater restrictions on abortion. Individual states now have more latitude to impose restrictions on abortion as a result of a number of Supreme Court rulings which have weakened the trimester framework set out in *Roe v. Wade*. In the case of *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[94] the Supreme Court established that states can restrict pre-viability abortions, including those in the first trimester, in ways that are not medically necessary, if it does not 'unduly burden' a woman's right to choose. 'Undue burden' was defined as a substantial obstacle in the path of a woman seeking an abortion before the foetus attains viability. Applying the 'undue burden' standard in *Casey*, the Supreme Court upheld provisions of the Pennsylvania abortion law that required a woman to delay an abortion for twenty-four hours after hearing a state presentation on adoption and child-support alternatives, and that required teenagers to obtain the consent of one parent or the approval of a judge before obtaining an abortion. However, a requirement that the woman's husband be notified was found to be an 'undue burden' on a married woman's right to obtain an abortion.

Abortion restrictions now vary from state to state. Many states have laws that prevent a minor from obtaining an abortion without parental consent or notice. States have also introduced abortion-specific 'informed' consent laws requiring the pregnant woman seeking an abortion to receive information on foetal development, pre-natal care and adoption. Some states have introduced mandatory waiting periods.

APPENDIX 4
SUBMISSIONS RECEIVED

The Working Group received approximately 10,000 submissions from interested parties up to 31 March, 1998, the closing date for receipt of submissions.

The following organisations and groups made submissions:

Adelaide Hospital Society;
Aghada Prayer Group;
Alliance for Choice;
Association of General Practitioners;
Association of Irish Humanists;
Ballina Friends of Medjugorje;
Banúlacht;
Birth Control Trust, London;
Cabhair Interdenominational Women's Group;
Callan Enterprise Group;

93 *Roe v. Wade* 410 U.S. 113 (1973).

94 *Planned Parenthood of Southeastern Pennsylvania v. Casey* 112 S.Ct. 2791 (1992).

Catholics for a Free Choice, Washington DC;
Catholic Nurses' Guild of Ireland;
Cherish;
Children's Protection Society;
Christian Centrist Party;
Christian Family Association;
Christian Family Movement;
Christian Solidarity Party;
Church of Ireland;
Council of Social Concern;
Council for the Status of the Family;
Democratic Left;
Doctors for Life;
Doctors for a Woman's Choice on Abortion;
Dominican House of Studies;
Dublin Abortion Rights Group;
Family Life Centre (Billings);
Family Prayer Movement;
Family Solidarity;
Feminists for Life Ireland;
Feminist Legal Action Group;
Fianna Fáil Party - Dublin South East Constituency;
Friends of the Gospel of Life;
Galway for Life;
Human Life Concern;
Human Life International (Ireland);
Interact;
Irish College of General Practitioners;
Irish Congress of Trade Unions;
Irish Council for Civil Liberties;
Irish Episcopal Conference;
Irish Family League;
Irish Family Planning Association;
Irish Nurses' Organisation;
Irish Women's Abortion Support Group;
Islamic Cultural Centre;
Knights of St Columbanus;
Labour Women's National Council;
Laois Prolife;
Legion of Mary – Various Branches
Life Ireland;
Life Pregnancy Care Service, Cork;
Life Pregnancy Centre, Donegal;
Marian Information Centre;
The Marian Movement for Life;
Mary Immaculate Prayer Group, Shannon;
Milltown Institute of Theology & Philosophy;
Muintir na hÉireann Páirtí Teo;
National Association of the Ovulation Method of Ireland;
National Organisation for Women;
The National Party;
National Service Committee for Catholic Charismatic Renewal in Ireland;
National Women's Council of Ireland;
National Education Council, Waterford;
Navan Issues Group;
Nurses for Life;
Our Lady Prayer and Action Group;
Pobal Dé Prayer Group;
Positive Action for Children;
Presbyterian Church;
Pro-Life, Ennis Group;
Pro-Life, Drogheda Group;
Pro-Life, Wicklow Group;
Pro-Life, Cork South West;
Pro-Life Association, Dungarvan;
Pro-Life Campaign;
Pro-Life Campaign, Athlone;
Pro-Life Campaign, Cork North West;
Pro-Life Campaign, Donegal;
Pro-Life Campaign, Dublin West;
Pro-Life Campaign, Dublin North West Constituency;
Pro-Life Campaign, East Mayo;
Pro-Life Campaign, Offaly Branch;
Pro-Life Campaign, Sligo Branch;
Pro-Life Campaign, Waterford Branch;
Pro-Life Committee, Cavan;
Pro-Life Committee, Cobh;
Pro-Life Movement Ltd. t/a Family & Life;
Pro-Life, Pro-Family Movement, Co. Roscommon;
Psychologists for Freedom of Information;
Public Policy Institute of Ireland;
The Responsible Society;
Secular Franciscan Order, Co Donegal;
The Socialist Party;
Society for the Protection of Unborn Children, Arklow Branch;
Society for the Protection of Unborn Children Ireland;
Students for Life, University College Cork;
Students for Life, University of Galway;
St. Joseph's Pro-Life Campaign, Waterford Branch;
Thomas More Medical Association;
Trinity College Women's Group;
University College Dublin Pro-Choice Action Group;
'Women and Crisis Pregnancy' Study, Trinity College;
Women's Aid;
Women's Counselling Network;
Women's Education Research and Resource Centre, University College Dublin;
Women's Information Network;
Youth Defence.

The Working Group also received petitions bearing approximately 36,500 signatures requesting a referendum to ban abortion in Ireland.

APPENDIX 5
EXTRACT FROM THE REPORT OF THE CONSTITUTION REVIEW GROUP, 1996

Rights to Life (Unborn and Mother)

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.

This subsection shall not limit freedom to travel between the State and another state.

This subsection shall not limit freedom to obtain or make available in the State, subject to such conditions as may be laid down by law, information relating to services lawfully available in another state.

Background

The immediately preceding subsection (Article 40.3.2º) was in the original text of the Constitution and commits the State 'by its laws to protect as best it may from unjust attack and, in the case of injustice done, vindicate the life ... of every citizen'. Abortion, the unlawful procurement of a miscarriage, was prohibited by the Offences Against the Person Act 1861 (sections 58 and 59), a statute which is still in force. The right to life of the 'unborn' was recognised in the course of Supreme Court judgments (for example Walsh J in *McGee v. The Attorney General* [1974] IR 284, Walsh J in *G v. An Bord Uchtála* [1980] IR 36). However, the Supreme Court judgment in the *McGee* case, in which a right to marital privacy in the use of contraceptives was recognised, aroused concern that judicial extension of this principle of privacy might lead to abortion becoming lawful here, just as in the US the Supreme Court's decision in *Roe v. Wade* 410 US 113 (1973) led to its being lawful there. The two largest political parties undertook, in the context of general elections in 1981 and 1982, that a constitutional amendment would be introduced to block such a development, which they considered would be generally unacceptable, whether resulting from judge-made law or from legislation. The formula which is now part of Article 40.3.3º, guaranteeing explicitly the right to life of the 'unborn' with due regard to the equal right to life of the mother, was put to the people by referendum in September 1983, and adopted by a large majority.

Developments since 1983

Various Supreme Court judgments between 1983 and 1989 were negative towards the operation in Ireland of abortion referral services. However, a ruling of the European Court of Justice in 1991 undermined this stance by suggesting that agencies here of foreign abortion clinics, and these clinics themselves, might be entitled, under EC law, to disseminate information in Ireland about the services they lawfully provided elsewhere in the Community.

Efforts to preserve the existing Irish prohibition on abortion and on dissemination of relevant information gave rise to Protocol No 17 to the Maastricht Treaty on European Union signed in February 1992. Later (following the *X* case described below), a Solemn Declaration on that Protocol stated, in effect, that the Protocol was not intended to prevent travel abroad to obtain an abortion where it was legally available, or the availability in Ireland of information about abortion services on conditions to be laid down by law. While the Protocol was intended to prevent any EU law permitting abortion from overriding the application in Ireland of Article 40.3.3º before it was amended by the travel and information referendums of 1992, there is doubt whether it is still effective in the light of these amendments.

There is also a question as to the legal significance of the Solemn Declaration which provides that 'at the same time the High Contracting Parties solemnly declare that in the event of a future constitutional amendment in Ireland which concerns the subject-matter of Article 40.3.3º of the Constitution of Ireland and which does not conflict with the intention of the High Contracting Parties hereinbefore expressed, they will, following the entry into force of the Treaty on European Union, be favourably disposed to amending the said Protocol so as to extend its application to such constitutional amendment if Ireland so requests'. The effectiveness of this Declaration may be in doubt, since the European Court of Justice has generally refused to admit contemporary declarations of this kind as an aid to construing the EC treaties and legislation: *see R v. Home Secretary ex p Antonissen* (Case C-292/89) [1991] ECR 1-745.

In 1992, in *The Attorney General v. X* [1992] 1 IR 1, which became known as the *X* case, where a sexually-abused young teenager had become pregnant, was considered suicidal, and had been restrained by the High Court from travelling to England for an abortion, the Supreme Court, by a majority, held that the injunction restraining the girl from leaving the jurisdiction should be lifted. The Supreme Court held that the right to life of the unborn had to be balanced against the mother's right to life and that Article 40.3.3º permitted termination of a pregnancy in the State where there was a real and substantial threat to the mothers life, as distinct from her health. It also held that the threat of suicide constituted a threat to the mother's life for this purpose. Some statements of the majority of the court (in comments which were not part of the binding *ratio* of the decision) indicated that the constitutional right to travel under domestic law could be restrained so as to prevent an abortion taking place abroad where there was no threat to the mother's life.

This judgment, although it eased the widespread concern for the girl and her family, caused misgivings of principle both for those concerned about the admission of a suicidal disposition as a ground for abortion and for those opposed to permitting abortion at all in the State. There was also much concern about *any* restriction on freedom to travel and *any* curtailment of access to information. In a desire to ease some of these concerns and, at the same time, to augment support for the Maastricht Treaty, new referendums were undertaken to confirm freedom to travel to use an abortion service lawfully operating elsewhere and freedom to obtain or make available information relating to such services, subject to conditions to be laid down by law; and the third referendum proposed to amend the 1983 wording by adding the following:

> It shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life, not being a risk of self-destruction.

While the travel and information referendums were passed, the referendum providing for the foregoing change of wording was defeated by a two-to-one majority (1,079,297 versus 572,177). It was rejected, apparently, by those who disliked its restrictiveness as well as by those opposed to abortion being legalised here on any ground.

Incidence of abortion

Numbers of Irish women travel abroad annually to avail themselves of legalised abortion services in other jurisdictions, mostly Britain. Official British statistics (Office of Population Censuses and Surveys, London) show that over 80,000 abortions have been performed on Irish women in England and Wales since 1970. In 1994, the

latest year for which full figures are available, 4,590 women normally resident in the Republic of Ireland had legal abortions in England and Wales. The ratio of such abortions to live births in the State is almost 1 to 10.

While opposite standpoints – 'pro-life' or 'pro-choice' – have tended to dominate the public discussion of the abortion issue, there is much private sympathy and concern for the personal, social and moral anxieties of those facing crisis pregnancies, particularly where rape, incest or other grave circumstances are involved. It may be doubted whether enough attention is being given to such basic matters as education on sexuality, human reproduction and relationships as a way of reducing the incidence of abortion, counselling in relation to crisis pregnancies, and the promotion of women's and men's sense of parenthood as a valuable contribution to society. The Review Group appreciates that there are much wider considerations involved than constitutional or legal provisions but it is on these that the Review Group must necessarily focus.

Difficulties

The state of the law, both before and after the *X* case decision, gives rise to much dissatisfaction.

There is no definition of 'unborn' which, used as a noun, is at least odd. One would expect 'unborn human' or 'unborn human being'. Presumably, the term 'unborn child' was not chosen because of uncertainty as to when a foetus might properly be so described.

Definition is needed as to when the 'unborn' acquires the protection of the law. Philosophers and scientists may continue to debate when human life begins but the law must define what it intends to protect.

'Unborn' seems to imply 'on the way to being born' or 'capable of being born'. Whether this condition obtains as from fertilisation of the ovum, implantation of the fertilised ovum in the womb, or some other point, has not been defined.

In the context of abortion law, which deals with the termination of pregnancy, a definition is essential as to when pregnancy is considered to begin; the law should also specify in what circumstances a pregnancy may legitimately be terminated and by whom.

If the definition of 'pregnancy' did not fully cover what is envisaged by 'unborn', the deficiency would need to be remedied by separate legal provisions which could deal also with other complex issues, such as those associated with the treatment of infertility and *in vitro* fertilisation.

At present, all these difficulties are left to the Supreme Court to resolve without explicit guidance.

The impossibility of reconciling the 'equal' rights to life of the 'unborn' and the mother, when the two rights come into conflict, was manifested in the *X* case.

Following the *X* case judgment, the scope of admissibility of a suicidal disposition as a ground for allowing an abortion and the absence of any statutory time-restriction on intervention to terminate a pregnancy remain causes of disquiet.

Possible approaches

The definitional difficulties are open to four different approaches:

(i) to leave things as they are, relying on the Supreme Court to determine the meaning of 'unborn'
(ii) to write a definition of 'unborn' into the Constitution itself
(iii) to authorise expressly by a constitutional provision the making of all necessary definitions by legislation
(iv) to make definitions by legislation in the expectation that, if challenged, they may be held by the Supreme Court to be in conformity with the Constitution as it is.

The Review Group considers that definition is required. Approaches ii) and iii) would require approval by a referendum.

Apart from the definitional problems, there are various possible approaches to clarifying the state of the law. Equally, however, there is a great divergence of public opinion as to what issues should be addressed, and how; value judgments are involved in every case. The Review Group has considered five options which are discussed in turn:

(a) introduce an absolute constitutional ban on abortion
(b) redraft the constitutional provisions to restrict the application of the *X* case decision
(c) amend Article 40.3.3º so as to legalise abortion in constitutionally defined circumstances
(d) revert, if possible, to the pre-1983 situation
(e) regulate by legislation the application of Article 40.3.3º.

(a) introduce an absolute constitutional ban on abortion This must rest on a clear understanding of the meaning of 'abortion'. The 1861 Act prohibits' 'unlawfully procuring a miscarriage' which might nowadays be rendered as 'illegal termination of pregnancy' but, in either case, the words 'unlawful' and 'illegal' are significant. If an abortion can be either lawful or unlawful, the word on its own must be understood to refer neutrally to the termination of a pregnancy or procurement of a miscarriage. To ban abortion *simpliciter* could thus criminalise medical intervention or treatment necessary to protect the life of the mother if such intervention or treatment required or occasioned the termination of her pregnancy.

According to a press report (*The Irish Times*, 10 September 1992), the Pro-Life Campaign considers 'a complete prohibition on abortion is legally and medically practicable and poses no threat to the lives of mothers'. Reference is made to 'the success of medical practice in protecting the lives of mothers and their babies', and it is claimed that 'a law forbidding abortion protects the unborn child against intentional attack but does not prevent the mother being fully and properly treated for any condition which may arise while she is pregnant'. Either of two hypotheses seems to be involved here – that the termination of a pregnancy is never necessary to protect the life of the mother or that, if it is, such medical intervention is already protected by law and that this protection would not be disturbed or dislodged by a constitutional ban on abortion. It would not be safe to rely on such understandings. Indeed, as explained later, if a constitutional ban were imposed on abortion, a doctor would not appear to have any legal protection for intervention or treatment to save the life of the mother if it occasioned or resulted in termination of her pregnancy.

It would not, therefore, be reasonable to propose a prohibition of abortion (understood as termination of

pregnancy) which did not expressly authorise medical intervention to save the life of the mother.

(b) redraft the constitutional provisions to restrict the application of the *X* case decision The attempt to do this by referendum as recently as 1992, by ruling out the mother's suicidal disposition and mere risk to her health as justifications, failed conspicuously. There would obviously be extreme reluctance to go this route again, given the uncertainty as to what precise amendment of the 1983 subsection would be likely to command the majority support of the electorate.

(c) amend Article 40.3.3º so as to legalise abortion in constitutionally defined circumstances Although thousands of women go abroad annually for abortions without breach of domestic law, there appears to be strong opposition to any extensive legalisation of abortion in the State. There might be some disposition to concede limited permissibility in extreme cases, such, perhaps, as those of rape, incest or other grave circumstances. On the other hand, particularly difficult problems would be posed for those committed in principle to the preservation of life from its earliest stage.

(d) revert, if possible, to the pre-1983 position This presents itself as a reaction to the unsatisfactory position created by the equal rights provision of the 1983 Amendment. There is a view that experience since 1983 is a lesson in the wisdom of leaving well enough alone, of being content to rely on the judgment of a majority of legislators, and of recognising the superior capacity of legislation to provide, for example, necessary clarification as to when medical intervention is permissible to terminate a pregnancy.

It does not appear, however, that it would now be feasible or safe to revert simply to the pre-1983 situation, which was governed basically by the 1861 Act.

That Act prohibited the *unlawful* procurement of a miscarriage, leaving it to be understood that miscarriages procured consistently with ethical medical practice were not unlawful. So, before 1983, the position was that unlawful procurement of a miscarriage was prohibited by legislation, ethical medical intervention to protect the life of the mother, even if it occasioned or resulted in termination of her pregnancy, might well have been regarded under the 1861 Act as not being unlawful, and a number of comments of individual Supreme Court judges had affirmed the right to life of the unborn human being. However, the extent of the doctors protection under the 1861 Act was never tested in an Irish court and carried no certainty.

Reverting to the pre-1983 situation would, therefore, be unsafe unless there were an express assurance of the protection afforded to doctors.

It is essential to have specific legislative protection for appropriate medical intervention because it cannot safely be said how far, if at all, the presumed 1861 Act protection is now effective in Ireland. Moreover, the protection could not be allowed rest on such an uncertain base as ethical medical standards. These are not uniform even amongst doctors in one country and medical ethics may change over time. Even prior to the 1967 Abortion Act in England, it would seem (in *R v. Bourne* [1939] 1 KB 687) that abortion was permissible if the pregnancy threatened to make the mother 'a physical or mental wreck'. In any case, in this litigious age, doctors could not safely rely on any convention not clearly specified and confirmed by law.

Reverting to the pre-1983 situation would involve:

(i) removing the abortion issue from the Constitution by deleting, without prejudice to particular decisions taken under it, the 1983 insertion (the Eighth Amendment) and
(ii) placing renewed trust in the legislature by relying henceforth on the prohibition in the 1861 Act, reinforced, however, by specific legislative protection for medical intervention to save the life of the mother.

As shown by the 1992 referendums, however, there would be public insistence on retaining the travel and information provisions as independent entitlements.

Moreover, it would appear that recourse could still be had to the provisions which would remain in the Constitution protecting life and other rights (for example Article 40.3.1º and 2º).

There could, in any case, be no assurance that a referendum proposal as outlined at i) and ii) above would commend itself to a majority of the electorate.

(e) regulate by legislation the application of Article 40.3.3º Relying on legislation alone would avoid the uncertainties surrounding a referendum but the legislation would have to conform to the principles of the *X* case decision and be within the ambit of Article 40.3.3º generally.

In brief, legislation could:

(i) include a definition of 'unborn' (preferably 'unborn human') or, in the context solely of abortion law, a definition of 'pregnancy', even if 'unborn' were not thereby fully covered. Any legislative definition of 'unborn' would, of course, be open to constitutional challenge but could be an advance towards clarifying the law
(ii) afford express protection for appropriate medical intervention
(iii) require written certification by appropriate medical specialists of 'real and substantial risk to the life of the mother'
(iv) in preference to leaving the matter to medical discretion, and again subject to possible constitutional challenge, impose a time-limitation to prevent a viable foetus being aborted in circumstances permitted by the *X* case decision.

Conclusion

While in principle the major issues discussed above should be tackled by constitutional amendment, there is no consensus as to what that amendment should be and no certainty of success for any referendum proposal for substantive constitutional change in relation to this subsection.

The Review Group, therefore, favours, as the only practical possibility at present, the introduction of legislation covering such matters as definitions, protection for appropriate medical intervention, certification of 'real and substantial risk to the life of the mother' and a time-limit on lawful termination of pregnancy.

Appendix II

Public Hearings on Abortion

Verbatim Transcripts (Medical)

Appendix II
PUBLIC HEARINGS ON ABORTION

VERBATIM TRANSCRIPTS (MEDICAL)

TUESDAY, 2 MAY 2000, 2.30 PM
MEMBERS PRESENT:
DEPUTY T. ENRIGHT, S. KIRK, M. McGENNIS,
L. McMANUS, J. O'KEEFE, SENATOR D. O'DONOVAN,
F. O'DOWD, K. O'MEARA.

DEPUTY B. LENIHAN IN THE CHAIR

Dr James Clinch

Chairman: The schedule for these hearings has been circulated to Members and I propose to proceed with the hearings as outlined in the schedule. I ask members to have regard to the following. Your attention is drawn to the fact that while members of the committee have absolute privilege, this same privilege does not apply to our witnesses – they have a qualified privilege. Members are also reminded of the long-standing parliamentary practice to the effect that members should not comment on, criticise or make charges against a person outside the House or an official by name or in such a way as to make that official identifiable.

I propose the following format for these hearings. Where witnesses have made written submissions available to us, these have been circulated to members and copies laid in the Houses. I do not propose to allow oral presentations of those submissions. Witnesses who wish can make a short opening statement which will be followed by a question and answer session with members. If no opening statement is required, we will go straight into the question and answer session. When we complete our dealings with each witness I propose to suspend the meeting for five minutes to allow the following person take their place and to decide the order of questioning for the next session. Is that agreed? Agreed.

I wish to welcome Dr James Clinch. He is a consultant obstetrician and gynaecologist, practised at the Coombe women's hospital and was a member of the ethics committee of the Medical Council. Dr Clinch wrote to us on 20 January 2000 and asked me as Chairman to draw to your attention that he would be grateful if he could be permitted to speak briefly to our committee. He was chairman of the ethics committee of the Medical Council from 1995 until 1999 and was involved in formulating the current wording relating to the care of pregnant women. You will find that letter on page 161 of the book which has been prepared for this hearing.

The letter has been circulated to members, laid before the Houses and circulated to the press. Absolute privilege attaches to that letter. Absolute privilege will also attach to the transcript of these proceedings which will be prepared. The format of this meeting is that Dr Clinch may make a brief opening statement if he wishes, and I ask him to do that in view of the fact that he asked to see us. That will be followed by a question and answer session with members.

While the members of this committee have absolute privilege, this same privilege does not apply to you in your verbal statement today – you have a qualified privilege in that respect. I welcome Dr Clinch to the committee and thank you for offering us your co-operation. I know it is very much appreciated by the committee. I ask you to make a brief opening statement outlining what you wish to draw to our attention.

Dr James Clinch: I thank Mr Lenihan personally for your phone call and the committee for seeing me. I have not had much time to read the brief because I only got it at the end of last week, but I've read as much of it as I could, rather quickly, over the weekend.

I think I should introduce myself first of all. I was born in Dublin but, shortly after my birth, emigrated to south Wales with my father who was a general practitioner. I was brought up in south Wales, went to school in England and then returned to Dublin to do medicine. When I qualified in the mid-1950s – 1956 – I did a house job in Dublin and then some house jobs in the North of Ireland, and then finally an obstetric job in Cardiff. I was so exhausted at the end of that that I actually joined the Royal Army Medical Corps and was in the British Army. A few months in that made me realise that I'd sooner do medicine than soldiering, and I applied to get back into obstetrics because I had a diploma, and was sent to the Far East in the army where I worked for a couple of years. I returned to Cardiff where I spent the next five years doing my basic training, starting more or less at the very bottom and working my way up.

At the end of that I did a research job and got an MD

based on the pill – the contraceptive pill – following which I went to Aberdeen where I was a senior registrar. That was at the end of the 1960s, the latter part of the 1960s when the abortion Act was just coming into England and we did a large number of abortions, both in Cardiff and Aberdeen because both of them were well known for their predisposition to abortion and in fact Sir Dugald Baird in Aberdeen had been one of the people who advised David Steele when the Act was being passaged through Parliament. After I'd been in Aberdeen for 18 months I then went to Galway as a consultant and then 18 months later ended up in the Coombe as master. When I finished being master I remained on there as a consultant and into the '80s and into the '90s I worked at the Coombe as a consultant with a particular interest in the end of pregnancy, that is the induction of pregnancy and post-maturity, and with abnormal cytology and the management of the abnormal smear and cervical carcinoma in women.

My last five years I spent in St James's Hospital as well as in the Coombe – that was in the '90s. During that time I was chairman of the institute, I was on the Medical Council and I have been on a lot of committees. I have recently retired from gynae-clinical practice, but I am still teaching, examining and I am on the board of the Coombe, so I go in there, so I still have an interest in it.

The reason I asked to see the group was that in formulating the current guidelines of the Medical Council, which was done sort of '97, '98 ... and we took approximately 500 submissions when we were doing this so we canvassed a lot of people and got a lot of opinions. At the same time the report of the Constitution review group had come out and I think a lot of doctors felt that this failed to make a clear difference between treating the mother who was pregnant and actually simply killing the baby. So when the guidelines were produced they used quite small words, were very specific and in fact the paragraph on the child *in utero* in the current guidelines is only five lines long and it is very clear-cut we thought, but then about a year later the Green Paper on Abortion appeared and this seemed to go right back and make this confusion yet again. There are various bits – talking privately I could show it to you – where I think the writer has got it mixed up again and thinks that an abortion is treatment of the woman, and in fact there is no medical condition which is cured by simply killing the baby or getting rid of the baby.

My second reason for wanting to come here is, as I say, until very recently I was an active obstetrician and for every obstetrician when they see a pregnant woman they are thinking in terms of two people – they are thinking in terms of the mother and the baby. They actually balance their care the whole way through pregnancy, doing their best for both of them, and the concept of actually destroying one just like that is anathema to them: they don't like it. Now, if in the course of treating one of them the other one happens to die, this is certainly not intended and nobody sets out to do that. You can look at early pregnancy, but you can also look at late pregnancy. I mean there are some hospitals which have double the Caesarean section rate of others and I suppose if you were a terrible cynic you could say they are subjecting women to a very serious operation in order to put the baby first. Well they are not, they are working out what is the best way in those instances of delivering the baby.

So my submission is that there is a marked difference between actually killing what is inside the uterus – simply doing that – and treating a woman who happens to be pregnant for a disease and as a result of that treatment the baby may be adversely affected. The second is that we as obstetricians certainly feel we are looking after two people.

Thank you very much.

Chairman: I wish to raise just one short matter before I ask the members to question you. You said you were chairman of the institute. I take it that's the Institute of Obstetricians and Gynaecologists.

Dr Clinch: And gynaecologists, yes, sorry. I should have said that.

Chairman: I just wanted to clear that up.

Dr Clinch: Yes, yes.

Chairman: We are taking Professor Bonnar later and he perhaps can deal with the institute since he is the current chairman. I'll ask Deputy O'Keeffe to start the questioning.

Deputy O'Keeffe: Thanks, Chairman. Dr Clinch, you certainly bring a lot of experience today which we very much appreciate having before the committee. Could I get to the point that is obviously of concern to us and I am sure to many people who are interested in this subject? Are there circumstances where to save the life of the mother termination of pregnancy is medically necessary? If so, what in general are those circumstances and what is the attitude of the Medical Council to such interventions?

Dr Clinch: Can I answer that slightly in reverse? I won't speak for the council now because I am not on it.

Deputy O'Keeffe: Okay.

Dr Clinch: .... but the first part of the question, you are using the word 'termination'. Here we're in trouble because in fact if somebody is 40 weeks pregnant and you think they should be delivered, you've terminated the pregnancy, so that's why the council guidelines were very clear. They said direct and intentional killing of the baby. There are no circumstances where simply killing the baby cures the mother, none at all medically. There are circumstances where the mother has a lethal disease or a very, very serious disease where in treating it the baby might die, but I would add that all the really serious things that you read about, for example, in this, if you don't treat them, the baby will die as well as the mother, so that's where we're back to the balance that the obstetrician deals with. He or she does the best for both of them and I've actually been in a room where discussion has gone on and I suddenly realised half the room thought they were delivering the baby to save it and half thought they were delivering the mother to save her but in fact they were both along the same lines because they had a serious problem and they wanted to treat it and deal with it.

This would be something like very, very severe pre-eclampsia, roaring blood pressure at 24 weeks in pregnancy when the baby is very, very immature. Now if

you don't do something, a lot of people will say 'well, the mother will die' but the baby will die as well, so you end up doing something and doing your very best but you don't do what … so you do your very best between the two of them.

Deputy O'Keeffe: Could I just follow up on that? I appreciate, of course, that you do your very best in the circumstances taking into account both the mother and the unborn baby. I was deliberately not using the word 'abortion' trying to … because there are connotations attached to that word and I used the expression 'termination of pregnancy' instead. One of our problems in fact is that in the Government Green Paper there isn't a definition, what is an 'abortion', but could I explore the situation a little further with you? When you say in the case you have described that you have to do something, could that something involve termination of the pregnancy for the purpose of saving the life of the mother?

Dr Clinch: Well, in that particular case if you simply kill the baby there's nothing more. It wouldn't cure the problem the woman has.

Deputy O'Keeffe: Yes, so what do you ....

Dr Clinch: You deliver the baby at the same time of course as treating the woman for the blood pressure and emptying the uterus of both the baby and the afterbirth will start … the process of severe blood pressure and everything will start to wane.

Deputy O'Keeffe: The result is that the mother generally would be saved in that situation?

Dr Clinch: We hope the mother will do well and we also hope the baby will do well.

Deputy O'Keeffe: What would be the chances of survival of the baby in that situation?

Dr Clinch: You know, Mr O'Keeffe, that the more premature you are the less likely you are to survive, so depending on the maturity of the baby, the more mature it is the more likely it is to survive. Also depending on the sex, if you are lucky and it's a girl – women are stronger – there's a greater chance that it will survive.

Deputy McManus: First of all, Dr Clinch, can I thank you very much for taking the time to come here? We've a process of deliberation now and various members of the medical profession have offered to come forward and agreed to come forward and we are very grateful for that because it is a very complex matter. I thought, as somebody who was pregnant on a number of occasions, I knew something about it but I clearly didn't until I started to read all the material and some of the questions I have may seem a little obvious but I would go back to what you have stated in terms of saving the life of the mother.

Reading the Green Paper I would ask you, do you feel it's reasonable for me to state that in certain conditions direct termination of pregnancy is needed to save a woman's life because certainly in the Eisenmenger Syndrome case the indications would appear to me that it is … the treatment is actually the termination of the pregnancy? I am interested to hear you saying that there aren't any circumstances – I hope I'm getting you right – where you save the mother's life by terminating the pregnancy because this seems to be in conflict with the Green Paper and also with some other medical submissions that have come forward. That is one question I would ask you to come back on because I think it's important. Also I would like to know if it is the case as is stated that this is the only treatment, is it available in Irish maternity hospitals where a woman is found to have this very rare condition that needs this kind of treatment, of terminating the pregnancy?

The other area I'd ask you to comment on is in the area of ectopic pregnancy where, as I understand it, historically, the practice was that there was a surgical procedure to deal with ectopic pregnancy where – and this was found to be ethically acceptable – an organ was removed or part of the organ was removed and if it happened to have the foetus in it, well that was a side effect of the treatment that now with laparoscopy it is possible simply to remove the products of conception and leave the woman intact. I don't know … I am sure you're aware of this but in the April edition of the British Medical Journal, there is a clinical review of further treatment now which is purely medical, which deals with the ectopic pregnancy without any kind of evasive surgery at all. I would be grateful if you would inform us as to whether this is an option, where it is suitable obviously. Is this an option provided for Irish women who need it or is there any question that because it is in effect killing the foetus, removing the foetus, that it is not the option provided and that the surgical option is provided for ethical reasons?

The other question I would ask you is this issue of acardiac twins where in order for one twin to … Now it is an issue that has been raised by one of your colleagues ....

Dr Clinch: By Dr Denham, yes. I read it. Yes, indeed.

Deputy McManus: Indeed, you know that again we are all aware that they are rare conditions but we have to ensure that the woman's life in all circumstances is protected, so this is obviously one aspect, rare and all as it is, that we must ask you. What is your view in relation to the position put forward by Dr Denham, which is in effect, as I read it, that in order to save the twin that has the heart you must abort the twin that doesn't? Is it the kind of practice that you feel is appropriate? Does it, obviously, come within the medical guidelines?

At the moment, there is a general view about Irish people that we don't like the idea of abortion and we don't agree with it but clearly an enormous number of women, relatively speaking, are availing of the option of having an abortion in Britain and the numbers are rising all the time. Is this something that would concern you as a practising consultant, that women are choosing to have medical treatment outside of the provision here, and possibly without the proper ante-abortion treatment or post-abortion treatment, more importantly, or do you feel it is a matter of their private, individual choice?

Finally, in terms of future medical developments, it would appear to me, and maybe you could comment on

this, that medical practice and clinical practice is changing and that what we now would consider, as a lay person, to be direct abortion was not carried out in the past but is carried out now in order to save women's lives and may increasingly be in the future? Do you see changes into the future? I cited the example of the ectopic pregnancy where a woman would be intact because of medical treatment now that is available that presumably wasn't available in the past.

Dr Clinch: That is a lot of questions.

Deputy McManus: I'm sorry.

Dr Clinch: I thought I'd get one question at a time. I will start at the beginning. I was going to start at the end but I think I'd better start at the beginning and then we'll look at the future.

I'm not a cardiac surgeon; all I do know is that if you look up the most recent maternal mortality report from England, they had three Eisenmenger's deaths in three years. One of them refused a termination and she died much later in the pregnancy, one was picked up later and she died too – these are just the deaths – but one of them came in, had her termination and went home and died two weeks later. Termination does not cure Eisenmenger's. If you review all the literature on Eisenmenger syndrome you will more or less get a headache because it is obviously riskier than having a normal heart but it would appear that the, as it were, the death rate is not inevitable amongst women and, with very, very good care, it seems to be lower than it might be and Dr Denham quotes a lower incidence than some others.

Now, the ectopic pregnancy. You are working in a hospital, you find somebody with a tube that's swollen, bursting, about to rupture and maybe do something terrible. You're a registrar or senior registrar. You treat that woman the best way you can. Your intention in treating that woman and her tube is not to kill a baby. That's why the word intention was put in. So that's how I would look at that.

Then you have the acardiac one. In fact, that's not to save the life of the mother. It was a surprising comment. I didn't actually read it in here but I talked about it before hand. I don't know how Dr Denham decides if he rushes into a burning house and there are two people, I don't know how he decides which one to take out first. There is a certain element of that in it but it's certainly nothing to do with the mother's life. If you care to make a judgment on whether you should kill one person instead of another one, I think that's extremely difficult.

Then you spoke about abortion abroad. Obviously, you worry about anyone having a termination, obviously there isn't a doctor in this country who wouldn't see someone and discuss what is euphemistically called a crisis pregnancy but, in fact, the first time you are pregnant, everyone, I think, is in a bit of a crisis and a bit agitated, and they would certainly see them afterwards. I can actually show you records of loads of women I've seen post-termination who've ended up in the Coombe and been looked after and nobody would refuse to look after them.

The last one you asked me was about the future. I actually do see things happening in the future which will be quite interesting. Thirty years ago, if a baby was very premature, you put it in an incubator and it quite likely died. Then we realised that if we put a tube down the baby and did its breathing for it, it might well survive. Whereas 30 years ago, babies of 34 and 35 weeks were dying, now we get very angry if a baby of 25 weeks dies. I do feel that if the human race was extremely short of people, which we're not, but if we were extremely short of people, by now someone would have designed an artificial uterus full of saline and you'd take the baby out if a woman had cancer of the cervix, you'd take the baby out, put it into this thing, plug in its umbilical cord and it would grow because we all know with ultra sound over the last 20 years that you can see a baby's heart when it is six millimetres long from head to bottom, and that all that baby needs is nourishment. That would be six weeks after the woman's last period, four weeks after she conceived and ten days or so after the period she has just missed. So we know that from very, very, very early on, much earlier than we thought, the foetus or the contents, are a competent unit which, if fed, grow into something bigger, then into an infant, then into a child, then into a teenager, then into an adult and then into an older person. There is a continuum along which your obstetricians want to give the best possible care.

The word termination, if I could come back to it a bit, it partly answers what you said, Ms McManus and Mr O'Keeffe – it is very, very confusing. That's why we use the word kill or destruction. If you read the missives from my own college, from the Royal College of Obstetricians and Gynaecologists, it actually has a very interesting booklet published in 1996 because they are getting worried in England you see about late abortions – they call them terminations – in case the baby survives because, of course, the whole point of all these procedures is that the baby is dead. If a woman goes to England and has an abortion, and they take the baby out and hand it to her, they have missed the whole point. So, in fact, this booklet, which I can give you, or you can buy from the college, says how important it is that the baby is dead before it is born because foeticide is legal, infanticide is murder. It gives instructions in one of the appendices about the various methods of making certain the baby is dead. Obviously it doesn't use the word 'kill' but kill is a very short, simple word and that's actually what they're trying to do. So, I would use the word destruction or kill and that's what a deliberate and intentional disposal of the foetus is, unfortunately.

I hope that answers your questions.

Chairman: Deputy McManus, do you want to ask further questions?

Deputy McManus: No thank you, Chairman.

Senator O'Meara: Thank you, Chairman, and may I also extend a warm welcome to Dr Clinch today.

I wish to ask him a specific question arising out of the Medical Council guidelines issued in November 1998, which I understand from your comments that you were responsible for or partly the author of, and that you have referred to and described as clear cut – very clear cut in fact – in your opening remarks. The specific guidelines are referred to here in the publication of the Green Paper

and, indeed, as you have set out yourself, treatment is given to a mother where a real and substantial risk arises and failure, indeed, or refusal by a doctor to treat a woman with a serious illness because she is pregnant would be grounds for complaint and so on. What I want to propose to you is the issue that arises and, indeed, is referred to in the Green Paper, if you want to refer to it, or to look at it, page 29 of the large document before us, that an issue does arise with regard to how the courts have seen what constitutes a real and substantial risk, specifically in the X case and the C case where the courts have seen that a risk of suicide, in other words, where a mother threatens suicide because of the pregnancy posed, in those cases as a result of rape and alleged rape, that that actually does constitute a serious and substantial risk to her health and that the courts have found that in those cases that abortion can be carried out. Does that then not conflict directly with the Medical Council guidelines? The Green Paper finds that it raises a number of questions, firstly as to the powers of the Medical Council to strike a doctor from its register in the event of a complaint of carrying out an abortion in circumstances equivalent to those of the X case, in other words, presumably where a mother presents with a risk of suicide or has threatened suicide and the doctor takes the view that that constitutes a real and substantial risk to her health and, therefore, an abortion should be carried out. In your view, how then does one reconcile this problem? To us, as legislators, and in terms of making recommendations on this whole issue, this is a very important and central point. On the one hand, the courts are saying that suicide does constitute a real and substantial risk to the health of the mother, therefore justifying or allowing an abortion to take place within the law, but the Medical Council guidelines appear to take a narrower view of that. Can I ask you your view on whether the threat of suicide by a mother does constitute a real and substantial risk to the life of the mother?

Dr Clinch: Medicine and law make very bad bedfellows. Certainly a thing can be legal and unethical, you know that. There are some countries where they circumcise women. We would hardly think that was ethical. There are certainly countries where they amputate limbs. I would regard that as unethical. I do not really think that hanging 'baddies' is ethical, or if a doctor is involved in it. A thing can certainly be legal and unethical.

One of the big problems, if I might, Mr Chairman, just say one thing, is that the law looks backwards and medicine looks forward. We know this in many ways. Just as an aside, one of the great troubles of modern technology is that the law cannot keep up with it, and if it was not for our own in-built ethic and public responsibility standards and the way we treat other people, I do not think we would be able to deal with it at all, because the law will catch up with it and by the time the law catches up, there will be new technology. The law is not very good on these things. The law is confrontational as we practice it in these islands; medicine is empathetic, and it is different.

Now we come back to suicide. If you look at the most recent Maternal Mortality Report, it says quite clearly that pregnancy appears to damp down the tendency towards suicide. If you look at Anthony Clare's work in the 1980s – now he may have changed his mind but I have a lovely picture of him saying that psychiatrists are not very good at predicting suicide. If we look again at the English Maternal Mortality Report, we see that one woman was brought into hospital for a termination because she was going to commit suicide, and she committed the suicide before they got her down to the theatre. So it does not seem that even termination stops it. I am not a psychiatrist. That is only a general reading of it. I really think you should get a psychiatric opinion from a psychiatrist, again with due respect, not from a barrister. I do not want to be rude, and I am obviously not being rude or trying to be rude, but psychiatric opinion, from what I can see, seems to think that pregnancy is almost protective from suicide.

Senator O'Meara: I would like clarification. I want to ask again about the issue of the Medical Council guidelines and how doctors can see that in the context of suicide.

Dr Clinch: Sorry. I gave the illustration. That lady in fact obviously needed very marked psychiatric treatment, not a termination. In the previous triennial report there were two deaths from suicide within weeks – two and five weeks, I think – following termination for psychiatric disturbance. So really, if somebody is very psychiatrically disturbed, what they need is really good psychiatric therapy. One of the problems with termination in the UK is if there is an awful lot it comes to be seen as the treatment for everything, so you get a woman coming in in cardiac failure who happens to be pregnant, so they terminate her pregnancy, and then she dies of cardiac failure. Quite a lot of that goes on, if you read these reports. The proper treatment for somebody who is psychiatrically disturbed is to treat the psychiatric disturbance not, as it were, cut a lump out of them.

Senator O'Meara: Does mental illness or a serious psychiatric disturbance constitute a serious illness under the Medical Council guidelines?

Dr Clinch: If you are psychotic or psychiatrically depressed, it is an illness and it should be treated. I am not trying to escape from this, but I do not like talking about other specialties too much, if that is reasonable, but from everything I have read ....

Senator O'Meara: I am just simply trying to tease out if mental illness, psychiatric disturbance or a threatened suicide, for instance, in the context of mental illness, is covered by the Medical Council guidelines in relation to carrying out abortion or termination.

Dr Clinch: The council took the view that standard medical treatment of the mother … and termination is not actually treatment, is it?

Senator O'Meara: Does the risk of suicide constitute a serious illness in the context ....

Dr Clinch: The risk of suicide constitutes an illness. If you came up to me and said 'I'm thinking of committing suicide', I would think you were ill. I would not say 'You're fine, it's a sunny day. Don't bother'.

Senator O'Meara: Thank you, Chairman.

Deputy McGennis: I join in thanking Dr Clinch for coming in to speak to us today. The first thing that is learned in the first few moments, if we did not know it already, is that although the guidelines from the Medical Council are clear, as Deputy O'Keeffe has said, we do not seem to have a very clear definition or interpretation of abortion as we are dealing with it. That is the first problem we have.

You have stated that it never would be necessary to kill a foetus in order to save a mother's life. It would be part of something else, but there will be a point at which you have tried the other interventions, medical or surgical, in order to bring down blood pressure or whatever the problem is, so you will reach a point, having gone through the medical alternatives or supports or whatever it is you are doing, at which you may have to make a decision to kill a foetus. It may happen as a result of a treatment, but surely there are instances in which it actually turns out to be a decision that has to be taken separately.

The Green Paper and the submissions which were received in connection with the Green Paper and which we have received ourselves draw a very clear line between what is described as direct and indirect abortion. The Medical Council's definition certainly would deem that kind of intervention as being indirect abortion.

It is in the Green Paper and I know you have already said it and it is clear that law and medicine are not very compatible bedfellows, but unfortunately the decisions we make will be transferred into law at some stage. If there were an absolute constitutional ban on abortion in the morning – this is probably the question everybody would hate to be asked – would you feel that people like yourself, people in practice under the Medical Council's guidelines, might be in a situation where you could not in fact perform the procedures to which you have referred? I do not mean simple direct abortion because you have stated that is not what you do and that is not what happens here. If there were an absolute constitutional ban on abortion without wording to allow for the kinds of procedures that you currently have to carry out, would you feel that your hands might effectively be tied? Would there then be a risk to the life of a mother in those kinds of circumstances?

Dr Clinch: You have asked me about abortion and you said there was a difficulty defining it. On the understanding that we mean simply killing what is in the uterus, if we take it as that, I would not feel I was spancelled in any way whatsoever. I feel I could get on with treating my patients, all of them. In fact that is paragraph 7.23, and that was one of the ones where I thought the people writing the Green Paper were a bit confused. There were several others, but that was one of them. There is no doubt that for years people have treated pregnant women, or certainly should have treated pregnant women, with the correct therapies. If I could turn it slightly the other way round, the baby has to take its chances as well. I used to say years ago that one of the biggest hazards babies had in the city was that their mothers were breathing. Remember what it was like in the winter. It has got to take those hazards. A large proportion of our women still smoke. A large proportion drink. Once you are that human being, albeit a tiny one, you are exposed to a whole load of things which go on around you and you take your chance. If the person attached to you has to have treatment which adversely affects you, that may be hard luck on you. It would be like Siamese twins having operations on them.

These sorts of things arise and the doctor is always trying to do his or her best for both people. That is the way medicine and obstetricians have always looked at it, not always non-obstetricians because they do not actually have to do some of the procedures they expect obstetrician gynecologists to do. I would see no difficulty whatsoever in being able to look after my 'patients' – meaning both lots – properly. There are procedures. You can look at things like large placental abruption and bleeding at term. I remember in the 1970s the way we managed them in the Coombe and Holles Street was different. Somebody who was a terrible nit picker would have said you might be favouring one or favouring the other. In fact it ended up that whichever way you managed them the results of large placental abruption weren't very good. We used to section them immediately. Holles Street used to wait until they had resuscitated the woman because they felt that gave her a better chance. In fact the end results from the point of view of baby survival and mother mobility were identical. As I pointed out, somebody could criticise one of the hospitals here for doing lots and lots of sections and exposing the women to risk but they feel that, in fact, this is the correct way to deal with it. So there will always be these slight balances but everyone that I know is doing their very best for both the patients under their care.

Deputy McGennis: And you would be quite confident that that would not change if there were an absolute constitutional ban?

Dr Clinch: If there was a constitutional ban on the direct killing of the contents of the uterus that would not change my practice.

Deputy McGennis: Why would you feel that maybe some of your colleagues who have made submissions to the Green Paper and to our own committee might have reservations about that?

Dr Clinch: Well I think some of them don't work in obstetrics and gynaecology and they do not realise this. You must remember historically the mother or the baby child thing started coming up when cesarean sections were first started well over a hundred years ago. This woman had a baby in utero and she was in labour and looked as though she would not push it out. Depending on what the man who owned the two of them thought, maybe it was better to deliver the baby and have a son and heir and let go of the wife, or maybe you should destroy the baby, as you had to then, and as is done in very early pregnancy now and the mother had a better chance of surviving. But that is all gone. That is how it arose historically. It is way out of date.

Senator O'Donovan: I welcome Dr Clinch. Most of the questions have been asked. I do not want to go over the same issues. You have been very frank. I ask for your view on a couple of simple questions. When would you feel, in your expertise, life begins? If you take any direct interference – I understand from you that you are saying

any intentional interference resulting in the termination of pregnancy is wrong morally and whatever, that is the train of thought I am getting from you – what would your views be on something, say, which I understand a lot of young people use nowadays, the morning after pill? Is it damaging to the foetus? Is it a direct attempt to terminate the pregnancy? My view from speaking to some GPs is that its use is relatively common in the last ten years as opposed to 20 or 30 years ago. What would your views be on that?

On a final point, what would your view be in relation to a woman in her late forties or maybe early fifties who would become pregnant and there is a very strong probable chance that the baby will be Down's syndrome? Where would the Medical Council stand in that situation, where somebody is facing a risk to her own health number one, and number two the likelihood of maybe a deformed or handicapped child?

Dr Clinch: The first question, sorry, I did not write them down. What was the first one?

Senator O'Donovan: What is your view on the use of the morning after pill?

Dr Clinch: That was number two actually.

Senator O'Donovan: Basically life, when ....

Dr Clinch: When life begins. I frequently saw patients who said, 'Now doctor, can you tell me absolutely you see something or other?' And I would say, 'Look, I left my halo in the office.' Until somebody proves that it does not begin at the beginning we have got to assume that it does. And when sperm meets egg we have got to work out whether, in fact, that means it begins then. I think most practising physicians would sort of vaguely assume it begins then and that is that and don't get caught up on the minutiae of travel down the tube and implantation in the uterus. So I would be quite happy to say it began at the beginning, but I am not a very very early pregnancy scientist and I haven't done work on that.

The morning after pill – the wording used was the deliberate and intentional destruction. I think that is what we said of the unborn child. If you actually believe that there is a child there I don't think you will use the pill. If you don't believe there is a child there – the morning after pill, if you don't believe there is a child there you will use it. And if you have doubts you will, in fact, go along with your doubts. So, I think that people who sincerely believe that there is a child there will not use it.

Now as for the older woman and, incidentally younger women have children who aren't well as well, this raises the whole question of what society is to do with its people who are handicapped in any way. If you are going to get rid of handicapped people in utero why not do what Lionel Arthur did and get rid of handicapped neonates and then you can expand it? I have a handicap. I have got crooked fingers. So the definition of handicap is very difficult.

Then you get on to the whole problem of quality of life of the people who are handicapped. We all know an awful lot of very very fit people who have very poor qualities of life because of various habits they have developed. I would hate to make any comment about anyone else's quality of life. I think people who are handicapped in any way need every possible sympathy and support from the start of their life to the very end. It is a big big problem and it is a little philosophical because you can, of course, train doctors to do anything. I mean, when you first do medicine you faint when you see all the blood. After a year or two you're thinking in terms of not getting blood on your socks. You can train human beings to do anything. We all know those studies of German and American soldiers. I mean the Americans thought killing Japanese was quite normal, that killing Germans wasn't quite so bad, whereas the Germans thought the killing of Americans or western Europeans wasn't such a great idea whereas killing Russians was sport. The human race can be very unsympathetic and to take it out on people who are handicapped or, indeed, to take it out on people who are infants or to take it out on people who are in utero really is very very uncivilised.

Deputy O'Keeffe: Dr Clinch, am I right in summarising you, to some extent, that the core issue here in your book, the direct killing – there is a clear distinction between the direct killing of the foetus or the unborn baby and the indirect killing? Is that where the distinction lies and whether we are talking about ....

Dr Clinch: Yes, that is where the clear distinction lies. As I say, most doctors can see the difference. We felt that the – I felt, that was why I wanted to come in, and please do not quote me as being the Medical Council because I am not on the council now, but that is why I wanted to come because I felt that the Green Paper got that a bit mixed up.

Deputy J. O'Keeffe: At all times as far as the doctor is concerned, it is a question of intent. If the intent is direct killing it is wrong and if the intent is to deal with the condition of the mother and this indirectly results in indirect killing, that is okay.

Dr Clinch: Indirect death of the baby. That would seem all right. If the mother has a serious disease it must be treated. That is why the wording in the guide was very specific about that.

Deputy O'Keeffe: There are two other issues which I will put to you although they deal with the law side as opposed to the medical side. We are sitting in the Houses of Parliament where we have to cross over. You were asked earlier in relation to a blanket constitutional amendment prohibiting abortion. Do I take it that unless that constitutional amendment allowed for the continuation of the present practice of indirect killing it could cause problems to the medical profession?

Dr Clinch: I have in my office at home, five judgments which I collected while I was on the Medical Council and which I occasionally read to give me an excuse to have a large brandy so, I cannot answer that question legally.

Deputy O'Keeffe: Okay.

Dr Clinch: The legal side of it I find confusing and

possibly, because you asked the question, you also find confusing. It can be very difficult to deal with exactly how the various courts think on certain things: not their conclusions so much as their premises, which lead to conclusions which do not seem to follow the premises. I could not make a comment legally. I am saying that doctors see a distinct difference. If I were to do an operation on you – a very big one because you had a very serious disease – I would be doing my best for you and if you happened to die no one could say that I had actually killed you.

Deputy O'Keeffe: Fair enough. One last question since you are sitting in the seat of one of our lawmakers: If you wanted to put forward a view as to whether or how the law on abortion should be reformed, is there any particular view you would like to put forward?

Dr Clinch: I said to Senator McGennis that I could work very happily with a law which said you must not directly kill the unborn baby. That would not restrict me in any way in dealing with any of my patients.

Chairman: Although we are in the Seanad Chamber it is actually Deputy McGennis. We are a joint committee. I call Deputy Enright.

Deputy Enright: I join the other speakers who have welcomed you here this afternoon. We appreciate your giving us your time to discuss this very important and emotive matter.

The X case has been discussed somewhat but I return to it briefly. As you are aware, the evidence in the X case hinged around a report of a clinical psychologist. I do not know if there was much medical evidence, if any, sought. The court basically dealt with the report of the clinical psychologist. You have referred to suicide as a type of illness. In the event of your having to look after the young girl and as a medical person, I take it that you would have your own assessment before you took any act in any procedure. I would like to tease out your attitude in that type of instance.

To get back to ectopic pregnancies, you said you have no intention of killing in the case of ectopic pregnancy; you must do what you can to save both the mother and child. In the middle of the treatment, does the choice arise as to what is the next step and how you will proceed when you are treating that patient? In speaking to some medical people they have felt that a decision may have to be taken that in order to save the mother one must terminate the pregnancy. That is the view of some people. I would like to know what your views are. How do you decide and when do you decide?

Dr Clinch: You do not set out when you go to manage a thing like that with a view in your mind, 'I am going to go off and kill an unborn baby'. Some of you may remember, with the ectopics, the great thrill there was two or three years ago when there was a report in the *British Journal of Obstetrics and Gynaecology* that someone had taken an ectopic out of a tube and put it into a uterus and it had grown into a baby. That would have been very positive and it was a little bit like what I was saying to you about how, if science advances, this type of thing might happen. In fact, it turned out to be completely false and the second last president of the College of Obstetricians had to resign because he was involved in that case report. It turned out that they could not find the baby and then they could not find the mother. So, you do not set out with that in mind.

If a young woman needs treatment of any sort you would give it to her. If she needs psychiatric, or it is usually social support, you would arrange that for her and you would support her in every way. There are numerous papers to be read on both sides about the handling of pregnancy in very, very young women. Just taking the pregnancy away, taking the baby away and throwing it away does not please them all by any means. You look after her and you try to help her to produce as fit and healthy a baby as possible.

Deputy McManus: I presume you are a member of the Institute of Obstetricians and Gynaecologists, are you?

Dr Clinch: I am, yes.

Deputy McManus: I presume you are aware that in their submission, they consider the Green Paper to be comprehensive, up to date and an objective analysis of the issues arising in the care of pregnant women? The institute obviously takes a rather different view on the Green Paper than you have presented today.

Dr Clinch: They did not say it was accurate. That was in the original draft and someone took it out.

Deputy McManus: Well, I think they are fairly clear that they are certainly not stating it is in any way inaccurate. But maybe I could finish my point.

Dr Clinch: I am sorry. I apologise.

Deputy McManus: Page 127. It also refers to rare complications where therapeutic intervention is required at a stage in pregnancy. I would like you to clarify because I am afraid I am not clear in my head what you are saying. In the last few minutes you said that treatment would be given to a woman. It is quite clear from the Green Paper that there are rare circumstances – and in relation to ectopic pregnancy it is not so rare – where the treatment is the termination of the pregnancy. That being the case, would it not be fair or justified to have a concern that if there is an absolute ban on abortion that the treatment that those particular women need in order for their lives to be saved would be at risk, because the treatment is actually the termination of pregnancy?

Dr Clinch: I think the courts would have to show that the doctor set out to deliberately kill a baby. I spoke earlier to the last Senator about the fact that if you could actually take it out and put it somewhere else you would do that. It was you who asked me about the future of medicine and this type of thing may well be possible. But with what we can do in the year 2000, you have this swollen tube about to burst and you do something about it. I remember saying to somebody who was saying that was a termination, 'Look, I have a lady here who came in with an early spontaneous miscarriage and she is really, really bleeding. I want to give her some ergometrine to

make the uterus contract. Is that making her abort?'. They looked at me as if to say, 'Is it?'. I said 'I haven't the slightest idea but I am not going to let her die in front of my eyes'. That is what happens when you are a registrar or a consultant on call and it is two or three in the morning. You do something which you consider at that time is the best thing you can do and it is very important that doctors do that. If they start getting too uptight about various things you find that people, the public may in fact suffer and that's why the guide is very keen on that and very straightforward – 'The deliberate and intentional destruction …' That's why it's worded that way.

Deputy McManus: So what you are saying too is that the Constitution and legislation should ensure that doctors do have that particular judgment that they can exercise.

Dr Clinch: Golly, if it got established that there were all sorts of legal things – I don't think that it's just obs and gynae which might be in a bit of trouble – we might have a thing about intensive care and there would be a thing up on the wall, 'It is the law that' people over 90 should have their tubes taken out after 12 hours and so on down and the Chairman would probably get about 76 hours of resuscitation, so you've got to be very careful, you've got to leave some leeway to doctors in that respect and I don't think the law would be very good at defining that. Sorry, you have trapped me into talking about the law and I really should take most of that back. I am not a lawyer.

Chairman: Are there any further questions from the members? There are just one or two short questions I want to put to you ....

Dr Clinch: Yes, thanks.

Chairman: .... and they do relate to the law. The first point was really the Constitution and the statute law that the people or ourselves as representatives of the people enact here. That has to provide a framework within which the standard medical treatment can take place. Isn't that right? You don't want to see the law interfering with your clinical judgment and your capacity to make clinical judgments, I take it.

Dr Clinch: Not in detail.

Chairman: Not in detail. Again sticking just to one legal matter – the Medical Practitioners Act of 1978 – I take it the ethics committee of the Medical Council is established under that.

Dr Clinch: Yes.

Chairman: And their function is to prescribe ethical guidelines for the profession?

Dr Clinch: Yes.

Chairman: And any breach of those would be ethical misconduct on the part of a doctor?

Dr Clinch: Could be.

Chairman: Could be, depending of course on the judgment taken by the fitness to practise committee on the facts established in a particular case.

Dr Clinch: Yes.

Chairman: So those guidelines would apply to – I want to choose a word – any procedure in relation to an expectant mother? Any procedure carried out falls within the scope of this guideline. Isn't that correct?

Dr Clinch: Yes.

Chairman: It doesn't matter whether we are talking about a psychiatrist or an obstetrician or a gynaecologist – whatever the particular speciality is the guideline does apply to all procedures in connection with an expectant mother.

Dr Clinch: Yes.

Chairman: You can bear with me for a few minutes on this, I take it.

Dr Clinch: I can, yes.

Chairman: But the guideline is clear – it's on page 29 of the brief book – the guideline provides that 'The deliberate and intentional destruction of the unborn child is professional misconduct' and 'Refusal of a doctor to treat a woman with a serious illness because she is pregnant would be grounds for complaint and could also be considered professional misconduct' and '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.' The crucial question then of course is what amounts to standard medical treatment for the purpose of the application of that guideline. Is that a fair comment?

Dr Clinch: I think so, yes. Before you go a lot further, I don't mind talking about this but I feel a little bit – you have Gerry Bury next week and he is president and I don't want to cut across him. I have been trying to get hold of him all weekend and unfortunately I couldn't because I wanted to say to him that there were two things I wanted to talk about, one was the clarity which I felt the Green Paper didn't have and the second thing was the view of an obstetrician.

Chairman: Yes, I ....

Dr Clinch: I can't speak, Mr Lenihan, for the present Medical Council. It would be unfair of me ....

Chairman: No, you don't ....

Dr Clinch: .... because I am not on it.

Chairman: You don't have authority there and I accept that ....

Dr Clinch: No.

Chairman: .... and you are not being taken as having

authority there by the committee. What I am anxious to establish is the meaning and as you are an author – a part author of the guideline ....

Dr Clinch: One of 26.

Chairman: .... one of 26 but a person who played a part in that process and an important part clearly ....

Dr Clinch: I was on it.

Chairman: .... to simply give your assessment. It brings me to the very unusual condition, the Eisenmenger case which has been referred to already in the questioning. The Green Paper suggests that ....

Dr Clinch: There is 'a window' and it doesn't give a reference.

Chairman: Indeed, and it suggests that there is a clinical view that termination may be required or at least it is a clinical option which should be operable in such a case.

Dr Clinch: Actually – while you are looking it up – termination of pregnancy can be an option for anyone. It obviously is in the UK where 26% of maternities, as it were, are terminated and in some ways society over there is quite happy with it because it removes an awful lot of the social problems. You are back a bit to terminating abnormal babies and then those of a lower social class.

Chairman: At page 12 of the brief book prepared for this hearing ....

Deputy McGennis: Sorry, Chairman, just on the last point that you made about the 26% – I probably should not cut across – I don't know if you are saying on the record that the 26% would reflect society dealing with the handicapped or those of a lower social order. That's not what you are saying surely.

Dr Clinch: No.

Deputy McGennis: No, I misunderstood you.

Dr Clinch: I am sorry, I was saying that there was a huge number and society over there seemed quite happy about it.

Deputy McGennis: But you did make specific reference to the ....

Dr Clinch: Sorry, I didn't mean to put the two together. I just followed on that nobody in that society bothered very much about inter-uterine life.

Deputy McGennis: No, it just seemed to be a huge leap to make that 26% of ....

Dr Clinch: Sorry, I was talking while I was looking up.

Deputy McGennis: Okay. With the literature which we have given I don't think even we could make that leap.

Dr Clinch: No, I didn't intend to.

Chairman: I just wanted to relate the guidelines to Eisenmenger's syndrome, a syndrome where you have a cardiac disease with pulmonary hypertension in pregnancy. It is a very rare condition. I think that is acknowledged in all the literature but it is a condition that can develop. At page 12 of the brief book the Green Paper says that, 'Clinicians consider that there is a high mortality from this condition and some recommend an elective termination of pregnancy to protect the life of the mother.' In the standard medical practice referred to in the Medical Council guideline, is that a clinical judgment that is permitted under the guideline?

Dr Clinch: No, because if you deliberately destroy the baby, that's considered unethical. If you read the whole of paragraph 1.16 it gives lots of references the other way round.

Chairman: Yes, I accept that ....

Dr Clinch: I can only depend on the references they give; I am not a cardiologist. You would have to have a cardiologist to talk about that.

Chairman: I accept that but still there is a diversity of clinical view on this question disclosed in the Green Paper. Do you accept that?

Dr Clinch: It says, 'It is further considered that there may be …' That's two ifs and once you get to more than one if in a scientific study you are really losing it. It then says, 'more likely …' As I told you, in the most recent maternal mortality report – just to go down to the medicine of it – Eisenmenger's does produce pulmonary hypertension but you can get primary pulmonary hypertension anyway and there is an additional death after termination for primary pulmonary hypertension, so it may not even be good medical practice. One of the criticisms about the whole management of heart disease in the last maternal mortality report was that perhaps some of them should have been – their cardiac condition should have been treated first and then thoughts given to something else. That's the view that would be taken in this country – somebody with a bad heart condition should be looked after by a really good cardiologist in conjunction with a obstetrician if they were pregnant.

Chairman: Suppose that obstetrician in Ireland formed the opinion that surgical intervention which would have the side effect of harming the foetus *in utero* had to take place to safeguard the mother's life, would that clinician be protected under the present guideline? Would he be acting ....

Dr Clinch: I think you've put it obliquely which might, incidentally … I think you started off by saying to me if he decided to simply kill the baby, or she decided to kill the baby … I think that would probably be considered unethical. As I say, I am not on the council. I am not on the fitness to practise committee.

Chairman: I appreciate that but I am putting it now obliquely. Would it be considered unethical if he didn't have that intention but that his primary intention was to safeguard the mother's life – or her primary intention?

Dr Clinch: If he did what you're suggesting, I think it would be unethical because his intention in doing it would be to kill the baby. If he said it … if he said, 'I am going to treat this Eisenmenger's by killing that baby'.

Chairman: That's how I put the question initially. But suppose I reformulate it obliquely and say that the primary intention, or his or her primary intention, was, in fact, to safeguard the mother's life. In that situation would the clinician be within the guidelines and protected?

Dr Clinch: If he deliberately and intentionally destroyed the unborn child I think he might have a question to answer.

Chairman: Under the present guideline?

Dr Clinch: Under the present guideline. That's how it's written, so I'm interpreting it from the actual words. I'm just reading them. I'm not even interpreting them. You can read them as well.

Chairman: Yes, but suppose the consultant takes the view that the risk of mortality in this case is so great that there is no option available to him to safeguard the mother's life other than to carry out a procedure which has, as its indirect effect, the ending of the life of the unborn? Is that within the guideline or not?

Dr Clinch: I think if you add up all the references under that chapter, there seems to be … I mean you can do a count. We're getting right down to the head of the pin now.

Chairman: But this is the difficult one.

Dr Clinch: You can do a count of references that some people are saying that … some people give much better figures than others. Most reputable units would look after the woman and her heart disease. That would be the practice.

Chairman: So you're saying the standard treatment excludes that option. Effectively, that's what you're saying.

Dr Clinch: Killing a baby isn't treatment.

Chairman: I accept that and you've made that very clear.

Dr Clinch: You can't go further than that. You can go round and round this but if you want to be direct that's the sort of final statement on it. I should add to Miss McManus that Professor Bonnar is following me and he will speak to the institute's submission, obviously. I don't want to cross him either.

Chairman: In the treatment of ectopic pregnancy clearly you rely on the dominance of the good intention there. That's the key factor there. Is that a fair summary of your evidence?

Dr Clinch: You must take into account intention. I mean, if I walk up to you with a gun and shoot you, that's intending to kill you quite clearly. However, if you attack me and in the resulting fracas I manage to push you down the stairs or you fall over me and go down the stairs and kill yourself I didn't intend … I mean that's different. I mean the courts would see that. So there is always some intention in any act.

Chairman: Just returning to the acardiac case which you mentioned in the course of your evidence and which Dr Denham mentioned in his written submission. That acardiac case, as you rightly say, involves a choice between two unborn lives rather than a choice between the life of the mother and the life of the child. If I could put it that way. But, in the case of the acardiac instance, what is the ruling? What is the position of the Medical Council? Perhaps I could reformulate it. What is the position under the guideline?

Dr Clinch: Deliberately killing a baby *in utero* is considered unethical. Now, I'm not a paediatric cardiologist, Dr Denham is and I've never seen one of those. So, I really … it would be very difficult for me to make a comment on the clinical situation because I've never seen one and I've never dealt with one. You're getting me to talk about other people's specialities and if there are any of them in this room they'll be hopping up and down. Dr Denham would not like me speaking about cardiology or paediatric cardiology.

Chairman: We'll pass on from the acardiac case but it does raise a very important ethical question in that particular context.

Dr Clinch: But, Mr Lenihan, from the day you start doing medicine you have ethical problems all the time. I've had people ask me about doing obstetrics and isn't it awful having to get up at night. I said that that's easy compared with some of the ethical and social problems you run into. You run into these every day.

Chairman: Yes, but the guideline is very general in character but are there any specific rules of guidance or rubrics for doctors which clarify the application of the guidelines in concrete instances?

Dr Clinch: Yes, you preserve life and promote health. It says that on a couple of occasions in them. If you have a medical practice which doesn't do that you can be in big trouble. What would you do if you walked into a surgery and a doctor had a big sign up behind his or her desk saying, 'I am anti-life'? You might leave.

Chairman: Yes, but in the present context of the present guideline which is, as you say, a clear-cut guideline, but it still has to be applied in different circumstances like any legislative instrument. It has to be applied to particular sets of circumstances.

Dr Clinch: Yes, but the law will come. I mean, you will propose or not propose some legislative change. As I said, there can be differences between ethics and the law. Is this not so?

Chairman: Yes, but the ethical guidelines have statutory force under our legislation in this State.

Dr Clinch: As far as the Act has, but you can go down to the courts and appeal them. Can't you?

Chairman: You can but I would anticipate that the ethical guidelines … a doctor could be brought before the fitness to practise committee for any breach of the ethical guideline that we've been discussing this afternoon. So that's a legal ....

Dr Clinch: And he might go down to get the … we've all seen cases go down and have what the fitness to practise committee say modified or changed. The Act is, what, 22 years old and doctors still have to go down … in fact, sorry, the fitness to practise has to go down to confirm its decision.

Chairman: Just one other question which arose this afternoon was the whole question of suicide. I think the question that was posed was, can pregnancy of itself increase or decrease the risk of a suicide? Have you a judgment to make on that as a person with considerable experience in obstetrics?

Dr Clinch: I am not a psychiatrist, thank God. They have a very difficult job. All I know is what I read in the references and if I could read you an extract which I accidentally found on the Internet. It goes as this. It's the last maternal mortality report and the sentence is, 'The most striking fact is that despite the clearly elevated rates of mental illness in child bearing women, (which I didn't know) the risks of completed suicide and of self harm are markedly reduced'. That's page 3 of chapter 12 in the 1994-6 report. It then goes on to say … I mean pregnant women do commit suicide. Lots of people commit suicide of all ages but it says here that the presence of a young and dependent child is, therefore, probably protective against suicide. Now, that's as far as I would go because I'm not a psychiatrist. I think you have … I think some of the other people coming in are psychiatrists.

Chairman: Yes, but of course a psychiatrist would not be involved in carrying out any procedure in connection with a pregnant mother. Isn't that correct?

Dr Clinch: Well, a psychiatrist might be asked to see a pregnant mother obviously. But I obviously read the maternal mortality reports. The reason I've only got this extract is that I haven't got the most recent report. I've got the one before it with me but this came up when I was looking up something else.

Chairman: We've taken somewhat longer than we anticipated and I do want to thank you very much for your assistance.

Dr Clinch: I'd like to thank you. Could I just say one thing to finish with? I do think society and women in this country actually do respect intrauterine life. As you know, a lot of people miscarry and if you look at the number of people who turn up to the miscarriage clinics, if you look at the number of people who make careful arrangements for the burial of miscarried babies or miscarried remains, whatever you would like to call them, obviously there is great respect for intrauterine life, and it would be very nice if that tradition was continued. It might look as though Ireland is out of step with a lot of other countries but, in fact, we all know some other countries where they treat pregnant women and, indeed, intrauterine life very very badly, but here they respect it a lot and I think it is quite important to realise that. Thank you very much for seeing me and for all your hard work on such a lovely afternoon.

Chairman: Thank you, Dr Clinch.

Dr Clinch: May I stay for the next session, if that is possible?

Chairman: You can indeed.

Dr Clinch: Thanks.

Chairman: We will suspend the hearing for five minutes.

SITTING SUSPENDED AT 3.51 P.M. AND RESUMED AT 3.59 P.M.

Professor John Bonnar

Chairman: We are now in public session. I would like to welcome Professor John Bonnar, who is Chairman of the Institute of Obstetricians and Gynaecologists, to this meeting of the Joint Committee on the Constitution in connection with its consideration of this issue.

Professor Bonnar, we received your letter, which has been circulated to the members. I think it has been fairly widely circulated at this stage but you will be glad to know that as of today it enjoys absolute privilege.

The format of this meeting is that you can make a brief opening statement, if you wish, which will be followed by a question and answer session with the members. I want to draw your attention to the fact that while members of the committee have absolute privilege, this same privilege does not apply to you, as a witness, in your verbal utterances. You will have a qualified privilege. What you say will be written down and recorded and an absolute privilege will attach to the copies of that recording … or to that recording.

I now invite you to make an opening remark, in which perhaps you would elaborate on the letter which you sent to the committee on 29 February this year which is at page 127 of the brief book.

Professor John Bonnar: Thank you, Mr Chairman. First, I would like to say that I found the Green Paper one of

the most comprehensive documents I have ever seen in relation to the legalisation of abortion. I would be familiar with the situation in the UK, the United States and in the most of Europe. I don't know any jurisdiction where, in fact, there has been such a thorough examination of the whole area. I congratulate the committee on the very detailed work and comprehensive way in which the whole subject has been presented.

I am Chairman of the Institute of Obstetricians and Gynaecologists, which is the professional body in Ireland representing the specialists who look after pregnant women – the obstetricians and the gynaecologists. We are part of the Royal College of Physicians of Ireland. I should explain that I was born in Scotland of Irish descent; my family comes from County Donegal. I had my initial degree in medicine in Glasgow and I did my initial training in Glasgow. In 1975, I moved to Oxford as the reader and consultant in the John Radcliffe Hospital. In 1975, I came to the Chair in Trinity College, Dublin, and I have just finished 25 years as Professor and Head of Obstetrics and Gynaecology in Trinity. When I came at first I worked in the Rotunda for about ten years and subsequently in the Coombe Women's Hospital and St James's. I am a Fellow of the Royal College of Gynaecologists in England. I am also an Honorary Fellow of the American College and a member of the American Society of Pelvic Surgeons. I am still in practice as a gynaecologist.

The statement on the Green Paper which I have submitted to you was the result of consultation with all the members of the Institute. We have approximately 150 obstetricians and gynaecologists. These would be the consultants and the doctors who have completed their training or are in the pre-consultant grade of senior registrar. This would represent the view of between 90% and 95% of the obstetricians and gynaecologists in the Republic of Ireland. I have already referred to the first paragraph. The Institute certainly echoes those sentiments in the first paragraph.

In the second paragraph, I have made it clear that there are a few situations where real complications arise, where we have to intervene in a pregnancy. The whole of our ethos is the care of mother and baby. Perhaps we are the first generation of specialists who recognise we have got two patients. We have initially from Glasgow, in fact, the ultrasonic advances which really allow you to study a foetus from about five to six weeks of pregnancy. We are probably the first generation of obstetricians who have got a continuum of care for both the baby and the mother. Our whole practice is aimed at the care of both and the protection of the baby. I use the word 'baby' because in Ireland I have learned that when a mother comes to see you and she is perhaps only six to eight weeks pregnant, she says, 'How is the baby?' She doesn't say to me, 'How is the foetus?', she says, 'How is the baby? Can I see the heart?' She'll ask for that. That is, of course, one of the best signs we have that we have a healthy pregnancy when we see a foetal heart perhaps at six, seven or eight weeks gestation.

Sadly there are occasions when a mother develops a disease. We didn't specify all the conditions because we can't be certain that things couldn't change within the next five to ten years. But there are situations, and I think you have been dealing with some of them, like ectopic pregnancy. They don't just occur in the tube, they occasionally occur in the cervix and occasionally occur in the abdomen. These do present a very serious threat to the life of the mother and we have no option but to deal with that situation.

There are other situations and I have personally had to deal with these because I have had a special interest in gynaecology malignancy. A mother, for example, may have cancer of the cervix and she may present in the first half of pregnancy, she may present at 12 weeks, and often this masquerades initially as a threatened miscarriage. Then we find to our great consternation that there is a cancer there and we have got to go ahead and deal with that, we have got to treat it. I have had to do the operations. We have got to remove the uterus. That means certainly the baby cannot survive. I think we are doing the same procedure as we would do if she wasn't pregnant. So what I want to make clear to the committee is that that may have to be done.

The other situation referred to earlier was the condition of very severe pre-eclampsia. Fortunately, that usually presents after the 28th week of pregnancy, but there are exceptional cases. If you have worked in the Rotunda or Coombe hospitals, or in Oxford or Glasgow, in the main teaching hospitals, you do see these cases; they come in. It would be totally wrong to deny they exist; they do exist. We have no option there but to intervene and deliver the foetus which may only be 20 weeks. We will certainly resuscitate it. We will give oxygen, we will give it warmth and care but we know it's not going to survive. We have to do it because if we don't, the likelihood is that both mother and baby would die.

We have never regarded these interventions as abortion. It would never cross an obstetrician's mind that intervening in a case of pre-eclampsia, cancer of the cervix or ectopic pregnancy is abortion. They are not abortion as far as the professional is concerned, these are medical treatments that are essential to protect the life of the mother. In my day, and in your day also, viability has moved down from 28 weeks to 24 weeks. In Australia, it is 20 weeks. Probably in some of these cases at present where babies have to be delivered and tragically succumb because they're so immature, I would be optimistic that with the rate of advance of medicine and technology, we will become able to save these babies. So when we interfere in the best interests of protecting a mother, and not allowing her to succumb, and we are faced with a foetus that dies, we don't regard that as something that we have, as it were, achieved by an abortion. Abortion in the professional view to my mind is something entirely different. It is actually intervening, usually in a normal pregnancy, to get rid of the pregnancy, to get rid of the foetus. That is what we would consider the direct procurement of an abortion. In other words, it's an unwanted baby and, therefore, you intervene to end its life. That has never been a part of the practice of Irish obstetrics and I hope it never will be.

What I am describing here in this Green Paper sub—mission is that we wouldn't want any intervention by the law that would compromise existing practice which is geared to the protection of both. In dealing with complex rare situations, where there is a direct physical threat to the life of the pregnant mother, we will intervene always. I think you know and I know that Ireland has got the best record in the world in the care of pregnant women. We

are talking about a maternal mortality in Ireland which is much lower than the UK, lower than Denmark, Holland, France and Germany. When people look for care of pregnant women, the country that has the best example of it is Ireland. This is not because of the obstetricians – don't let me argue that point – it's because in general we have healthy women, we have women who are educated, we have women who report early in pregnancy and have good care and good nutrition. We have, in fact, a proud record in Ireland and it's one I hope that would never be compromised by, as it were, the introduction of abortion, in the sense that I would use it, in other words, simply asking the obstetrician to intervene to get rid of unwanted pregnancies or unwanted babies. We are not in that business; we are in the business of protecting the life of both, and that is the principle of our work.

We are concerned like you are about the number of women going to England for abortion. This is a great sadness. We are talking of numbers in excess of 5,000.

I was in England when the Abortion Act came in. When the legislators introduced it they understood that abortion was a very dangerous operation and they thought very few women would avail of it. They introduced a clause that in pregnancy … legal abortion, would be allowed where there was a greater risk if the pregnancy continued than there was of an abortion. We are now at the stage with the advances in medicine that abortion itself is very low risk. In England that legislation has created abortion on request. That is a classic example where legislation came in with good intentions but it has had the effect of creating a situation where since it has been introduced we have had of the order of five million abortions in the UK.

We must be very careful in relation to interfering with a situation, I think in Ireland which, to a great extent, has certainly meant good care for pregnant women. But we need to provide more care for the women going for abortion. We cannot remove the social pressures that are on young women to have an abortion, but we certainly know that when women have spontaneous miscarriages in Dublin and the rest of Ireland that these women go through a bereavement process. It has recently been clear in our own newspapers about the concerns 20 years ago what happened to foetuses that were miscarried, etc. They wanted to know what happened to their baby.

We would like to see a lot more care being made available for the women who do decide to avail of what is liberal legislation in the United Kingdom. We would like these women to get care when they come back. We would like to make sure they get appropriate advice in family planning. Some of the abortions sadly relate to poor advice or lack of education in family planning. We want to help these women so that we will do our utmost to reduce the number who are seeking abortion as a solution to their social problems. I think that is all I would say, Chairman.

Deputy McManus: Thank you, Professor Bonnar, for attending the joint committee. We appreciate you taking the time to attend. You have clarified some of my questions with regard to rare complications. I will ask all my questions now to save time.

On the matter of ectopic pregnancies, there are different choices a doctor can make. Is it the case that the best option will always be provided for the women, even though the best option may be to terminate the pregnancy, pure and simple, rather than to have some surgical procedure that removes tissue or an organ? For example, where there is a medical remedy to deal with ectopic pregnancy, which targets the pregnancy and terminates it, but means that there is no surgical treatment for the woman, is that an option? It would appear from, say, the clinical review of further medical treatment in the April edition of the *British Medical Journal* that that is certainly an option that should be provided for women where it is appropriate. Are there ethical questions around that?

Professor Bonnar: No. I think there are none … will I answer or wait for all your questions?

Deputy McManus: Yes, if you do not mind, just to save time. Would you believe that it is important that your clinical judgment is safeguarded in any possible constitutional amendment or legislation? In the briefing document you will see that there is a reference to the constitutional review group which very clearly states that if there were, regardless of what you term abortion, an absolute ban on abortion, your clinical judgment or freedom to act as you have described would be impaired. That is the judgment of the expert group. I can refer to page – it is here, I can read it out to you if you wish.

The other area I would ask you to comment on concerns the position we have at the moment. It is certainly of credit to the obstetricians as well that our maternal mortality is so good. I think you should take a certain credit for that. But, is it not a factor that we have abortion in this country and the idea that, somehow, obstetricians here are operating in an environment where they do not have to take on this particularly difficult, and I can understand this very painful obligation or responsibility is because there are British obstetricians who are doing it for you and that if, for any reason, that safety valve was not there you would find yourself very quickly having to face the dilemma where there are women in crisis pregnancies who are seeking abortions and may, in the way that you have justified – rightly in my view – your actions in direct terminations where there is a need, they may be able to, with their own conscience, justify their need to have an abortion and that, in a sense, unless we recognise that we now have a tradition in Ireland of abortion, that we are really not dealing with the reality of modern Irish life? Thank you.

Professor Bonnar: You have covered several areas there. The first thing about the ectopic pregnancies, you are referring to methotrexate treatment, which is a treatment that will inactivate the placental tissue and result in foetal death. We have experience of that. It may be applicable in very early pregnancies in some unusual cases, but I do not see any difficulty about using it.

Normally with an ectopic pregnancy you basically have two types – you have the woman who comes in with a diagnosis of an ectopic … and she may have very few symptoms. That is more likely in modern obstetrics because of ultrasound, etc., and other diagnostic facilities. The more common is the emergency case, where the woman comes in with acute pain. She is already bleeding into her abdomen. These are emergencies. You go ahead and deal with it.

I think when a pregnancy is outside the uterus, that is a totally different situation to a normal pregnancy that is developing within its normal habitat, the uterus, I referred earlier, to a rare type of ectopic pregnancy which is in the cervix, the neck of the womb. That is a treacherous ectopic pregnancy.

When these situations arise we have got to act. By failing to act in my view, you could be up before the Medical Council for possible professional misconduct because you are dealing with a life threatening situation for the mother. In the non acute case, the modern view is to do the operation through a laparoscope, provided the tube has not ruptured. That is to protect the fertility of the woman. You simply split the tube in then enucleate the foetus, the placenta and suck it out.

But, this is not abortion. Abortion is actually interfering with a normal foetus in a normal uterus for usually other than health reasons. An ectopic pregnancy will occasionally continue in the abdomen and I have seen them at 20 weeks. You have no option but to go in and remove it. That has been standard practice in the civilised world for the last 100 years. There is no way that care should be endangered. No obstetrician in my view is going to have this practice modified for ectopic pregnancy. A ban on abortion does not involve treatment of ectopic pregnancies; you would have to be a misguided doctor to think it did.

The next question related to clinical judgment. You are referring here to cases where we do actually intervene. Normally in these cases, we know the situation is very serious for the mother. If the patient is in a district hospital outside Dublin, you can take it from me that she will be put in an ambulance and brought up to Dublin to see the best experts and most experienced people. If it is a case of severe hypertension, there will be consultations among experts. A gynaecologist who realises that he may have to intervene and get the baby out at 20 weeks will speak to a colleague. There is a team element involved to bring the best possible expertise to the woman whose life is on the line. It is not a situation which is left to junior doctors to decide. You will have experienced consultants and it would be the same with the cardiologist. If you have a patient who is in cardiac failure, you will bring in the best cardiologist you can get. We have superb cardiologists in Dublin. We rely on the best expertise we can for a woman's specific condition.

If you are referring to these interventions, such as occur in pre-eclampsia or ectopic pregnancy, as abortion, to me there is something wrong with the term and you need to get a clearer definition. As far as the medical profession is concerned, these are not abortions; they are medical treatments and interventions to protect the life of the mother. The object of the exercise, as was already said by the previous speaker, is not the direct or intentional taking of the life of the foetus. The foetus sadly succumbs because one has to intervene at a particular stage to protect the life of the mother. We will always protect the life of the mother whose life is sacrosanct.

You said that abortion was here already. I do not think it is. It is interesting that although we had a Supreme Court judgment on the X Case, that did not change the practice. No abortions are being done in Ireland for psychiatric reasons – that is certainly my understanding of the case. I do not think we have abortion here already in the sense of the intentional taking of the life of the unborn.

Deputy McManus: Perhaps you could comment briefly on Eisenmenger's. You might be interested in what the review group states which I think would be different from your view on this. The constitutional review group, the expert group set up to look at this issue, stated:

> If a constitutional ban were imposed on abortion, a doctor would not appear to have any legal protection for intervention or treatment to save the life of the mother if it occasioned or resulted in termination of her pregnancy.

That, I would submit, is quite a different view from yours. Perhaps you would like to comment on that.

Professor Bonnar: I think it comes down to what we actually mean by abortion. It is quite clear that we need to get the terms clearly defined. If the use of the word in the quote outlined means that a gynaecologist could not interfere to treat a pregnant woman with an ectopic pregnancy or a pregnant woman with cancer of the uterus or the ovary or a pregnant woman with fulminating pre-eclampsia, that is clearly wrong. That is totally in conflict with what is professional practice in the Republic of Ireland. I would remind you that the professionals dealing with it do not regard what they do as abortion. If we do not regard it as an abortion and the constitutional committee does regard it as an abortion, we need to get our lines clarified because we will mean different things.

Eisenmenger's is a very difficult one. We would probably see a case in Ireland about every eight to ten years. It is the expansion of the blood volume in pregnancy which puts an additional load on the heart. We do not have any evidence i.e. there has not been any what I would call 'study' which has proved that terminating a pregnancy will actually save a woman's life. There is a view – and it is well expressed in the Green Paper – that there may be a window, although I think the Green Paper has it slightly later than it really is because in the last confidential inquiry in the UK there were two deaths in mothers who had terminations.

A termination is also a very dangerous procedure in an Eisenmenger's case. It would be naive to say that terminating pregnancy is the answer to Eisenmenger's syndrome. It is not. The cases of Eisenmenger's with which I have had to deal have been women – and I certainly wish they had not become pregnant – who wished to continue with their pregnancies. They knew there was a risk of death. They had been told that but they were quite adamant that they would continue with the pregnancies. You are dealing with a situation in Eisenmenger's where, theoretically, there may possibly be less risk of death. You could argue that if there was intervention as early as eight weeks, that would carry a lesser risk of mortality and I would accept what has been said in some of the papers. Mortality with Eisenmenger's is running at around 30%. The mortality with the termination is probably between 10% and 20%. It is a very rare situation where there is not really any way you could provide guidance to say that an Eisenmenger's should have a termination of pregnancy and all would be well. You could simply have an earlier maternal death than you would have if the pregnancy continued.

Cardiologists who have worked in the National Maternity Hospital, mainly cardiologists in the Mater Hospital, have had a lot of experience in this and, to my knowledge, they have never been able to present a case where they would say a termination had to be done. It just has not happened in practice but it is a very serious problem and I totally agree with you that it is a difficult issue. There is no easy solution to that problem except, as far as I am concerned, doing everything possible to ensure that women are aware of the risks and ensuring that these women do not get pregnant.

Chairman: Is it an area where we, as legislators, have to leave an element of clinical judgment to doctors caring for the mothers in question?

Professor Bonnar: I think you have got to leave these areas in pregnancy which we have been discussing – ectopic pregnancy, cancer of the cervix, cancer of the ovary etc … These are all situations where the clinical judgment should prevail. With regard to Eisenmenger's, it is certainly going to require very experienced cardiologists to make that decision but the decision so far in Ireland has not been to advocate termination to save the life of the mother.

Chairman: Just one other matter which arose from Deputy McManus's questioning, the fact that termination of pregnancy is widely available for Irish citizens who travel to the United Kingdom, other than Northern Ireland. The fact that that is the case means that you are living in a very safe climate as obstetricians and gynaecologists. That point was made and I would like to give you the opportunity to deal with it.

Professor Bonnar: You mean there is not the same pressure on gynaecologists in Ireland to do abortions?

Chairman: No, I think the way the question ....

Professor Bonnar: Because it's available ....

Chairman: Yes, the way the question was put was that because abortion is readily available in the United Kingdom outside Northern Ireland that in some way it meant that the risk to maternal mortality in this jurisdiction was thereby diminished. I think … is that how ....

Deputy McManus: Well, there were two points. One was that it may be a factor in terms of our maternal mortality that, you know, that isn't being recognised and also somehow it's difficult for someone like me to accept that it's all right for British doctors to do our sinning for us, but not Irish doctors.

Professor Bonnar: Well, could I make the point that maternal mortality has specific causes? We know what these causes are, they are all investigated. There is no way that the maternal mortality in Ireland is low because of the availability of abortion in the UK. Abortion will only reduce mortality in relation to criminal abortion. I think there is good evidence, Mr Chairman, that in England before the introduction of the abortion Act there was in fact around about 12 deaths per annum from criminal abortion. Now, the deaths from criminal abortion have virtually disappeared, so it did reduce deaths from criminal abortion. To my knowledge there never was a tradition of criminal abortion in Ireland and there certainly was never any contribution to maternal mortality. I would have to assure you that there are no ways that sick mothers in Ireland are leaving the country to have abortions in England because they cannot get them in Ireland. That would be totally false.

Deputy McManus: But, I mean, you have to accept that the level of suicide among pregnant women ....

Professor Bonnar: Yes.

Deputy McManus: .... has dropped considerably in Ireland over the years, and would you not, I mean, you seem to be authoritative as to who goes to Britain, and I am interested to know how you know these things because it is not clear the condition of the women who travel to England for abortion. This is not something that is generally known. But certainly in terms of people who feel suicidal, taking the option of having an abortion in England ....

Professor Bonnar: Yes.

Deputy McManus: One of the few things we do know is that generally speaking over, let's say the last 40 or 50 years, the level of suicide of pregnant women has gone down considerably, and it may be a factor, that is all I'm suggesting.

Professor Bonnar: I must bow to your knowledge in that I have not seen data on the suicide deaths in Ireland among pregnant women.

Deputy McManus: It is in the Green Paper.

Professor Bonnar: The evidence certainly that we have from the United Kingdom in relation to suicide, where it is subject to detailed report, is that the suicide death rate in pregnancy is lower. The main suicide risk is actually after delivery and indeed after abortion there can be a risk of suicide. In, the woman, for example, who suffers from a postpartum psychosis, that can often be related to a risk of self harm. So the main problem is often in the post-delivery period in terms of the risk, so I certainly wouldn't feel that the suicides in Ireland have been prevented. I haven't got the detail. I haven't seen definitive data on numbers of women who are pregnant committing suicide. If you can show me that intervention in these cases has been responsible I would be very surprised. We can get that detail from the UK – how many were actually having abortions because of a threat of suicide – and it would be tiny. There may be a number with psychiatric indications, but threats of suicide in pregnancy are exceedingly rare.

Deputy McManus: I won't say another word, but just in relation ....

Chairman: Speak freely, Deputy.

Deputy McManus: .... to the Green Paper, it does say

that in the first half of the century the figure was 10% of women who were pregnant. Now the figure is 2%. So something is going on there, whether it is the availability of abortion, I do not know and I do not expect any of us to know, but there is a reduction, as I read it in the Green Paper.

Professor Bonnar: Which page is that?

Deputy McManus: Page 15.

Chairman: In the briefing book?

Deputy McManus: Sorry, in the briefing text.

Professor Bonnar: The Green Paper?

Chairman: It is on page 15 in the book.

Deputy McManus: Sorry, 10% of those of child bearing age who committed suicide were pregnant. Now, only 2% are.

Professor Bonnar: Well, I mean if you look at that sentence, it talks about the first half of this century and that the incidence of suicide was 10% and it is lower since then. The abortion Act even in England did not come into practice until 1970, so I think a causal relationship there would be very questionable. I don't honestly see the connection. I mean other things have changed – attitudes to pregnant women. The attitudes in Ireland to the unmarried mother have dramatically changed, thank goodness. Mothers now can come with their teenagers to the ante-natal clinic and be welcomed. So these are more likely to be the issues that have affected that than the abortion Act in the UK.

Deputy McGennis: Can I thank Professor Bonnar for coming in and for giving us the value of his experience in this area? A lot of what he said, actually, has reinforced the points made by Dr Clinch, but specifically this intent versus effect, and you are saying categorically and absolutely that you don't regard medical intervention as abortion and, you know, in terms of the job that you do ....

Professor Bonnar: Yes.

Deputy McGennis: .... and we accept that. Now, what I think … everybody would support you and I certainly personally would support you in the statement you made, that you would not want any intervention which would compromise existing practice. Now that, if you like, is the dilemma that we're faced with.

Professor Bonnar: Yes.

Deputy McGennis: I would stress 'existing practice', because whether it's myth or fact there was a belief that in fact this wasn't the practice which pertained maybe 20 or 30 years ago, that the mother's life was not the one that was protected, you know, in medical circumstances, that it was the baby's life that had priority. But existing practice as you have outlined it and as the submissions we have received – Dr Clinch mentioned this – is that you are looking after both lives and in the course of treatment if there is indirect abortion to save the mother's life then that is what happens.

Can I just say to you – again, it is a bit like Blind Date, the question that I asked number one – you are stating emphatically that – I think in response to a previous question – if there was a constitutional ban on abortion it would not change existing practice. The problem we're faced with is that those who supported and were involved with the wording of the first constitutional ban – the 1983 ban – never anticipated that the result of that referendum, the result of the decision of the people in that referendum, would in fact be abortion being available in certain circumstances in this country.

Professor Bonnar: Yes.

Deputy McGennis: Now, just in response to the question that Deputy McManus raised with you you have stated that, well, we don't have abortion in this country even as a result of the judgment in the X case. Is it because nobody has pushed it? If somebody were to come into a doctor's practice in the morning – into your practice in the morning – or a maternity hospital and push legally the result of the X case, would you not be faced with a dilemma? I know as legislators we've been told that we haven't faced up to this and we haven't. What I am saying to you is that with the best will in the world, the effect of the first referendum – the 1983 referendum – when challenged in the court led to the opposite of what it was hoped it would or was intended to achieve and with the best will in the world, listening to what you have said – and it is very reassuring – might we not see the case that somebody might go into a court and challenge your right carry out a procedure if we were to have this absolute ban on abortion, and you might find yourself legally being restrained from carrying out a procedure which was necessary to save, as you say … to try to save both, but certainly to save a mother's life? Whereas I know what you're saying and I know that you go about your daily work without the benefit of legislative support ....

Professor Bonnar: Yes.

Deputy McGennis: .... which, you know, politicians, if you like, were too spineless to provide and you have gone about doing what is necessary, you might actually find yourself in a position that legally you could be stopped from carrying out the procedures which you've been doing up thus far. That is the concern. I would absolutely share with you your concern that you don't want any intervention to compromise existing practices and I think that's where we are today as a committee and as a nation.

Professor Bonnar: Yes, I accept that. I mean the first amendment to the Constitution which I think was '83 didn't in any way influence the care. In fact ....

Deputy McGennis: No, I wasn't making that point.

Professor Bonnar: I mean it did emphasise in fact what was the dual role of the obstetrician.

Deputy McGennis: Yes.

Professor Bonnar: I mean it was actually putting in the Constitution what was actually observed in practice.

Deputy McGennis: Yes. No, I think ....

Professor Bonnar: It is recognising that the right ....

Deputy McGennis: I think, Chairman, what I was trying to point out was that the intent and the effect actually went completely the other way around. The intent and effect of how you're carrying out your work at the moment is absolutely perfect, but the intent of that referendum and the effect of it were totally contradictory.

Professor Bonnar: Well, I think you're bringing up the interpretation of what the Supreme Court made of it and that was an issue clearly that presumably is law because the interpretation was made but it is interesting that it has had no influence in practice.

We haven't had terminations or abortions being done on the basis of risks of suicide and I think the reason for that, Chairman, is that most people who have been practising certainly in gynaecology for some time know that prior to the Abortion Act in the UK risks of suicide were the indications for abortion and there used to be large numbers of patients having terminations on psychiatric grounds linked to risks of suicide and they all sort of suddenly disappeared when the Abortion Act came in. The problem in relation to the risks of suicide or the psychiatric indications is that these are clearly different to the physical problems that we've been discussing like pre-eclampsia, ectopic pregnancy, cancer of the cervix. These are entirely different. In practice it appears that the psychiatric indications become exceedingly elastic, legislation to control them has been usually unsuccessful and they have been used to achieve abortion.

Deputy McGennis: I wasn't actually arguing the case for abortion in the instance of suicide. What I was asking you is, despite the fact that Dr Clinch said it and you have again reinforced it, you know, there is a possibility, there is a risk that an absolute prohibition on abortion in fact may prevent you carrying out what is the best practice at the moment. That is my concern.

Professor Bonnar: Well, again, Chairman, it comes back to what you're going to mean by abortion and we need to get our lines absolutely clear on this.

Deputy McGennis: Yes.

Professor Bonnar: By abortion, I mean as Dr Clinch referred to in the Medical Council statement, it was the direct, intentional taking of the life of the unborn baby and that was the object of the exercise. We are talking about something entirely different. We are talking about the appropriate care of a pregnant mother and which may in rare situations be associated with the death of the foetus.

Chairman: Deputy O'Keeffe. Could I just ....

Senator O'Meara: Could I be excused?

Chairman: Do you wish to put any questions, Senator, before you're excused?

Senator O'Meara: No, the question that I want to ask has already been asked so I'm not ....

Chairman: Very good, well then I'll excuse both of you. Deputy O'Keeffe.

Deputy O'Keeffe: Thanks, Chairman. Do I gather then that you'd say the constitutional amendment didn't affect the normal medical practice in the hospitals at all, you continued as before? Am I correct?

Professor Bonnar: Yes, I think that would be true. I mean prior to the constitutional amendment there was no practice of abortion in Ireland.

Deputy O'Keeffe: Well, of course, there was a law, there was the 1861 Act.

Professor Bonnar: What?

Deputy O'Keeffe: We had the ....

Professor Bonnar: The 1861 Act, yes.

Deputy O'Keeffe: .... the Act which prohibited illegal procurement of ....

Professor Bonnar: That's right.

Deputy O'Keeffe: So effectively there was no change in practice, is that correct?

Professor Bonnar: No, there was no change in practice. The practice continued.

Deputy O'Keeffe: I am interested in, from the constitutional view, the references to the right to life of the unborn and the equal right to life of the mother. Do I take it then that if a complication arises, whether it's an ectopic or any of the others you've described, that in that situation that in fact the … your initial approach is to treat both the mother and the unborn baby but that if there's no choice, that if termination is the only option of saving the mother, that's what you do?

Professor Bonnar: I think you're using the phrase, I understand from what you're saying, 'termination of pregnancy' in referring to these rare complications where we've specified here.

Deputy O'Keeffe: Yes.

Professor Bonnar: And strictly speaking you're correct. The intervention results … ends the pregnancy.

Deputy O'Keeffe: Yes.

Professor Bonnar: Keeping it in simple English. The pregnancy ends if I take the uterus out of a woman with cancer who is 12 weeks pregnant.

Deputy O'Keeffe: Sure, of course

Professor Bonnar: The pregnancy in her tube ends when we take out the foetus and placenta.

Deputy O'Keeffe: Yes.

Professor Bonnar: Now these interventions are not abortion, as a gynaecologist would understand it.

Deputy O'Keeffe: I appreciate that and in fact the terminology is part of the problem ....

Professor Bonnar: Yes.

Deputy O'Keeffe: .... whether you call … refer to it as abortion or termination of pregnancy or, as Professor Clinch referred to it, killing the baby.

Professor Bonnar: Yes.

Deputy O'Keeffe: That is part of the difficulty. The practice is what I'm interested in mainly. The practice is that if that situation arises the mother's life is not allowed to remain at risk and, if necessary, the pregnancy is terminated

Professor Bonnar: Correct. Where there is a physical threat to a pregnant woman, her life takes priority. That is the situation.

Deputy O'Keeffe: Despite the references in the Constitution to equal rights and so on?

Professor Bonnar: I mean we're talking about situations where failure to intervene is going to mean the death of both.

Deputy O'Keeffe: I accept that.

Professor Bonnar: No obstetrician looking after a pregnant woman is going to stand by and fail to intervene to protect the life of the mother. Her life must take priority.

Deputy O'Keeffe: I accept entirely what you say, Professor, but from the point of view then of a committee interested in examining the constitutional and legal possibilities for the future, do I take it that your evidence would be that any change that we might recommend, whether it was a change involving an absolute ban on such practice, on abortion or otherwise, whether constitutionally or legally, that you don't want to see any such change which would in any way affect existing practice?

Professor Bonnar: Correct. I don't want existing practice affected because it would not be in the interest of the care of pregnant women.

Deputy O'Keeffe: Thank you.

Deputy McManus: I presume you … I'm sorry.

Chairman: Deputy Enright.

Deputy Enright: Thank you, Chairman, and again I'd like to join with the other speakers in welcoming you and thank you for your time and for your very considered views. You replied to Deputy O'Keeffe there, I think that is important in that a lot of people will be very pleased with your comments that you're happy with the existing practices. In *The Sunday Tribune* in January of this year the Master of the Rotunda Hospital, Dr Peter McKenna … I am quite certain you saw the article, it was a front page story. It generated a lot of debate in that the article stated that Dr Peter McKenna said there are one or two abortions being carried out in Irish hospitals on women with rare medical conditions where a continuing pregnancy would endanger their life.

Professor Bonnar: Yes.

Deputy Enright: Now there was a further article by a Mr Martin Wall on last Sunday's *Sunday Tribune*, that is 30 April, and he actually quoted from Dr Peter McKenna. I will be brief. It's a brief quotation, Chairman, if you'll bear with me. It is exactly, 'There is a recognition by and large that in some very rare situations the health of the mother can only be guaranteed or ensured by the pregnancy not continuing. These are very few and far between but in these situations you simply cannot allow the mother's pregnancy to continue and her to die as a result.' He told this newspaper. Do I take it therefore or, I would just like your views, do you consider the situations he has referred to as abortions or do you think that in these instances where there has to be termination to look after the life of the mother, do I take it that you do not regard those actions as abortion? In other words, there is no proper definition of abortion, that what's happening is that your colleague would be acting to save the life of the mother in those instances where there are medical problems. That is the first thing.

In your direct evidence to us, you also stated normal practice now is to save both mother and the foetus or the child and that Ireland has the best record of protection and care of pregnant women and children and then about our excellent record. I take it that you are happy with the existing situation, overall you are happy with the current situation?

There is one other thing there. In regard to the suicide and pregnancy, Deputy McManus asked you about that, about the high numbers that were committing suicide, the high numbers of unmarried mothers … the vast majority of those, in my view, would have been unmarried mothers. At the time, I can't say for certain, but there were no allowances for people, lone parents or anything else. The social climate in Ireland at the time was very anti-single parents. Thankfully that day has gone and people accept it and our social conscience has changed dramatically and I think it's a good thing. I think that may have been part and parcel of the change, which is good to see, that there has been a reduction.

Overall, it's to try and arrive at a situation that is presently working and to see how best it can be, we'll say, perhaps even continued. Have you any views as to how you would address the situation to have a situation that you are reasonably happy with at the moment continue? How would you advise to go along? Have you any assistance to advise us as people who are going to

have to report to Government on this?

Thank you, Chairman.

Professor Bonnar: First of all you referred to Dr Peter McKenna and Dr Peter McKenna is a member of our Institute. I think there's a difference in words, I don't think there's any difference in meaning. When he talks about these rare situations, they are the same ones that I am talking about. Even, I think, Peter McKenna would not be calling them abortions in the Rotunda. What he may be inferring is that, if the Legislature is going to bring in a phrase 'abortion' which means a catch-all situation – that if a foetus exists, you can't do anything – that would be totally unacceptable and I don't expect anyone would ever consider that because there are these situations.

I think we need to be clear, we need to define our terminology. When I talk about distinguishing this intervention, and I hope that you all see that there's a clear difference between intervening to protect the life of a mother in a situation where failure to intervene will result in the death of both, when dealing with, say, pre-eclampsia, cancer or ectopic pregnancy. That's totally different to doing what would be called an abortion, for example, in England where abortion is a legal termination of a pregnancy, often for a non-medical reason. When we say this intervention is current practice and we don't want it interfered with, that, to my view, is on the basis that we do not regard this as abortion. What you need to be legislating against, if you're going to legislate, is against other interventions which are not to do with the life of the mother. That's my case.

Deputy Enright: Thank you.

Professor Bonnar: The only thing I would say, Chairman, when you asked about what we should do. I think you'll need legislation relating to what was the '83 amendment because I think everyone did expect there would be legislation. I would simply say if a pregnant woman's life's in danger she needs the best possible help she can get. Therefore, she should be looked after in this State's best hospitals – in the major teaching hospitals where the facilities exist to deal with complicated problems. I have enough faith in my colleagues of good repute that they will do the right thing in terms of the care of pregnant women.

The great danger with legalisation in relation to abortion is that it moves to a situation where it is, to be blunt, often in the private sector as a special service that's being provided and it's being done often purely in relation to financial gain. If we have a situation in Ireland where if there's a genuine threat to the life of a pregnant woman and she's looked after in a State hospital by the State's consultant specialists, I have every confidence that she will have the appropriate care. I wouldn't be concerned that there will be any risk of legalised abortion going out of control.

Deputy Enright: I thank you very much for your very comprehensive reply which I found contained a lot of helpful information to me. Basically what you're saying is that it's intervening to protect the life of the mother.

Professor Bonnar: Yes.

Deputy Enright: Thank you very much.

Senator O'Donovan: I will be very brief. I would like to compliment Professor Bonnar on his very succinct and frank approach here today.

The whole purpose of this committee is to deal with this debate going on for almost the last 20 years since prior to the '83 referendum. Do I understand from you that, as it currently stands, your Institute can work well within the current laws? Following on that, is there a need, from your point of view, both professionally and from your position in the Institute, do we need a referendum or do we need legislation to clarify the current situation?

This is the whole thrust of this debate, that is why we're all here, we're here as legislators. There is a lot of pressure on for a referendum; other people are of the view that we should have legislation. From the replies you've given here today, you feel that your Institute can work and has worked for decades – not just recently – well within the current situation, that there is no abortion in the real sense in Ireland. Is there a need for change and, if so, how would you see it? To amend the 1861 Act or by way of referendum to amend the Constitution to copperfasten the existing position?

Professor Bonnar: I think, Chairman, there would be some concern in the profession, certainly among obstetricians and gynaecologists, about the X case judgment. There is concern that it did not seem to be made on the basis of medical expert evidence so there is a degree of discomfort, as it were, in relation to that particular interpretation of the '83 amendment. You're the experts, you're the legislators. You're asking an almost impossible question.

I think it is quite clear to me that some legislation is going to be required but it's also clear to me that the Irish people are very, very concerned about this. It strikes me that … and I understand there may be a way, … heads of legislation can actually be put to the people, as it's a very, very important situation in Ireland. I think the Irish people are going to request that, whatever you decide has to be done, and I wish you every success in making the right decision, that they will wish to approve of it. That is the feeling I get from the contacts I have.

Senator O'Donovan: Following that, I have one final question. In your view so, is there, as it currently stands, a lack of clarity in Irish law, either by way of the existing constitutional provisions or legislation? I am asking you that in your professional capacity. If there is, that is how we might decide which way to go.

Professor Bonnar: There is a lack of clarity since the Supreme Court made its interpretation in the X case. That was not an interpretation that was expected in the medical profession. From that point of view, the situation has to be clarified.

Senator O'Dowd: I would like to welcome the views of Professor Bonnar as well here today. In summary, at the moment, the medical profession, your experts, and your professionals can carry out all procedures and treatments necessary to treat any mother in this State even if that means indirectly the baby dies as a result of treating the mother.

Professor Bonnar: Correct.

Senator O'Dowd: So the problem is that if we do have another referendum, the interpretation that the Supreme Court could put on such a referendum if it were passed could, theoretically, affect or put into limbo your present practices. Therefore, what you seem to be saying is that if we go down the legislative route and go back to the people on heads of legislation, that might be the choice that you and your Institute would prefer.

Professor Bonnar: I am not speaking for the Institute. The Institute are professional obstetricians and gynaecologists. You need the wisdom of Solomon on this one as to how you deal with it. I personally think it is going to be difficult to get a wording. We have already had an example of that where the people voted on a wording, and the profession in fact works with that wording, and then another interpretation is made of it. So clearly, if legislation can be produced which is in accord with what was intended in the 1983 amendment and that is approved by the people … I may sound odd to you but I understand that it may be possible for anything that is proposed in legislation also to be put to the people. I cannot see a simple sound bite of half a dozen words covering the complexity of this situation.

Senator O'Dowd: It would be preferable in any event to another referendum, is basically what your saying, if we got the right legislative proposals.

Professor Bonnar: My feeling is that the people want to be consulted about any legislation that the Dáil proposes to enact, and there should be some way of doing that, and I think it is their right under the Constitution.

Deputy McManus: I have just two very brief questions. First of all, as I understand what you are saying, your concern was the decision by the Supreme Court in relation to threatened suicide. The people were consulted by way of the Twelfth Amendment, and the people rejected what had been proposed to deal with that particular aspect of the whole issue of abortion, that suicide would be taken out of the equation. The Irish people have already been consulted on that and have rejected that, so the original amendment still stands. I am curious as to why you feel we should revisit that, even though the people have already made their decision clear on that, for varying reasons, I have no doubt, but the record does stand. The other question I would like to ask you is this. I understand, again from the briefing document, that the medical dictionaries' description of abortion is the termination of a pregnancy before the child-foetus is viable. You are indicating that you do not accept that description in terms of medical practice where, I suppose, from the foetus's point of view the effect is still the same.

Professor Bonnar: Yes.

Deputy McManus: I am trying to get my head around the idea that what has the exact same effect is not abortion because a doctor does it for the right intentions, even though the medical terminology would seem to me to cover both, whether the intention is broader, what you are terming social reasons, or to save the life of the woman. This is a new idea coming from the medical profession, from both you and Dr Clinch, that you are now saying that a term that I have always understood in fact used to cover miscarriages – isn't that right, that you now want to have a different description or definition? Maybe you could clarify how you would define it. What would you call it?

Professor Bonnar: I agree that is one of the definitions. The other one that we usually teach is the expulsion of the foetus and placenta post-conception prior to the age of viability, but the understanding of all is that it is from a uterus, a pregnancy in the womb. When you get these simple definitions, they are not going into the complexities of pregnancies that end up in the ovary or in the fallopian tube or in the abdomen or in the cervix. They are not talking about a woman with cancer of the neck of the womb. They are talking about a healthy woman with a normal intra-uterine pregnancy, where a pregnancy is developing, a healthy pregnancy in a healthy woman. When we talk about termination or legal abortion, we are talking about intervening in that situation with the direct intention of taking the life of the foetus or unborn. That is what we mean by procured abortion. We do not talk about a doctor dealing with a mother with severe pre-eclampsia as procuring abortion, or dealing with an ectopic pregnancy as procuring abortion, or dealing with cancer of the cervix as procuring abortion. We do live in different worlds, but it is perfectly clear in the medical profession. The waters are not muddy in the medical profession. We know exactly what we mean when we talk about intervening to protect the life of a mother and a baby dying tragically because of immaturity as a result of the intervention to protect the life of the mother.

Chairman: Dr Clinch came close to this earlier this afternoon when he said that doctors are looking forward and lawyers are looking backwards. You are resting your case on intention which, of course, is an ethical principle and a respectable one in ethics. The law has to judge from the consequences of an action and then infer intention from that. There is a distinction in the way the lawyer and the legislator looks at the world and the way the doctor does. We are legislators. I am just coming to your submission – I take it there are no further questions. Taking your submission where you speak on behalf of the Institute, your wording, if you like, is that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example for social reasons, and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother. That is your core wording in the letter, when we are talking about wording. Taking 'for social reasons', do you categorise the threat of suicide essentially as a social reason? Is that what I take you to be saying?

Professor Bonnar: By 'social' we meant in effect what were non-obstetric, non-medical reasons, because we are conscious that by far the overwhelming indications for abortion are social reasons. We as obstetricians whose lives are specifically dedicated and trained to the care of a pregnant woman are not prepared to accept the taking of the life of the baby for social reasons. We do not think that is part of our business. I accept that there are other

jurisdictions where it has become part of the obstetricians business, but the obstetricians in Ireland that I am speaking for will have no part in abortion for social reasons.

We agree that medical reasons are an entirely different area. We are referring particularly to medical situations where the life of the mother is in danger; where there is a physical threat to her life we will always act on behalf of that mother to protect her life. I hope that distinction is clear.

Chairman: The wording of the original amendment to the Constitution in 1983 you essentially construe as meaning that the duty was to vindicate both lives, just as in your summary of medical practice. Is that the position?

Professor Bonnar: That is our job, to protect mother and baby. That is the whole reason for the existence of obstetrics, the care of the pregnant woman and ensuring that her health and her baby are protected and delivered safely. We don't see it within our remit as extending the duty to take of the life of the foetus. That is an encroachment on what is current practice that we would find unacceptable.

Chairman: In speaking of the constitutional position you express satisfaction with the 1983 position subject to a degree of discomfort with the X case.

Professor Bonnar: Yes.

Chairman: I take it that degree of discomfort with the X case relates to the finding of fact made in the case.

Professor Bonnar: It relates to the findings on which judgment was made in the absence of medical evidence.

Chairman: Yes.

Professor Bonnar: That was a very surprising situation.

Chairman: In relation to ordinary legislation as distinct from the Constitution, we still operate here on the basis of the 1861 Act. I take it the Institute takes the view that where there are circumstances resulting in the unavoidable death of the baby caused by treatment to protect the life of the mother that the necessary intent can't be formed under the 1861 Act.

Professor Bonnar: The 1861 Act talks about unlawful termination and I think that in fact did potentially have an interpretation that there were situations of intervention as we have just described. Certainly it was never the practice in the British isles for obstetricians to be called up from intervening to protect life of a mother.

Chairman: But you spoke of the need for legislation. In what context would that legislation be adopted and would it be an amendment to the 1861 Act?

Professor Bonnar: It would actually put into legislation what would be the practicalities of protecting the life of the unborn and the mother, in other words, what we have stated in the Constitution. I think most people expected that there would have been legislation based on that. We would certainly take the view that there obviously is a need for it. We have got to spell out these situations where the complex problems arise and what are the principles that are to be followed and where, in fact, these situations should be dealt with. We aim at providing the best possible care for pregnant women. That is the whole purpose of it. We want to do that using the facilities that we have.

Chairman: Yes, I take it what you are saying is that general statements of constitutional principle only go so far and that there has to be detail spelt out in legislation in a matter of this kind.

Professor Bonnar: I would agree and I think that has been the view expressed by some of the judges in the past.

Chairman: Yes. I think in the X case reference was made to the failure of the Oireachtas to deal with the matter.

Professor Bonnar: Yes.

Chairman: Were we to look at the legislative route we would have to re-examine the 1861 Act because that contains the basic criminal prohibition on abortion.

Professor Bonnar: Correct.

Chairman: And, of course, the 1861 Act or some form of criminal prohibition is essential to vindicate the unborn life because the unborn life cannot vindicate itself so there has to be a criminal sanction. You would agree with that much.

Professor Bonnar: I agree there has got to be …. The profession has its own Medical Council and Dr Clinch has enunciated what the principles are and what is laid down in our ethical code. I still believe that legislation can be enacted that puts into practice what are the actualities of dealing with the 1983 referendum and ensuring that that is what happens.

Chairman: In relation to the medical practitioners' legislation, the ethical guidelines there are drawn up under an Act of the Oireachtas. Yet, with respect to Dr Clinch and yourself, they don't appear to have any greater clarity than the constitutional provisions of the 1861 Act.

Professor Bonnar: Well, we are coming into the legal area and it has got to be dealt with. We can give every assistance in telling you what the situation is at the coalface, what is the situation looking after the pregnant woman. That is all I am asking, that we pay attention to what is the reality of the care and hopefully reach the right decision.

Deputy O'Keeffe: On that issue there is just one thing in trying to look ahead at the Constitution or legal options. You seem very happy about the 1983 provision, but yet you tell me that the actual practice is that where the termination of pregnancy is necessary to deal with the medical condition of the mother then that is what happens. The actual 1983 amendment referred to due regard being

had to the equal right to life of the mother. I am not in any way critical of the medical practice that you describe, but is that medical practice actually giving an equal right to life of the mother? Is it not giving a priority right to the life of the mother?

Professor Bonnar: Well, in reality that is what actually prevails. I mean the only way you look after an unborn baby is by looking after its mother. It does not exist separately. The care of the baby in utero is the care of the mother. They are not competing with each other.

Deputy O'Keeffe: Except in relation to maybe interventions that you say in some instances are necessary.

Professor Bonnar: Yes.

Deputy O'Keeffe: And in that situation, perhaps competition isn't the right word, you have to make a decision.

Professor Bonnar: Yes.

Deputy O'Keeffe: Am I right in saying that in that situation priority is given to the life of the mother?

Professor Bonnar: Correct.

Deputy O'Keeffe: In that situation, therefore, – I am merely trying to look at it, I am not emphasising or critical of that in any way – but is that practice then in accord with the Constitution?

Professor Bonnar: The Constitution 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 ….

That is a phrase ....

Deputy O'Keeffe: Yes, but I ....

Professor Bonnar: .... which I interpret as meaning it is not practicable to save the life of a foetus that is an ectopic pregnancy. It isn't possible.

Deputy O'Keeffe: I see.

Professor Bonnar: It is not possible to treat a woman with cancer of the uterus who is pregnant and protect the life of the foetus. So 'as far as is practicable', my interpretation of that means that there are situations when it is not practicable, as it were, to give equal status to both. What we need is a legal interpretation and the laws spelling out what this actually means in practice. I think that original article, if it is actually studied in its totality, covers the situation we are talking about.

Deputy O'Keeffe: It ....

Professor Bonnar: What else could it possibly have meant, as far as is practicable?

Deputy O'Keeffe: Yes.

Chairman: But, Professor, just to conclude briefly, I take it, apart from the very wide question of social abortion which this committee has to look at and which you have expressed a view on, the somewhat narrower question of eugenic abortion which also has been canvassed in the submissions before us, as far as your Institute is concerned and the question of proper medical practice for the expectant mother, there is a very clear position that you want as much legal certainty in that area as possible. Is that a fair summary of the Institute's position on that issue? As far as the clinical treatment, as far as your Institute is concerned, as far as the expectant mother and the appropriate medical treatment for her is concerned, your institute wants maximum legal certainty. We do not require our professors of obstetrics and gynaecology to be professors of constitutional law. Is not that the position?

Professor Bonnar: I agree. It has got to be absolutely clear that we are not changing what is the current medical practice. That is very important.

Chairman: And that those who are expert in this area and have the tradition of expertise and the practice of expertise have the freedom to make the necessary clinical judgments, that is important. Do you accept that?

Professor Bonnar: I agree that is important. It is a highly complex situation and I think the clinical judgment as at present practised, to me is in accord with the Constitution as spelt out in Article 43.3.

Deputy Enright: Chairman, your reply covers it. You are entitled, as of now, to make a clinical decision and a clinical judgment. Do I take it that you are happy that any time you are interfering you protect the life of the mother as distinct from an abortion? The ethos is to act to save both the mother and the foetus and child.

Professor Bonnar: Right.

Deputy Enright: That is your ethos, to protect both. Then, on occasions you are entitled to make a clinical judgment. Do I take it then that, as of now, there is not actual abortion in Ireland as we know it, which is the interference with and bringing about the social destruction of the foetus?

Professor Bonnar: No. That does not take place.

Deputy Enright: It does not exist. Is that correct?

Professor Bonnar: That would be totally contrary to the ethical code of the Medical Council.

I would remind you, Chairman, that the code also states that a pregnant woman must be treated. I would be acting unethically if I did not treat a pregnant woman whose life was in danger. That is certainly my interpretation of it.

Chairman: Professor, on behalf of the committee and myself I would like to thank you for the assistance you have given us and also to thank, through you, the Institute for engaging in a process of consultation regarding this matter and coming forward and speaking to us. It is very important that your views have been communicated to our committee and I thank you for that and for your assistance to us.

I adjourn the meeting until 11.15 a.m. tomorrow.

THE JOINT COMMITTEE ADJOURNED AT 5.25 PM UNTIL 11.15 AM ON WEDNESDAY, 3 MAY 2000.

WEDNESDAY, 3 MAY 2000, 11.15 AM
MEMBERS PRESENT:
DEPUTY T. ENRIGHT, S. KIRK, D. McDOWELL, M. McGENNIS, L. McMANUS, J. O'KEEFFE, SENATOR D. O'DONOVAN, F. O'DOWD, K. O'MEARA.

DEPUTY B. LENIHAN IN THE CHAIR

Dr Declan Keane

Acting Chairman (Deputy J. O'Keeffe): We are in public session. I would like to welcome Dr Declan Keane, Master of the National Maternity Hospital, Holles Street, to this meeting of the Joint Committee on the Constitution in connection with its consideration of the abortion issue. The format of this meeting is that you may, if you wish, make a brief opening statement which will then be followed by a question and answer session with the members. Your attention is drawn to the fact that while members of the committee have absolute privilege, this same privilege does not in fact apply to you. The background to your attendance here is that the committee decided to invite you to come because of your position as Master of Holles Street which I understand is not just the biggest maternity hospital in Ireland but in fact the biggest in Europe with over 8,000 births per annum.

Dr Declan Keane: Correct.

Acting Chairman: We very much appreciate your response to our invitation and I would now invite you to make an opening statement and then, perhaps, to deal with the questions from my colleagues on the committee.

Dr Keane: My name is Declan Keane. I am the Master of the National Maternity Hospital, Dublin, which for some time has been the largest maternity hospital in Europe and the second largest maternity hospital in the English-speaking world. I have been in the role of master since 1998 but have spent time previously in training in the United Kingdom, having worked for four years in Bristol and three years in Oxford where I have been exposed to matters concerning abortion under the UK system.

I am also, in my role as master, on the executive of the Institute of Obstetricians and Gynaecologists, the main board which governs both training and legislation regarding obstetricians and gynaecologists in this country.

Acting Chairman: Would you like to make any opening remarks in relation to your views on the present issues or would you prefer to leave it by way of response to questions?

Dr Keane: I would prefer for the time being to leave it by way of response, if that's okay.

Acting Chairman: If at any time you want to make a more expanded statement that would be fine too. On that basis I invite Deputy Liz McManus to open the proceedings from the committee's point of view.

Deputy McManus: First of all, Dr Keane, I thank you very much indeed for attending today. We appreciate very much that your time is valuable but your time here is very valuable to us. Could I ask you about the experience of your hospital in terms of the rare occurrences where a woman's life, a pregnant woman's life, is in danger and there is a requirement to terminate the pregnancy? This was an issue that came up yesterday with the other doctors who have been here. I would just like to know what the experience of your hospital has been in those circumstances and the protocol, the procedure that you adopt.

I would ask you to maybe comment on the approach that was outlined yesterday where the pregnancy is terminated in the particular circumstances to save the life of the mother and certainly I would use the word 'abortion' to cover that act. It seems to me to be abortion and certainly the medical dictionaries describe it as abortion. Do you as a practising doctor use that term? Do you consider that it is something else and, if it is, what is it? The advice that we have had by way of the expert group which looked at the Constitution very clearly states that if, for example, there was a constitutional ban on abortion this would interfere and prevent and affect current medical practice where intervention is required. So, clearly the expert group felt that abortion did cover this kind of practice and certainly it would seem to me that it does, but I would just like your views on that. Maybe if I ask you a couple of other points also, is that fair?

Acting Chairman: Yes.

Deputy McManus: Just to take less time on it. I am a graduate mother of Holles Street and I have great respect for the institution. I have noted that, since my time there, the practice and management of pregnancy and delivery has changed enormously and I would ask you in terms of the future developments and the changes that are occurring whether that is an aspect that we should be taking on board – for example, I understand that the actual techniques involved in abortion may change in the future, that it could be by way of taking a pill or whatever – and whether that has any bearing, or should have any bearing, on the work we are doing.

I ask also about the practice of the hospital at present where there is a choice to be made or where there are different options that may be suitable for individual mothers. Say, for example, with ectopic pregnancy, do ethical considerations come in where there is a choice – the doctor can make a choice between giving medical treatment to terminate the pregnancy or having to actually

embark on surgical procedure? It would concern me that the best possible option of medical treatment would be available to a woman, as appropriate. Maybe you could just advise us on the practice in the hospital.

Dr Keane: Okay, there are a number of issues you raised there. I think first of all regarding definitions, and I think one can … it is critical always whenever anyone is discussing any topic to define what one means by it. In the medical profession we have always defined – and in the clinical textbooks – an abortion as a pregnancy that is lost in the first trimester of pregnancy. It is unfortunate that the term 'abortion', certainly in the lay press, has become synonymous with the termination of pregnancy induced by a variety of means. But, as I say, an abortion is a pregnancy lost in the first trimester of pregnancy which is up to 14 weeks.

A miscarriage, technically, was the definition for a loss of a pregnancy between 14 weeks up to a period of viability of the foetus, which used to be taken as 28 weeks but which is increasingly coming down because we can now keep babies alive from about 24 weeks gestation onwards. However, I think in terms of the debate that we are having here at the moment and your committee we are talking about abortion in terms of terminating a pregnancy, and that is what I have taken it as to mean.

You started off by asking about those indications, perhaps, where medical termination of pregnancy is required in the maternal interest. I have been interested to read some of the submissions which have been sent to me prior to coming today. But there is no doubt that in my practice, both here and in the UK, there are rare but real indications where a termination of pregnancy is occasionally and unfortunately required in the best interests of the mothers. I say 'rare' because I would suggest that between the three Dublin maternity hospitals, where we account for about 20,000 deliveries a year and over 40% of the deliveries in the Republic of Ireland, we probably would be talking about, perhaps, one case between the three hospitals a year.

I can get into specific details of what cases they can be but certainly in the last couple of years both ourselves and the Rotunda Hospital have had two severe cases of HELLP syndrome, a condition that ....

Deputy Enright: What did you call it again?

Dr Keane: HELLP syndrome, which is a variant of pre-eclamptic toxaemia, a condition where the mother has severe hypertension where the liver is involved. The actual letters HELLP form a specific acronym for haemolysis elevated liver enzymes and low platelets. We had a case in 1998, as I say, where the woman was severely ill with this condition. She was transferred to a neighbouring general hospital under the care of the liver specialist and the medical opinion that we got from the liver specialist was that this woman was going to die if her pregnancy did not end. It was a very difficult decision to make. We obviously had to not only talk at length with the parents involved but with our legal team as well. But there was no other way in which this woman would have lived if the pregnancy had continued.

I think in the past, and I cannot comment too much on the past because I am one of the youngest masters in the hospital, but the hospital would have always been faced with rare but albeit real conditions like this. You have already alluded to the fact that, in the past, the surgical … the treatment of these women would have often been by surgery. One would have done what they would have called, or perhaps termed, a caesarean section but, of course, if you do a caesarean section at 18 weeks it is not in the foetal interest because we know that no baby is going to live at 18 weeks gestation. Effectively, what predecessors would have been doing would have been a hysterectomy, or opening of the uterus.

As you say, we now have at our disposal in medical practice drugs which can induce a termination of pregnancy without a surgical evacuation or termination of the pregnancy. These drugs can either be administered, inserted into the vagina of the woman or now even can be taken orally, as you say, in the form of a tablet. Needless to say, these cases when they come up are rare and there is significant discussion that goes on at hospital level, at the ethics committee in the hospital, as I say with the parents and often involving the legal team as well.

I note that the Green Paper and indeed the submissions have talked about other possible indications which would include severe cardiac disease in pregnancy and Eisenmenger's syndrome has been mentioned. The Coombe hospital had a woman who died from Eisenmenger's syndrome only last year and I suspect that the master of the Coombe may wish to make a comment on that later on. Certainly in my experience in Oxford we unfortunately again had to terminate two pregnancies in women with Eisenmenger's syndrome because the real risks to the woman, if the pregnancy had continued, were considerable.

The issue of malignancy in pregnancy is always a difficult one because one often tries to make distinguishing features between direct and indirect abortion, and obviously at the end of the day for most of us practising in clinical medicine the health of a woman is paramount. And if a woman does happen to develop a severe cervical carcinoma in pregnancy where the only way of treating that is by a possible hysterectomy, and delay in treatment was going to compromise the woman, again we would have to consider performing a hysterectomy in those situations, but I'd have to say each case is taken on its merits. Each of these situations which I have given you, as I say, is extremely rare but they do happen.

Deputy McManus: In relation to the ectopic pregnancy, what I was asking you about in relation to that was this question of – as far as I can see, there are three options that may be appropriate, but one is simply a medicine rather than a surgical procedure, Methotrexate.

Dr Keane: Right, but ectopic pregnancies, I think, are different. They are pregnancies that are never viable. They have a life period that will generally not exceed eight weeks, or maybe ten weeks at the most, because they are in a part of a woman's body that cannot sustain a pregnancy. It is not possible, even with current medical developments, to relocate the ectopic pregnancy back into the uterus again, so to all intents and purposes by the time most ectopic pregnancies are diagnosed the pregnancy has died in the fallopian tube anyway. And as you say, the way of dealing with it can either be by medical methods or surgical methods, and the methods can either

be the administration of a drug into the woman's system, which is effectively an oncology drug, an anti-cancer drug – you can administer that drug directly into the tube itself under direct ultrasound or, indeed, laparoscopy guidance – or you very often have to perform a surgical treatment to the tube. And certainly surgical treatment on the tube is required if the ectopic has actually ruptured through the fallopian tube. If that is the situation, it is a life-threatening emergency where the woman can lose considerable blood and you do have to operate on the fallopian tube.

Deputy McManus: Could I just ask one last question?

Acting Chairman: Indeed.

Deputy McManus: Where a woman develops cancer and there is this issue of chemotherapy where the foetus is likely either to die or to be extremely badly damaged, is that woman given the option of having an abortion, not necessarily in the hospital? Is there any approach or protocol from the hospital in that particular circumstance?

Dr Keane: The opinion and the views of the woman would always be the most important in that situation. What tends to happen in most cases of malignancy in pregnancy in my experience – again we had two cases last year where a woman required treatment in her pregnancy with chemotherapy agents – is that you invariably try to delay the administration of the chemotherapy until the baby has reached a viable age. So there will be, needless to say, on the medical front discussions between the cancer or oncology doctors and ourselves on what would be a period of viability. You would generally try and carry the pregnancy through to a period where you can deliver the foetus with a good chance of both survival and survival intact so that the chemotherapy is then given after the baby is delivered. Now this will very often necessitate the delivery of the baby ten, 12 weeks before the normal period of viability, so it is always to a certain extent a degree of a juggling act so that you are trying to prevent, as you say, the exposure of the pregnant foetus to chemotherapy.

In the circumstances where chemotherapy cannot be delayed until that period of time, then again the mother's views would have to be sought. You will have mothers who will not wish chemotherapy to be given and will take it that they will want their pregnancy to continue, albeit knowing that this could have effects on their life. You will have other mothers who would be happy for chemotherapy to be administered and will take the consequences that that may have on the foetus either directly, as you say, by causing intrauterine death of the foetus, or perhaps handicap. But, as I say, my experience in the Irish context so far has been always that we have tried to delay chemotherapy until a time when the foetus is delivered and, therefore, we are not having the problem of the foetus to consider in the administration of the chemotherapy.

Acting Chairman: Senator O'Donovan.

Senator O'Donovan: Again I'd like to welcome Dr Keane here. Just a couple of questions. I understand from the two speakers yesterday and gauging by your comments today that in a conflict of interest situation you would obviously endeavour to save both mother and child ....

Dr Keane: Correct.

Senator O'Donovan: .... and you would use your extreme medical abilities to ensure that would be possible; and that the only instance where termination would arise is where if something isn't done both will die but by terminating the pregnancy, be it ectopic pregnancy or cancer or whatever, you are doing it as a last resort so that at least one would survive.

Dr Keane: Correct. I mean the cases that I've mentioned, the difficult case we had in '98 was a case that if we hadn't done something, as I say, not only would the woman have died but if she had died at 18 or 20 weeks, by necessity the foetus would have died as well. So, as you say, we … Although I've mentioned already that the woman's life is paramount, we obviously do take into consideration the life of the baby and the mother, very much so.

Senator O'Donovan: Right. Following on from that, you mentioned, and I gather from you and I have no doubt the other people who spoke yesterday, that there is a very high ethical code attaching to obstetricians and gynaecologists. That has become crystal clear to me, as a lay person. Following from that, could I put two questions to you? One, is the existing legislation that we have, either medically or under the Constitution, adequate or do you see it as an encumbrance or, as in the question I raised yesterday, do you require clarity of the law as it currently stands? In other words, we are here, I suppose, somewhat as a political committee investigating which road we should go down – do we have a new referendum, do we try to deal with this by legislation maybe to clear up the X case. I would like your comments on the Supreme Court decision in the X case because one of your colleagues yesterday said that in his view proper medical evidence wasn't put before the Supreme Court in the X case. I got the impression that he was rather taken aback by the decision. In other words, where we are at, at present, is it unsatisfactory? And if we require clarity by way of legislation or referendum, which would you choose having regard to the current, I suppose, crisis that is facing the public and facing politicians at the minute?

Dr Keane: In answer to your question, we, as medical practitioners in this country, are governed by the Medical Council and we do feel somewhat exposed in the field of obstetrics and gynaecology that we are not protected for these already mentioned rare cases because technically any form of termination of pregnancy or abortion is against the law of this country and, therefore, despite the serious considerations that are given to these individual cases, the technical termination of pregnancy that we occasionally and very rarely, thankfully, have to perform … we are technically on the wrong side of law in doing so and we feel exposed in that area.

The proposed amendment to the Constitution in 1992, I think, was trying to effectively tackle this situation. I mean it actually stated, as you know, that:

> It shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother …

And we are talking about situations where it is the life of the mother. I am not getting drawn into psychological effects which some of these previous, you know, cases, the X case and so on, have involved. I am talking about real cases where if the pregnancy continues, the woman's life is at risk. I am not talking about any other aspect of her health, and we do feel in the field of obstetrics somewhat exposed because the law and our own Medical Council at the moment are not on our side.

Senator O'Donovan: Can I take it, just in conclusion, from what you have told me that whether or not we face a referendum, which would be for the public to decide on a particular wording or whatever, if that can be agreed, do I take it that, in addition to this, to protecting yourselves professionally, you would also like to see legislation to copperfasten it and spell out clearly the exceptions that we now know medically and scientifically exist – they may be very rare – and maybe other possibilities where your profession might decide in five years time some other unusual disease might occur?

Dr Keane: I think that is correct, we would like that. As a group, the Institute of Obstetricians and Gynaecologists looked carefully in terms of submitting its wording on its submission to the Green Paper on mentioning these specific cases but it was then felt that that actually might tie us too much, that if you had a woman with Eisenmenger's syndrome or HELLP syndrome that you are almost duty obliged then to terminate their pregnancy, which certainly wasn't what we were wishing to put forward either. As I say, I think we would like the amendment – or the Constitution amended so that in these cases that I mention there would be a degree of protection for the medical practitioners that what we are doing is done in the best interests of the woman and is medically correct to do.

Acting Chairman: Before I call Deputy Enright, I will pursue one of those issues, clarity. Do I take it that you believe that in certain rare circumstances direct abortion is necessary to save the life of the mother?

Dr Keane: Correct.

Acting Chairman: In that situation, if there were to be an absolute abortion, would you feel even more exposed than at the moment?

Dr Keane: Correct.

Acting Chairman: Thank you.

Deputy Enright: The answer given to the question asked is a matter of concern in that, as you said, you can find yourself on the wrong side of the law on this issue. You say the Medical Council is not on your side. We understood there was a code of ethics which are your guidelines. Could you clarify the situation regarding the code of ethics and how it varies with the Medical Council?

Dr Keane: Our own Medical Council is essentially siding with the views of the Constitution that termination of pregnancy, for whatever reason, is illegal, and it is also a view of a considerable number of medical people – I respect their views – who, as I say, feel there is no indication where a termination of pregnancy is required to save the life of the woman. As I say, currently the Medical Council – and I haven't read the specifics of all of their guidelines to us recently – would side on the fact that termination of pregnancy is illegal.

Deputy Enright: Pardon?

Dr Keane: Is illegal.

Deputy Enright: Oh yes, is illegal. Who prepared the code of ethics to which you adhere?

Dr Keane: There would be a sub-division within the actual Medical Council itself that would look at ethical guidelines within general medical practice.

Deputy Enright: Yesterday, your two colleagues were both emphatic that there is no abortion at all in Ireland and that they attempt to save both lives. Do you go along with that?

Dr Keane: I can certainly state from my experience in the United Kingdom that I would hate to see the situation in this country ever mirror what is happening in the United Kingdom where 98% of terminations of pregnancy are done so because of failed contraception. That is why I think the wording of any amendment or any referendum has to be carefully chosen so that we, I mean, are talking totally about – certainly I would be talking totally about those rare cases that I have mentioned where the life of a woman is at risk considerably if the pregnancy was continued.

One could get on to the whole other issues of foetal abnormality, which I would prefer not to. I also think it is very difficult when one gets into the psychological aspects of prolongation of pregnancy and the effects that may have on the psyche of the woman as well.

I do not agree with my two colleagues – I didn't hear their full evidence obviously yesterday – but, as I say, there are rare but real cases where termination of pregnancy is required to save the life of a woman, and I suspect that some of the colleagues of mine who are due to give evidence in front of you later on today will be saying the same thing.

Deputy Enright: You say that 98% of the cases in England where abortions take place are done due to failed contraception. I take it you were unhappy, very unhappy from what you've stated, with the situation in Britain? I take it you would be totally against such a situation developing here in Ireland?

Dr Keane: Absolutely. Absolutely.

Deputy Enright: Senator O'Donovan more or less put it to you and I come back to it again, is it possible to provide safeguards for people in your profession through legislation, or is a referendum the most desirable approach –

Professor Bonnar particularly was of the viewpoint that the vast majority of people want a referendum? That seems to be the demand, people want a referendum. At the time of the other referendums there was a fear amongst the people on one side of the fence that they couldn't trust politicians at the time. I think that was the general view at the time. Which way would you prefer to go?

Dr Keane: I actually think that of all of the aspects of the abortion issue, the most clear-cut as far as I'm concerned is the medical issue. I think the moral and the legal issues are far more complex than the medical issues which, as I said to you, are rare, but they're real and I think we in the medical profession know what the risks are for that woman of the pregnancy continuing. We have medical literature to back us up on the significant risks in these conditions that I've mentioned. I can't comment on the general public's wish or not for a further referendum on the issue. As I say, I think there are certainly specific areas in medical practice where I would like to see some changes made.

Deputy Enright: A lot of those people who were looking for a referendum at that time were a little sceptical and worried about politicians. The same people I think at this stage are somewhat concerned as well about some members of your own profession. However, having listened to what your two colleagues said yesterday and you have said today, it will have assured a lot of people.

Dr Keane: I think, I mean there's no doubt about it that termination of pregnancy is an abhorrent procedure. I mean even in the United Kingdom those doctors who perform it – and I never had to perform it thankfully in the seven years that I practised there – nobody enjoys doing a termination of pregnancy. In terms, as I say, of the medical profession here, I can certainly state I would think that the vast majority of my colleagues would do nothing, or would certainly not be seen to be doing anything to procure an abortion at all. They would hate to come forward and, as I say, certainly would hate to see the experience in the United Kingdom, which started off in 1957 when the abortion Act came out there for good reasons, but which soon – as I say, the waters got muddied very quickly and to such an extent now, as I say, that the current practice in the UK is that 98% of these are what they would consider social terminations, failed contraception.

Deputy Enright: Thank you very much.

Deputy McGennis: Thank you very much, Chairman. I thank you, Dr Keane, for being here today. I had one of my deliveries in hospital .... Certainly it's a bit like a policeman, I must be getting fairly old if the master looks as young as you do.

If ever there was a case to be made for having full hearings, I think the fact that we are following on from yesterday with you first thing this morning is proof positive of it. The two previous witnesses stated categorically yesterday – and I hope I'm not misrepresenting them – but that there was absolutely no case, medical case, which would necessitate an abortion. Their definition of abortion … I think maybe yours is a little bit … or maybe what you say … they were stating that what they were doing in the other cases, the ectopic pregnancies, not the very, very rare cases which you've talked about, were medical treatments and certainly weren't abortions. To my mind, and I asked both of them at the time, it resulted in the same effect, the baby's life was lost. Certainly, it does not fit in with the kind of procedure you described in the 98% of cases in England, where there is failed contraception and somebody elects to have an abortion on that basis. You have rightly described this as an abhorrent procedure and I think it is as well that is on the record from your point of view.

I asked one of the witnesses specifically why a case was made by other practitioners that there were rare cases in which this was necessitated. If I quote him correctly he said, 'You'll find that those people are not involved in obstetrics or gynaecology'. I think that can hardly be said in your case. I totally agree that what we need during this week is to consider the medical issues. We will have to deal with the moral and the legal issues and if it goes to a referendum the public will decide.

You have stated that you have had a concern that even the very few procedures you have to deal with at present might put you on the wrong side of the law. That is very worrying for someone in your position. I asked both of the witnesses yesterday – in fact one of the witnesses stated that he would not want any intervention which would compromise existing practice. I asked both of them if they felt that an absolute ban on abortion – I think the Acting Chairman posed the same question to you – would compromise existing practice. They both said no, it would not. Would you feel an absolute ban on abortion would, in fact, compromise existing practice, not to mention the ones that you have concerns about?

Dr Keane: I think you could compromise existing practice in those cases I have mentioned. I think, as I have said in the past, hospitals would have dealt with these women in a slightly different way.

Deputy McGennis: Yes.

Dr Keane: They would have performed a hysterectomy procedure and perhaps called it a caesarean section in an attempt to try and fudge the issue and avoid the legal implications of what they had just done. It is a termination of pregnancy, no matter what way you look at it. It is certainly not done for any foetal interest if you are delivering a baby before its viability. It can only be done for the mother's interest.

If you put a complete and absolute ban on abortion it would have compromised our position. As I say, in the case we had in 1998, she was transferred under the care of experienced liver surgeons and liver physicians in a different hospital. Their imprimatur to us was when they transferred the woman back to us and said to us that if this woman's pregnancy continues she will die. That was the bottom line and we were left with that scenario that we had to deal with. So, if we had a complete ban on abortion, our hands would have been tied. We would have been compromised in that position.

Deputy McGennis: Probably a question I should not ask – but if I had been in the hands of one of the other witnesses yesterday who stated categorically then that abortion would not have been a medical procedure which

would have been necessary in the cases that you mention, my life would probably have been at risk, very much at risk?

Dr Keane: Correct.

Deputy McGennis: Thank you.

Senator O'Meara: In your setting out of the 1998 situation – the woman, the mother who had a pregnancy of 18 weeks with HELLP syndrome, I think you called it – you said in the course of your remarks, that among the consultations that you had included consultations with the legal team of the hospital. Was that on the issue of the constitutional law of the country or on the Medical Council guidelines?

Dr Keane: It was encompassing a lot of features. It was also encompassing at the time the feeling that although the mother herself realised the real risks and I think was in agreement with what we proposed and what the liver people had said to her in the general hospital, there was a feeling at the time that her partner was not in agreement with our views and, therefore, we wanted to get a legal opinion on what we could do if the mother was in favour of our course of action but the father was not. It was not primarily dealing with either the Medical Council or the constitutional feelings on it.

Senator O'Meara: I see. I assumed that it was. In fact, I was going to ask you if you did not feel at the time that the wording of Article 43.3, which gives due regard to the equal right to life of the mother would have covered a situation such as this?

Dr Keane: Well, we certainly in the medical system would believe it should do. When I have mentioned, as I have a few times this morning, that the life of the woman is paramount we are not ignoring the life of the foetus in saying that. As I say, we are also talking, as I have mentioned already, of a condition where if the mother had died within a couple of weeks of us doing nothing, the foetus would have died by necessity as well anyway.

Senator O'Meara: Picking up on a point made by other members, including Deputy McGennis, it was put to us quite clearly yesterday, specifically in relation to the Medical Council guidelines, that procedures such as you have described in relation to this particular mother is not abortion, it is medical treatment which has the effect of ending the pregnancy.

Dr Keane: Well here we go back to direct and indirect abortion. I think in the case of oncology and cases we have mentioned already, where you have to give chemo-therapy for a woman who has a tumour or a cancer, where perhaps a by-product or a knock-on effect of that treatment is that it could be deleterious for the foetuses – that is one issue. I think where you are actually directly terminating a pregnancy, whether that be by surgical or medical means to end a pregnancy in the interests of a woman, that, to me, is termination of pregnancy or abortion in any shape or form you wish to define it.

Senator O'Meara: As you said yourself, the medical issues are relatively clear cut, but there are issues which are not as clear cut, as you mentioned in one remark the issue of foetal abnormality, for instance.

Dr Keane: Correct.

Senator O'Meara: And also issues which have not been raised here, such as rape, incest and, as has come before the courts on two occasions, rape involving a teenager, so that the courts have in fact pushed out the whole grounds for what is considered to be a serious risk to the health of the mother by including suicide, potential suicide or the threat of suicide in the case of teenage rape as constituting a risk serious enough to the health of the mother as to allow an abortion to take place under the law in this country, that is, under the Constitution of this country.

It was put to us yesterday that suicide or the threat of suicide is extremely rare in pregnancy, in fact, evidence seems to suggest that it is less in pregnancy ....

Dr Keane: Correct.

Senator O'Meara: .... than it would be in the non-pregnant female population. However, there have been two cases that have come before the courts and have, in effect, defined the law in this country as it applies. Does that concern you? It was put to us yesterday that it is not happening arising out of these court judgments that women are presenting in hospitals saying 'I am in this situation, I feel suicidal, therefore, you know, I am asking for a legal procedure, a legal abortion under the law.' Do you have an opinion on that?

Dr Keane: I think it is more difficult to define. I am not a psychologist, I am not a psychiatrist and, therefore, evaluation of these women, where there is felt to be a significant risk of suicide if the pregnancy was to continue, would be decisions taken by clinicians other than myself. I am not saying psychiatrists cannot come to a very true and real appraisal of the risk in that woman's case, but unlike the situations I have mentioned, where, you know, we do have ball-park figures on the risks, the medical risks and the sequelae of the pregnancy continuing, it is a bit more difficult.

I think the foetal abnormality is an interesting one and I think it is one that we are concerned about, because routine ultra-sound is now common practice, certainly in all three Dublin maternity hospitals. Every woman will have a routine scan on her pregnancy between 18 to 20 weeks and we are diagnosing foetal abnormalities, many of which are inconsistent with life outside the womb. Some of these women will take the options of travelling abroad. Many in our profession would consider that regrettable because they often travel to places where the pregnancy is terminated, where no post-mortem or autopsy is done on the baby and, therefore, the ability to counsel that woman on subsequent pregnancies is reduced.

But, again, it is an even more difficult issue than the medical issues because there are a lot of anomalies that would pick up on scan that are not inconsistent with extra-uterine life, but may, nonetheless, leave the baby with serious handicap, but the child would live. But, as I say, it

was once said by a well known politician in this country – it is an Irish solution to an Irish problem.

Senator O'Meara: Indeed.

Dr Keane: And, as I say, that is the way it tends to happen at the moment. Even under the current guidelines, we are not meant to procure any information to that woman in terms of where she should go or what she can do. We, again, can tell her on the basis of the ultra-sound findings what the risks are for her baby, but, as I say, a lot of the mothers would takes matters into their own hands and travel abroad.

Senator O'Meara: I was about to put to you – What do you think would be the situation if we did not have, say, the Irish solution, the escape hatch so to speak?

Dr Keane: It varies, again, because a lot of women, even knowing that they have a baby with a significant foetal abnormality, for religious, personal and moral reasons will not want to terminate their pregnancies and we have to respect that. In fact, because of the situation in this country we support that woman consistently throughout her pregnancy. In many cases it is extremely difficult, they carry the pregnancy all the way to term and deliver a baby that may live only for a second or minutes after its birth. But, as I say, we have to take into account – and we do – the views of every individual woman in that circumstance.

I think if we did have the facility for termination of pregnancy for significant foetal abnormality then, of course, a lot more women would be far happier to avail of it in this country rather than travelling abroad to the United Kingdom or Northern Ireland without the back-up they would get if they were to stay in this country.

Senator O'Meara: Thank you very much, Dr Keane.

Deputy Kirk: I welcome Dr Keane. I have two brief questions. You have partially answered the first question on the psychological condition and the degree of psychological condition where you feel termination of pregnancy would be necessary to save .... Have you any theory on that?

Dr Keane: I don't really because, as I say, I would not be an expert in the area. Most, indeed all, of the maternity hospitals, certainly in Dublin, have a psychiatrist on staff and certainly those cases are evaluated. I know one of the people who is due to appear before the committee in the coming days or next week is an eminent psychiatrist who would be far more qualified than I to give you a view on that.

Deputy Kirk: On the rare and exceptional medical conditions which you mentioned earlier in response to a question, would the framing of a constitutional amendment cater for those?

Dr Keane: Would you repeat the last part of the question?

Deputy Kirk: In the very rare and exceptional cases and circumstances where you believe termination would be necessary to save the life of the mother, do you feel they can be catered for in a constitutional amendment?

Dr Keane: Yes, I do.

Deputy McManus: Would you like to elaborate on that?

Chairman: Deputy McDowell.

Deputy McDowell: Deputy McManus's question is obviously pertinent. How can it be catered for in a constitutional amendment?

Dr Keane: I think that we were not too far away from it in 1992. It actually says that it is unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother. We are talking purely here about the life of the mother where the continuation of the pregnancy is going to be detrimental to the life of the mother. There are probably only two or three instances that come to mind where those cases occur.

Deputy McDowell: The existing amendment deals with the equal right to life of the mother and the foetus. You have used the term twice now – I assume deliberately – that you believe the life of the mother is 'paramount'. That is distinctly different, is it not?

Dr Keane: That is true but I said that in the context … and qualified it by saying that these cases I am talking about are cases where if the pregnancy was allowed to continue and the woman was to die, the foetus would also die. We are, therefore, not making a choice between the mother and the foetus. We are making a choice between both mother and foetus dying or saving the mother. So, I think if there was a situation .... As I say, I feel for these reasons that these rare indications from the medical point of view are quite clear-cut.

Deputy McDowell: Are you saying that there is no distinctive difference between saying that the life of the mother is paramount and saying there is an equal right to life or are you saying that in these particular cases, it does not matter?

Dr Keane: I am saying that if there is a total and complete ban on abortion or termination of pregnancy where we would not be allowed in these rare cases to terminate a pregnancy, I would almost argue that very little consideration is given to the life of the mother in those situations.

Deputy McDowell: What I am getting at here is would it not offer greater clarity if the law or the Constitution were to clearly state that the life of the mother is paramount, to use your phrase? Is that in effect what the hospital currently does and believes? Is that your own belief?

Dr Keane: No, because one of the unique things about obstetrics as a branch of medicine is that we are dealing with two patients – we are dealing with mother and foetus and we take the considerations of both very much into account, leaving aside the legal issues in this country. I

think if one were to put into the amendment that the mother's life is paramount to the total … I mean, when you say it like that, it almost seems to the total exclusion of the foetus. I would not .... I think that would need to be carefully worded.

Deputy McDowell: I am not trying to be clever with you. You used the phrase twice and I assumed it was not intended to be casual ....

Dr Keane: No.

Deputy McDowell: .... and does seem to establish a … 'supremacy' is not the word I am looking for – seems to establish that in the event of a choice, you choose the mother. Is that effectively what you are saying?

Dr Keane: Well, certainly in the cases that I have mentioned, we have taken into strong consideration the life of the mother but, as I stated earlier, that was for the reason that if we had not saved the mother's life, the baby would have died in addition.

Deputy McDowell: You say that the medical cases are clear-cut and I think I understand what you mean by that, but in a sense it is also clearly not the case because is it not true to say that most terminations of pregnancy which occur in Britain occur, at least formally speaking, because of medical reasons and are basically signed off by doctors who give medical reasons for the termination?

Dr Keane: That is correct and the form in Britain has to be signed by two people, one of whom is generally the general practitioner or the person in the family planning clinic and the second is a doctor in the hospital in which the pregnancy is terminated. There are four reasons generally put forward as to why pregnancies can be terminated in the UK and the classic one is where a box is ticked where it is felt by the referring doctor and the doctor who carries out the termination that continuation of the pregnancy will have serious psychological effects on the woman. It is not done because of her physical health or because of a foetal abnormality. It is done because of probable or possible psychological damage to the woman in her pregnancy. They are signed off by doctors but that is purely a fudging of the issue. They are, at the end of the day, social terminations of pregnancy.

Deputy McDowell: This is really what I want to explore a little. Can we leave aside the psychological aspects for a moment? Are there cases in your experience – I assume there are but can you give us some sort of quantification – where the health of the mother, as distinct from the life of the mother, is placed in – 'jeopardy' is too strong a word – but where pursuing the pregnancy to term would or could have a detrimental effect on the health of the mother?

Dr Keane: I do not have figures on that. I think it is a very difficult thing to quantify.

Deputy McDowell: Well, based on your experience in Britain, for example?

Dr Keane: Well, in my experience in Britain, I thankfully never had to do anything to either procure an abortion in Britain or indeed to counsel women in Britain because, being a Roman Catholic, I was exempted from doing so in both centres I worked in. I would say a very small proportion of women who have a termination of pregnancy in Britain have a significant psychological problem that would necessitate the termination of pregnancy.

Deputy McDowell: I am not talking about psychological problems. I am talking for the moment about medical problems where there is a risk to the health, not the psychological health, the medical health ....

Dr Keane: To the physical health?

Deputy McDowell: Yes, physical health of the mother.

Dr Keane: Very few – in percentage terms, 3% or 4% at most, I would have thought.

Deputy McDowell: Of those who ultimately end up getting a termination?

Dr Keane: Yes.

Deputy McDowell: So, the total number of pregnancies, the number of cases where the health, as opposed to the life of the mother, would be endangered or would run the risk of detrimental effects, would be very small?

Dr Keane: Correct.

Deputy McDowell: What are we talking about, 1% or less?

Dr Keane: It would probably be in that region; it's certainly extremely small.

Deputy McDowell: So, the vast majority of terminations in Britain on medical grounds are for psychological reasons?

Dr Keane: That is what is quoted in the form that is signed off.

Deputy McDowell: You used an interesting phrase earlier where you talked about 'real' cases where the life of the mother was endangered. I take it that was to distinguish them from what you've just been describing where psychological damage was a possibility.

Dr Keane: Simply because, as I stated already, the risks in these medical cases I mentioned are quantifiable in terms of medical literature which would define the cardiovascular risks to a woman of a pregnancy continuing. Psychological effects, as I say, cannot be measured in those same scales and, indeed, two or three different people .... Well, you have already heard that different obstetricians can give you different views but certainly if you get a psychological evaluation from different psychiatrists or psychologists, they can give you different views.

Deputy McDowell: Do I get a sense of a sort of medical – 'hierarchy' is perhaps too strong a word – a sense of 'We're real doctors, psychiatrists or psychologists are not'?

Dr Keane: On the contrary, I have the greatest respect for psychiatrists and for the psychiatrists who work in our hospital. They play a very real and defined role. All I'm saying is that the .... I've already said that I am not a psychiatrist or psychologist and, you know, if the Constitution were to be amended to take into account a very real risk of suicide, I would certainly feel that I would not be qualified to make that judgment. I would certainly be depending upon my psychiatry colleagues for defining that risk because I certainly would not be qualified to do so.

Deputy McDowell: Can I take you back just a moment – I appreciate, Chairman, I am using a bit of time – to the medical cases? You say they are perhaps 1% or so. Would you have any ethical difficulties in terminating a pregnancy where there was a risk to the health of the mother as opposed to the life of the mother? I understand it's clearly not within the current guidelines, but would you personally – your own personal view – have a difficulty there?

Dr Keane: I think each case is obviously taken on its merits and I think with the improvement in the standards of medical care we would in this country feel generally capable and confident of looking after most women in their pregnancy, even where they have significant medical disease going into their pregnancy.

Deputy McDowell: Most but not all.

Dr Keane: Most but not all. I mean it has already been put on record, I think, by one of the speakers yesterday that you had in front of your committee that this country does have the lowest maternal mortality in the world, and I think that is a reflection both of the standard of the health of the women in this country and also of medical practice in this country. So that is why I have been trying to confine my discussion to date on those situations where we are predominantly talking about the life of the mother. I think the health of the mother again may be more difficult to quantify, but in most situations we would feel confident of looking after that woman and her baby and achieving a delivery without the need for termination.

Deputy McDowell: I don't want to push you, doctor, into saying something you don't want to say, but you have not, with respect, answered the question, which was, would you personally have a difficulty with terminating a pregnancy in those circumstances? You say you feel confident that you can help the woman otherwise, fine, but would you have a difficulty personally?

Dr Keane: Yes.

Deputy McDowell: And would that be the common view of people in the profession?

Dr Keane: I can't speak for everybody, but I think it would probably mirror the view of the majority of my colleagues.

Deputy McDowell: What I am getting at here is that a woman whose life is in danger will clearly feel very strongly that her life should be saved – or at least I presume most would – but is a woman whose health is in some way endangered but who is not in danger of death, is she not entitled to say, well, I would like my pregnancy to be terminated?

Dr Keane: That is the reason why, as I said, I would not be comfortable to do so because I think with modern medical practice we would be able to deal with most physical health issues that a woman will face during her pregnancy without the necessity for termination of pregnancy, and I have been trying to discuss so far – earlier on – those cases where there is a necessity to terminate the pregnancy.

Deputy McDowell: I appreciate you have done that and, if I may say so, with commendable clarity. May I ask a final question, Chairman, on a completely different issue, again to draw on your experience, Doctor Keane, on the issue of rape or incest? I assume you must have had women, perhaps young women, presenting at the hospital who have been victims of rape or incest. I assume that they are given some sort of counselling at the hospital.

Dr Keane: Correct.

Deputy McDowell: Have you experienced cases where the woman has nonetheless wanted a termination and how would the hospital typically deal with circumstances such as that?

Dr Keane: I think they would be totally different because, unfortunately, these are situations where, again, the physical health of the mother is normal, where the foetus is generally normal, where there is no evidence of a foetal abnormality ....

Deputy McDowell: Yes.

Dr Keane: .... and, therefore, termination of pregnancy in those conditions, as I say, we would not under obstetrical or indeed health – physical health – of the mother be happy with termination of pregnancy. You know, we are getting into a lot of other issues when we are talking about rape and incest from a moral ....

Deputy McDowell: I am simply trying to find out about what the practice in the hospital would be, and I assume this has happened where a woman has asked for termination. What would normally happen?

Dr Keane: Generally, they would do so not so much through the medical profession because she probably would feel that we would not be in favour of it and would more often ask for advice on that through either the social work department or indeed in many of the family planning clinics rather than coming directly, in my experience, to a maternity hospital and seeking that information.

Deputy McDowell: Well, has it happened?

Dr Keane: Not to me personally. I have never had a woman ....

Deputy McDowell: Are you aware of it having happened within the hospital?

Dr Keane: No, I haven't, and that's being honest, totally honest.

Deputy McDowell: Thank you.

Chairman: Deputy McManus.

Deputy McManus: I just want to go back on two points. First of all, I think I heard you say that you wouldn't be giving information on abortion to women in certain circumstances ....

Dr Keane: We would or we wouldn't?

Deputy McManus: .... because of the Medical Council, that you felt the Medical Council would prevent a doctor giving information even though there is obviously legislation in place to ensure that right.

Dr Keane: Well, we wouldn't be … we shouldn't be seen to do anything that would procure an abortion. I mean that's ....

Deputy McManus: No, but you did say you wouldn't be giving information. Now, there is a law to enable that right to be protected. Are you saying you reckon the guidelines actually prevent you giving that information?

Dr Keane: Well, it's always been taken as such because even those doctors who perform routine ultrasound scanning and are specialists in this field, who diagnose an anatomical problem with the foetus that may be inconsistent with life outside the womb, would still be unhappy to forward that information to a woman, to tell her, for example, where she could go to have her pregnancy terminated.

Deputy McManus: Even though it is legal to do so?

Dr Keane: Correct.

Deputy McManus: And you are saying that is the practice among your colleagues or are you saying you have a particular difficulty with it?

Dr Keane: I would not generally be in a position to .... Most of the routine, or the scanning, would be done by other colleagues in the hospital, but as I say their personal views on it would be that they would feel unhappy with giving the woman that information.

Deputy McManus: There is one last question I'd like to ask and it is a more general question. I appreciate and respect fully your views, and any doctor being faced with having to carry out abortions is put in a difficult position. I presume you are not implying that, for example, your European colleagues are in any way less professional or less compassionate because they operate in systems where abortion is allowed for various reasons. In this country we have, relatively speaking, a high level of pregnancies ending in abortion – it now appears to be around 12%. That is a reality. There is another approach to simply turning a blind eye and having what I would feel are deficiencies, where women are going without necessarily having counselling, without the senior doctor and coming back with the same arrangements not being in place – the post mortem, for example, is a very good and important aspect. Do you think there is any merit in us developing a different type of policy concentrating on reducing the level of abortion, of actually facing up to what is happening anyway and having a policy where we would aim to reduce abortions among Irish women, but that we also provide for that possibility here in Ireland, because we can't shut it down completely?

Dr Keane: If you are asking me, as I think you are, whether we need to face up to this problem sooner or later and perform terminations in this country instead of people travelling to the UK, I think that will be something that obstetricians would feel extremely uncomfortable with in this country because, at the end of the day, the people who would be asked to carry out the terminations of pregnancy are the gynaecologists in this country, and as I've mentioned already, you know, for religious, moral and ethical reasons most of my colleagues would be extremely unhappy to be asked to do so. In fact most, I am sure, would not do it. I would almost go as far as to say that even if it came under the legal and the law .... Indeed, if you take the UK, the law is that you can do termination of pregnancies and yet all of us who worked over in the UK had a moral opt out for not performing it and we didn't. I would consider that even if a legal right … if the politicians decided tomorrow to bring in termination on demand ....

Deputy McManus: I didn't say on demand.

Dr Keane: No, what I'm saying is that if it turned around and that this was the case I would think the vast majority of my gynaecology colleagues would be conscientious objectors to taking any part in that.

Deputy McManus: Is there the same conscientious objection to the morning after pill or the IUD?

Dr Keane: That again is more prescribed by general practitioners and family planning clinics than it is by gynaecologists. We are generally dealing with patients once they have become pregnant and want to hold on to their pregnancy. The vast majority of prescribing of the morning after pill and intra-uterine devices would not be done in a maternity hospital setting.

Senator O'Dowd: I would just like to thank Dr Keane for answering the questions that have been put to him. I am just trying to draw a trend between the people who spoke yesterday and yourself. Basically you have agreed – all of you agree – that where there is a threat to the life of the mother that medical intervention can and should take place. Would it make sense to list all of those, or is it possible to list all of those life threatening conditions in legislation, that will allow people the freedom to make sure that they don't feel under threat if they perform one of these operations?

Dr Keane: We discussed at great length among the executive of the Institute of Obstetrics and Gynaecology in this country putting in those indications. Then it was – I think, rightly – pointed out by a couple of members that this in a way could tie our hands, that if a woman did have such a complication of pregnancy we would be almost duty bound to terminate her pregnancy because of the considerable risk. So, we decided 'against' in our submission on the Green Paper putting in those situations, such as HELLP Syndrome and Eisenmenger Syndrome and perhaps one or two other indications. But in our experience we could probably draw up a short list of about four or five conditions where the mother's life is at considerable risk. But, as I say, we didn't put it in because if those conditions, for example, were brought into any amendment to the Constitution you would be almost duty bound in a way to terminate a pregnancy or if you didn't terminate a pregnancy and a woman had this condition, are you then leaving yourself open to medical legal redress if that woman subsequently dies in her pregnancy?

Senator O'Dowd: The other question I have is that – we didn't speak about this yesterday – of the question of foetal abnormalities we are talking about today, where there is no possibility of independent life outside of the womb. What you said there was that some people in your profession feel they cannot counsel the mothers about this issue.

Dr Keane: No, I didn't say that. In fact it is quite the opposite.

Senator O'Dowd: I picked you up incorrectly there.

Dr Keane: We can and do counsel women and we support them throughout their pregnancy but what we're saying is that it is difficult for a lot of these women because they have a pregnancy. As long as a foetal heart is present under the laws of the country you cannot terminate a pregnancy and yet this woman has to live with the realisation that she is carrying a pregnancy where once that baby is born the likelihood is it's going to die within a very short period of time. We counsel and we do support those women but, as I say, in an alternative setting, in an alternative country, most of the women with these lethal anomalies will generally have their pregnancies terminated much earlier on.

Deputy McDowell: Just very briefly, Chairman, I think I … just in case I'm … wrong. I thought you said that you're not supposed to give information about termination to women in those circumstances. Is that the phrase you used?

Dr Keane: Doctors have been uncomfortable in doing so.

Deputy McDowell: But you are allowed to do so? Do you accept that?

Dr Keane: Well again, this is where we're looking for a degree of clarity because even when you diagnose these abnormalities, to be seen to be proactive almost in telling the woman that she can go to X centre to have her pregnancy terminated is not the right … because, as I said already, a lot of the women with these abnormalities in an Irish context for religious and moral and other reasons would not wish to have their pregnancy terminated anyway, would want to continue their pregnancy, but the option … and that's how we've always managed these women because termination of pregnancy in our context has not been possible.

Deputy McDowell: Sorry, I'm just not clear in my mind as to what you would like to see happening in those circumstances. What is the ideal scenario?

Dr Keane: I tried … I was drawn into it and tried to avoid it but I am more concerned, as I've stated at the outset, about the medical life of the woman in those conditions. I think foetal abnormalities are a little bit more difficult. I think there's perhaps only one or two situations where extra-uterine life is not possible and in those situations it would be useful to have perhaps some alteration to the Constitution that gives the women the ability to have that pregnancy terminated if she should so desire.

Deputy McDowell: In a hospital in the Republic of Ireland?

Dr Keane: Agreed, and where a structured and proper autopsy could be carried out on the foetus after delivery so that when the woman comes back to her obstetrician for subsequent counselling about the implications and the risks of that happening on a future pregnancy, it can be given. The unfortunate scenario at the moment is that women with these abnormalities go to units in the United Kingdom, many of which … most of which do not perform an autopsy on the baby so the pathology back-up for subsequent counselling, indeed the psychological support of that woman, is also lacking in many of these institutions as well.

Deputy McDowell: So you think it would actually be preferable if the termination were carried out in your own hospital for the sake of argument?

Dr Keane: I do because there were ....

Deputy McDowell: If the woman had been appropriately counselled in the circumstances in which you described?

Dr Keane: Exactly, because it gives us the ability as obstetricians to appropriately counsel that woman on the risks and the implications that it has for subsequent pregnancies.

Deputy McDowell: I think you used the phrase again that these were rare, these sort of cases.

Dr Keane: Well, they're less rare than the medical conditions I've spoken about

Deputy McDowell: Sure.

Dr Keane: I mean Ireland has the second highest risk of neural tube defects in the world, in which although the

risks are coming down thankfully, as I say, we would still have a significantly high figure in this country, probably about four to five women … four per thousand – I think, is the current figure – in this country would have a neural tube defect. That would either be spina bifida or anencephaly. Spina bifida is more difficult because many babies and indeed most babies with spina bifida will live, very often with a compromised lifestyle. Anencephaly is that situation where the brain has not developed and, of course, if the brain has not developed, then it is inconsistent with extra-uterine life.

Deputy McDowell: So there is again a grey area ....

Dr Keane: Correct.

Deputy McDowell: .... where the foetus is viable in the sense that it could continue to live but the quality of life would be pretty ....

Dr Keane: Well, it lives in-utero because the actual placenta and the mother is giving life.

Deputy McDowell: But outside the ....

Dr Keane: Once the connection to the mother is taken away, once there is no higher centre, no brain, the foetus will not live.

Deputy McDowell: So am I getting the correct – I will finish with this, Chairman – sense of what you're saying, that in certain senses where it is in your view certain that the foetus is not viable outside the womb you would be happy enough that … in fact you would think it preferable that termination should be carried out here but in circumstances where there is some doubt or where the foetus is viable but obviously wouldn't be in good health, you think it would be preferable if the pregnancy were pursued? Is that a reasonable summary of your views?

Dr Keane: I think we would only be happy in this country in terminating a pregnancy for a foetal abnormality if, as you say, we were 100% sure ....

Deputy McDowell: 100%.

Dr Keane: .... that that foetus would not live outside the womb.

Chairman: You're talking of cases of lethal deformities?

Dr Keane: Correct.

Chairman: And all your remarks have been made in that context?

Dr Keane: Correct.

Deputy Enright: Deputy McDowell clarified a certain amount with his question that time. You stated there were four reasons in England for abortions and the referring doctor and the other doctor then would sign the necessary forms and you referred to serious psychological damage to the mother and so the pregnancy is terminated. You also said in the course of your remarks that you had the height of respect for psychiatrists and psychologists and you respected their views.

Dr Keane: Absolutely.

Deputy Enright: Pardon?

Dr Keane: Yes.

Deputy Enright: But you wouldn't be happy, would you, in that sort of a situation, if there were reports from a psychologist and a psychiatrist that the mother's life was in danger because of suicide or something else, perhaps suicide? Would you still have reservations in that instance of acting?

Dr Keane: I have never been faced with the situation, but I think, if one of my learned psychiatry colleagues did an evaluation on a woman and said that there was a significant risk of that woman committing suicide if the pregnancy was to continue that is something we would have to face up to in time. As I say, it is not a situation I have ever had to face in my medical career to date.

Deputy Enright: You mentioned also that because of your religion that you decided … you had the right to a conscientious objection to performing abortions in England and you exercised your conscientious objection. In Ireland, as you are aware, we have quite a lot of people of different beliefs. Would there be many people in Ireland in your profession who would not wish to avail of that conscientious objection either in England or Ireland, more particularly in Ireland? In other words, would there be people in your profession, do you believe … and I think from what you've said the vast majority of people in your profession would not be in favour of actually deciding to terminate a pregnancy without good medical reason. Are there people in your profession who have a different viewpoint than you? Are there people who would carry out such an operation?

Dr Keane: I can't answer that question with a total degree of conviction because I think there is about 87 consultant gynaecologists in the Republic of Ireland and I don't know the individual views of all 87. I do know from both my own hospital and the views of the executive of the Institute of Obstetrics and Gynaecology that I sit on …. I think I would be fairly happy in saying that most of those would be against termination of pregnancy.

Deputy Enright: A very sizeable majority.

Dr Keane: Exactly.

Deputy Enright: You referred to the 12th amendment to the Constitution in 1992 and said you thought there was quite a lot of merit in that particular amendment. Is that correct?

Dr Keane: Correct.

Deputy Enright: Unless such termination is necessary to save the life as distinct from the health of the mother. Do you have any suggestions on how that can be improved?

Dr Keane: I have thought about it and I have to continue thinking about it. I do not know. As I say, reading back on it, I think it is almost inadequately summarised, you know those cases that, as I say, we are left with a real predicament in every day practice. They do not occur all that rarely but if this amendment had been passed in 1992 then it certainly would have protected our ability as clinicians to terminate pregnancies in those where there were real indications that I have mentioned.

Deputy Enright: Thank you very much.

Deputy McManus: Except for suicide.

Dr Keane: Correct.

Chairman: But you have not expressed a view on suicide, as I understand it.

Dr Keane: No I have not because, as I say, it is not something that I have ever been faced with in my medical career. I have been talking more about medical, as in physical, complications which have been more related to liver disease or cardiovascular disease.

Senator O'Donovan: I will be brief as you have been under intense inquiry. In view of the fact that there is an increasing incidence of medico-legal cases in this country – unfortunately maybe for you – some in your department where very substantial claims may emanate for various reasons – I do not want to go into specifics – do I take it, and if possible, I want a simple yes or no, that, first, you would like to see the constitutional position clarified and, second, to back this up, you would like to see legislation to safeguard your medical profession in instances which you have already mentioned, that are fairly obvious to most lay people?

Dr Keane: I would agree with that.

Deputy Kirk: The 1957 abortion legislation in Britain was referred to earlier. With the advantage of having practised in the UK for a period of years, would you care to reflect on the moral, ethical, medical and psychological impact of the free availability of abortion on the medical profession and the wider population since then?

Deputy McGennis: And could you sign copies of your book?

Dr Keane: That is a difficult question to answer in summary. I think it is a regrettable aspect of obstetrics and gynaecology practice in the United Kingdom as it currently stands. I have no doubt that when Britain decided to go down this route in 1957, they did so with the best possible intentions and possibly started off with the same kind of discussions we are having now, that it was going to be primarily done for very good … physical and psychological risk to the mother. Over a period, time has eroded into the current *status quo* which I think is regrettable.

Deputy McManus already alluded to the fact that the real answer at the end of the day is not dealing with these unwanted pregnancies but in fact preventing them from happening in the first place. I bemoan the fact that so many of these terminations of pregnancies are done for fear of contraception and indeed, in the United Kingdom it is not unusual to see the same young girl of 20 or 21 coming forward for her third termination of pregnancy, where the real issue should have been adequate counselling to prevent her from getting pregnant in the first place. But, as I say, I would need considerable time to sit down and answer your question in its entirety.

Chairman: You mentioned that you were on the executive council of the institute and I think the letter from the institute signed by Professor Bonnar is on page 127 of the brief book. I am sure you are familiar with the letter.

Dr Keane: Yes.

Chairman: It might be as well to open it. In the first paragraph, the institute welcomed the Green Paper and described the document as a comprehensive, up-to-date and objective analysis of the issues arising in the care of the pregnant woman. It then made clear that the institute, as you have this morning, is confining its comments to its area of expertise. The second paragraph is the key paragraph. There is a very strong difference of emphasis between you and Professor Bonnar in the nomenclature you use, but in relation to the final sentence of that paragraph, 'We consider that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example, for social reasons and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother', I take it you would agree with that particular sentence.

Dr Keane: Well, certainly, as he has put in 'for social reasons', I would agree, yes. By and large that sentence, I would agree with.

Chairman: So the difference between you comes down to this point of whether the unavoidable death of the baby resulting from essential treatment to protect the life of the mother is a result of a termination or not. Is that right?

Dr Keane: One could look at it that way.

Chairman: On the third paragraph, I think there is full agreement on all sides. 'We recognise our responsibility to provide aftercare for women who decide to leave the State for termination of pregnancy' and you recommend full support and follow-up services be made available, whatever the circumstances. Do the current Medical Council guidelines inhibit the implementation of the policy referred to in paragraph three?

Dr Keane: No. We have consistently had to deal with the consequences of women who have had termination of pregnancy outside the State, both physical and psychological and I see no reason why that should not continue.

Chairman: You confirmed in reply to, I think, Senator O'Donovan, and I just want to ask you again … I take it you attach a lot of importance to us as legislators creating maximum legislative certainty at your place of work.

Dr Keane: Correct.

Chairman: The issue of lethal foetal deformities was raised in questioning. I asked you at the time that your remarks are confined to lethal deformities. The question then of the right to life of the unborn in such circumstances is a legal or constitutional question but it has posed difficulties in practice, I think you are suggesting.

Dr Keane: It has because any time that there is a foetal heart present, by right, you cannot terminate your pregnancy. As you say, I would like to confine the remarks totally to lethal ones because once you talk about non-lethal ones it gets very ill-defined, very muddy.

Chairman: But the current criterion, you say, is the heartbeat.

Dr Keane: Yes, I mean, once the foetus is alive, *in utero*, under the law of the country, one should not terminate the pregnancy.

Chairman: Is it possible by scanning to establish whether there is brain death at this stage?

Dr Keane: No, not really, because if a scan shows significant anencephaly or absence of brain tissue then we know by definition that that foetus cannot live outside the womb. It will have a foetal heart because through the placenta of the mother, nutrients will go which will keep that baby alive. Once outside the womb the baby will die.

Chairman: Dr Keane, I thank you very much for your assistance this morning. We held you somewhat longer than anticipated and I hope you have not missed any appointments as a result. We are all very grateful for your assistance.

SITTING SUSPENDED AT 12.30 PM AND RESUMED AT 2.30 PM

Dr Peter McKenna

Chairman: We are now in public session. I welcome Dr Peter McKenna, who is the Master of the Rotunda Hospital to this meeting of the Joint Committee on the Constitution.

We asked you to talk to us Dr McKenna because you are master of our great maternity hospital in Dublin. The format of this meeting is that you can make a very brief opening statement if you wish, which will be followed by a question and answer session with the members. I have to draw your attention to the fact that while the members have absolute privilege the same privilege does not apply to you. I welcome you and ask you to make a presentation.

Dr Peter McKenna: Thank you very much, Mr Chairman. I probably would be happier with the format of answering questions, but possibly I should outline that my interest in this comes from working in the area of obstetrics and gynaecology and working in a busy maternity hospital that very occasionally, possibly as infrequently as once a year or once every two years, would come across a woman who is critically ill and whose medical condition will require that the pregnancy, for one reason or another, is terminated. That, I suspect, is probably the main reason I am here. I have some interest in this subject stemming back over the 1990s as, for a short period of time, I was involved in the in-patient care of case X in the Rotunda Hospital prior to her leaving the country.

Chairman: Perhaps I will take you through the letter from the institute at page 127 of the brief book. In fact, you have it open.

Dr McKenna: I have it open in front of me.

Chairman: Are you a member of the institute?

Dr McKenna: Yes.

Chairman: And were you involved in the preparation of this document?

Dr McKenna: I hope that I was encouraging in getting a submission to the committee and, in broad terms, I would be supportive of the submission, yes.

Chairman: The other matter you mentioned was the X case. You were involved in that case?

Dr McKenna: Before we leave the submission, I would have been happier if it had included some reference to serious congenital abnormalities as well. The reason I say that is because I feel they are significantly different from the bulk of the 5,000 Irish women that leave this country every year to be terminated in the UK. The difference is that the majority of the 5,000 women will never see an obstetrician or a gynaecologist, and it is probably of interest to the committee to know that in 20 years of practice not one person has ever approached me looking for a termination of pregnancy. I say that because you will probably come across people who will say, 'In a lifetime of practice I never saw this' or 'I never saw that'. I say that because I know there are 5,000 people leaving the country every year but not one of them has ever come forward to me looking for either referral or a termination. The fact that they are there does not mean to say that you will see them. People will be very selective as to where they will go.

To revert to my point about foetal abnormality, the patients with foetal abnormality are unlike those, because we are the people that diagnose the foetal abnormality. They are diagnosed within maternity hospitals and because those foetal abnormalities will have recurrence rate in future pregnancy it is important that those patients should have the best information available to them on their babies' post-mortems and on the likely risk of recurrence.

Chairman: I hope members will allow me to take the witness for a few moments. It is just to assist with the opening statement in effect. I think when Professor Bonnar said yesterday that there was 90-95% support for the letter in the institute, that the one reservation area that was shared by the 5-10% related to that issue of foetal abnormality. Is that correct?

Dr McKenna: Well ....

Chairman: Or is that an unfair assessment?

Dr McKenna: I suspect that is not quite correct. I would suspect that the reservation that I have voiced … but then again, I am not in a position to know, but I would have thought that the reservation that I have voiced would probably be shared by a larger minority than that.

Chairman: Yes, but that is the main divergence of opinion within the institute?

Dr McKenna: Yes. I suppose really, you then come down to what you actually call the procedure that you undertake, in the middle paragraph, and that, I think, probably is a stumbling block. I suppose from the patient's point of view the important thing is that the right thing is done. It is a secondary consideration what you call it, whether you call it treatment or whether you call it an abortion. I would agree that that is what should be done. What you call it is a matter for argument.

Chairman: Yes, but there is agreement that that is what should be done, on the body?

Dr McKenna: Absolutely.

Chairman: You touched on the X case. Did you want to develop that at all, your role in the X case?

Dr McKenna: Well ....

Deputy Enright: Could you clarify the point on foetal abnormalities? I did not hear you.

Chairman: We will come back to that.

Deputy Enright: It is the sound. I did not quite hear what you said.

Deputy McGennis: The sound is actually bad.

Chairman: Could you repeat what you said about foetal abnormalities because a number of the members did not hear what you said?

Dr McKenna: I apologise for that. As regards foetal abnormality, I draw a distinction between the people that leave. Possibly there are 50 or so women a year will leave the country to have severely abnormal foetuses terminated outside the country. I think that they are different from the 5,000 women who leave for social reasons, and the reason is that the follow-up of those women, the reasons why their babies are abnormal are important to know in order that they can be advised what the recurrence risk is in subsequent pregnancies. That really is the difference from my point of view.

Deputy Enright: I heard you perfectly this time. Thank you very much. I just could not hear you the first time.

Chairman: On the last question in relation to your opening remarks, you touched on your involvement in the X case. Did you wish to develop that for the committee?

Dr McKenna: That was the first time that, like many people, I was involved in this as an issue in the country. Because the patient was an in-patient under my care for some of the time, I was quite closely involved and I must say I do share some of the reservations that are expressed by many of the people who have written to this committee about the conclusion that was arrived at and how it was arrived at in 1992.

Chairman: I take that as your opening statement and I now ask the members, Deputy O'Keeffe.

Deputy O'Keeffe: Dr McKenna, thank you for responding to our invitation to come to advise us. Could I deal first with one of the options that is presented to us in the Green Paper and that is the proposal that there should be an absolute ban on abortion. Do I take it from your evidence that in certain circumstances where the life of the mother is at risk an abortion is, in fact, carried out?

Dr McKenna: Yes, I think I can say unequivocally that possibly once a year a woman would be seen in this country who, if her pregnancy is not terminated within a matter of probably hours or days, will die from a complication. The complications that I would allude to would be the one which we have personal experience of recently and that is, fulminating high blood pressure associated with heart failure, associated with a molar pregnancy and a live, an ordinary ongoing pregnancy, a most unusual condition, one which I will probably never ever see again. But the only way in which that woman could be stopped from dying of heart failure that day was by terminating the pregnancy. Other hospitals which you have probably heard about this morning or will hear about have had not dissimilar experiences that needed immediate attention.

Deputy O'Keeffe: Dr McKenna, you have been prepared to openly state the facts from your own experience in this regard.

Dr McKenna: Yes.

Deputy O'Keeffe: Could I ask you if there has been any reaction to that open statement of opinion on your part?

Dr McKenna: Well, I must say I was flabbergasted at the attention that those remarks received because to me they are nothing more than stating facts. They do not necessarily in any way state my opinion on the subject of abortion in general. They simply say that if these women didn't have their pregnancies terminated they would die and that is a medical fact in my opinion. I was extremely surprised at the interest that these comments generated and I was

also surprised at the reaction that these comments have generated in some members of the public who would feel that I am crusading for an open-door termination policy. I have certainly, on foot of those comments, received many anonymous letters and the occasional anonymous telephone call.

Deputy O'Keeffe: Have these 'phone calls been of an objective nature or have they tended to ....

Dr McKenna: I suppose most euphemistically you could say they are people who have very deeply held beliefs and, as you probably would agree, the more deeply you hold a belief the less rational you are likely to be.

Deputy O'Keeffe: Just on that very issue then one of the options before us, as I say, is that we would further amend the Constitution to introduce what is called an absolute constitutional ban on abortion.

Dr McKenna: Right.

Deputy O'Keeffe: Could I take it that if that route were followed that the type of medical practice to which you refer which you say is necessary in some rare instances ....

Dr McKenna: Well, I ....

Deputy O'Keeffe: .... would not be constitutionally permissible?

Dr McKenna: I think one of the reservations I would have about that is that when the first referendum on abortion was held we were reassured that people were never seen but for example cancer of the cervix in pregnancy and then when it did come up that they were seen, this was called treatment. It wasn't abortion it was treatment and the same for these cases to which I am referring now where you have got to terminate the pregnancy. It appears that if you are acting in good faith and that you are absolutely correct the woman would die that that is then referred to as treatment not abortion. Personally, I think that you are better to be up front and clean about this and say that the pregnancy is being aborted. That is the treatment. It's not that it is a side effect of the treatment, it's not that it's an unintentional side effect of the treatment. The treatment is you end the pregnancy. That is I think abortion. Therefore, putting a total constitutional ban on abortion will inevitably maybe not this year, maybe not next year but the year after next …… inevitably somebody's life is going to be put at risk, if they don't leave the country either the doctor is going to have to break the law or the woman is going to die. I would be absolutely unequivocal about that.

Deputy O'Keeffe: And that woman will die because the type of practice which is now carried on in our hospitals in such extreme cases would no longer be constitutionally possible.

Dr McKenna: I would have to say that even if that were the law and I was faced with the option of breaking the law or doing what, not only just myself, because nobody would undertake any of these procedures without fairly widespread consultations with their colleagues, but if I felt that the woman was going to die I would probably prefer to break the law and then argue the issue afterwards.

Deputy O'Keeffe: Could I explore one other area with you, doctor, before my colleagues will raise their issues? This is the question of the foetal abnormalities.

Dr McKenna: Yes.

Deputy O'Keeffe: Could I go into that in a little more detail with you. You say that about 5,000 women and girls go to England every year for abortions ....

Dr McKenna: Yes.

Deputy O'Keeffe: .... of whom about 50 would be those with foetal abnormalities.

Dr McKenna: Yes.

Deputy O'Keeffe: Putting it bluntly, how would those foetal abnormalities be dealt with here according to established practice in Ireland?

Dr McKenna: I am unaware of any hospital or institution that has ever terminated a pregnancy in this State because of foetal abnormality.

Deputy O'Keeffe: Taking it one step further then, how do you suggest that the law should be changed, in any way, to change that practice on foetal abnormality?

Dr McKenna: There are two alternatives, one is that the law would be changed to allow to terminate pregnancies in the face of serious handicap. That is an enormous and seismic shift in this country if such a law were to be allowed and I would have to say that I am far from sure what is the correct thing to advise. I mean I just haven't even thought that far myself but what I would suggest that we do arrive at, is that in those cases where this is necessary that we have all the mechanisms in place, that these people can be referred to the correct places, that cost is not an issue, that safety is an issue and that their future wellbeing and their future reproductive health can be discussed openly, that they be given the best advice. That would be my more immediate concern rather than advising that we would so enormously change to termination on the grounds of foetal abnormality.

Deputy O'Keeffe: Would you distinguish between foetal abnormalities of what might possibly be called a relatively moderate degree as opposed to those of a profound degree?

Dr McKenna: I think that there are no – anencephalics do not survive and consequently one does not offend anybody if they are singled out for, as it were, special mention. However, there are many survivors of some of the conditions that would travel for termination and one has got to be very careful about the legitimate feelings that people would have on this subject. If you were going to advise to terminate abnormal pregnancies in this country

– foetal abnormal pregnancies in this country – I would have to give that a lot of thought before saying where I stood on that issue.

Deputy J. O'Keeffe: Would it be correct to interpret your view that you believe it is an issue to be considered but you are not giving a strong view either way on it?

Dr McKenna: This is one area where I really do feel quite inadequate to advise people on. The repercussions of advising people as to whether they should travel to have a baby with Down's Syndrome terminated or not are so huge that I would feel, as I say, really inadequate to give that advice. That is a case where the parents have got to make the decision themselves. I simply do not know that the people or the hospitals in this country could make that step yet.

Deputy J. O'Keeffe: Thank you.

Chairman: Just one matter arising: In the case of a lethal abnormality, do you have any view?

Dr McKenna: Well, it does certainly seem fairly pointless that if somebody has a lethal congenital abnormality where you know the baby is not going to survive, that whether they like to or not, they are subjected to a full pregnancy.

Chairman: Thank you. Senator O'Meara.

Senator O'Meara: I want to pick up on that point. It seems to me that you would make a distinction between, say, a pregnancy which had no possibility of … a foetal abnormality which had no possibility of life outside the uterus and that which does so. Maybe, if I put it in a specific context … what would your view be on the availability of termination – abortion – in Irish hospitals for pregnancies which have no possibility of life outside the uterus?

Dr McKenna: Well, I think that would be a welcome option for many of the mothers who have such conditions diagnosed.

Senator O'Meara: And as a practitioner what would your view be on it?

Dr McKenna: Well, I can certainly understand their decision if they decided that they wished to have the pregnancy terminated, yes.

Senator O'Meara: From a medical point of view it has been put to us that the fact that abortions in these cases take place abroad means that, from the point of view of say yourself as a practitioner, you would not have the opportunity to study a post mortem and provide other information. Having the availability of conducting the abortion in your own hospital would give you that possibility and then would supply more information if it was wanted?

Dr McKenna: That is correct. It is not that long ago – it is possibly about 18 months ago – that I got a telephone call from an official in the Department of Health and Children concerning a woman whose baby did have a lethal congenital abnormality and who was travelling outside the State. It was felt appropriate that that baby would be brought back to the country for a post mortem and the official in the Department of Health and Children had the dilemma as to how to advise that woman to bring the baby back. Should it be declared and then coffined and flown back as a dead corpse or should it be brought back, almost surreptitiously, as hand luggage? That is the sort of practical distasteful dilemma that we are currently working in. I did not know the answer to the question, I should say, and neither did the officials in the Department of Health and Children when I was speaking to them. But the practical problem was landed with the family and I do not think it is being unduly over-dramatic to say that is not the sort of dilemma that somebody who has lost a wanted baby needs or wants.

Senator O'Meara: Can I ask you, in relation to the 50 or so cases that you referred to – about 50 a year – of foetal abnormalities where mothers would travel to Britain for abortion, they would not all be cases where the foetus would be non-viable?

Dr McKenna: No. When I say 50, that is a guesstimate. I would again guess that the majority of those would be chromosomal abnormalities.

Senator O'Meara: Such as?

Dr McKenna: Such as Down's Syndrome, which, of course, can have a relatively normal life expectancy, or other chromosomal abnormalities most of which do not have a long life expectancy.

Senator O'Meara: In the case of those pregnancies would the parents receive counselling and information from the hospital?

Dr McKenna: Well, I would have to say that we are probably a little bit guarded as to what advice we can give, or we feel we can give. What I would like to move to is a situation where we could discuss this openly, we could say, 'the Department of Health and Children has negotiated a contract with a preferred hospital in the United Kingdom, this is the route, if you have got to leave the country this is what you do and this is what will happen, we will see you, we will have a copy of the post mortem when you come back'. At the moment it is a little bit under cover.

Senator O'Meara: So, you would like to be able to refer patients, in effect, where they choose to take that route.

Dr McKenna: Almost … indeed, that this was done at an official level, that we could go and buy services officially or it would be done for us, that parents could go to such and such a hospital. Many of these terminations are done privately where cost is the major consideration. As I say, that is not the sort of pressure that you want people to be put under. You would like them to get into a system that can look after them carefully and comprehensively.

Senator O'Meara: So I take it that the parents would arrange those terminations themselves?

Dr McKenna: Usually, yes. We would certainly give them some pointers but, as I say, one has got to be a bit circumspect.

Senator O'Meara: The 1995 legislation arising out of the 1992 amendment on information does allow for a situation where doctors can give information.

Dr McKenna: Yes. That is not quite the same as a direct referral where you would, for example, speak to somebody and arrange 'you go here at such and such a time'. I appreciate that there may not be a huge division between information and referral but it is a distinction that has been made in the past.

Senator O'Meara: Can I return for a moment, Chairman, to the X case? You made a comment on it which I wanted to explore a bit more if I could. I understood from your comment that you were taken aback … you were surprised at the court judgment in the X case and I wanted to ask you about the legal situation now arising as a result of the X case and the C case where the courts have determined that a risk of suicide is a serious enough illness to allow for an abortion to take place legally in this country. Obviously, they are hugely significant cases in the context of this whole area. What is your view on that and on the issue of suicide as a risk?

Dr McKenna: First of all, I was not surprised that Miss X was allowed to leave the country but I was surprised at the grounds on which she was allowed to leave the country. I would have thought that it would have been less contentious on a right to travel. I felt that the evidence presented from the suicide point of view was not challenged, for whatever reason. In other words it was not subject to scrutiny by a second or indeed a third opinion.

Senator O'Meara: I know you are not a psychiatrist or a psychologist and we have been told that the risk of suicide or the incidence of suicide among pregnant women is very low ....

Dr McKenna: Yes.

Senator O'Meara: .... probably lower than in the non-pregnant female population. But in the case of a teenager who has been raped – or indeed any woman who has been raped – and is then effectively, under the law, being asked to carry that pregnancy to term against her will, that situation is clearly very different than, we will say, in a situation where one might be depressed.

Dr McKenna: It is clearly undesirable but that doesn't mean to say that the girl is depressed. Your statement or question almost exactly echoes the question that I was asked at the time, that is, 'Is this girl depressed?' I said, 'No, she is upset, she is tearful but so would I be if I was 14 and I was in London waiting to have a termination and my father got a telephone call to say that unless I came back to the country I would be, or the family would be prosecuted on our return.' That is going to upset any individual or any family but that's different from being depressed. That family, the individual is subject to enormous pressure but that is not always the same thing as being depressed.

Senator O'Meara: I take it and indeed judging from other evidence that we have heard and other comments that we have been presented with it is very, very rare, if indeed it does not happen, that women present suicidal.

Dr McKenna: In medicine it is very dangerous to say things don't happen. I certainly was of that opinion but last year – the first time again – we had a woman – I had never seen it before – was brought into hospital, attempted suicide quite far on in the pregnancy, and it was a very serious suicide attempt, so it can happen. When you are dealing with humans you simply can't say it never will happen. I think you are probably on fairly safe ground to say though that the incidence of suicide in pregnant women is less than in the non-pregnant female population of a comparable age. I think that probably is true but that's not the same as saying no pregnant woman will ever seriously commit suicide.

Senator O'Meara: Thank you very much, Dr McKenna.

Senator O'Donovan: I have just a couple of queries. I am referring to the evidence or submission by Professor Bonnar yesterday, particularly arising out of questions put to him by Deputy McManus. We went on to discuss these unusual situations like ectopic pregnancies and where there is cancer and this unusual situation where a woman had a serious heart condition. In his reply – his reply was, 'If you are referring to these interventions such as occur in pre-eclampsia or ectopic pregnancy as abortion to me there is something wrong with the term and you need to get a clearer definition.'

One of the difficulties facing me as a lay person is that you are the fourth person who has come before us. We have listened to all the various views and I am very much grateful for the knowledge that I am extracting from every submission. What puzzles me is that there seems to be a different emphasis on what each of you in your own different way have put on abortion. Your view, from what you say, is that any termination, technically is abortion but as I understand it, either under the old legislation, the 1861 Act or in any legislation since, the word 'abortion' has never been defined legally. Is there a different emphasis and, if so, is there any common denominator? I accept from all of you that there is a common trend of a very strong ethical moral code that in most instances, almost in every instance where possible, you strive in your professional capacity to protect the lives of both persons but in extreme instances this is not possible.

To move on from that, I grew up in a rural Irish society, prior to the original referendum, going back, say, to the 1960s and 1970s I understand that these problems also came up at that time and maybe different terminology was used. In other words, if we left well enough alone before the 1983 referendum and the subsequent X case, were the provisions in the old Constitution adequate to deal with what was existing practice and, if so .... I gather from you that you would prefer to see legislation to change what is now not a very satisfactory position from your point of view professionally, to change the law so that, I suppose, you are protected from actions of malpractice

or otherwise and if such law .... As I understand it, even if we as a group or the Oireachtas brought in legislation, I would foresee a challenge to the legislation before the Supreme Court as the Constitution currently exists arising from the amendment in 1983. What would your view be on that?

I put this question to others and the general trend seems to be that not alone would we require up-to-date legislation to deal with an unsatisfactory position and to clarify these issues but also I think the three other medical witnesses suggested that we may also need clarification by way of referendum, that the existing situation, particularly as a result of the fall-out of the X case, which many people, including me, felt was unsatisfactory, or the decision wasn't very clear .... Is it your view that we need both or would legislation be sufficient? There are two different issues. The interpretation is rather a concern for me and the abortion ....

Dr McKenna: There are actually more than two there, I would have thought.

Senator O'Donovan: If you can reply to them, I'd appreciate it.

Dr McKenna: I suppose the term 'abortion' – in the Green Paper the term 'abortion' is conspicuous by its absence in the glossary of terms for definition, I think. I don't think it is actually there and that is, I would agree with you, a difficulty. As I said earlier, there is no disagreement between me and some of the other people as to what you should do, but there is a degree of difficulty over what you call that procedure. That is the stumbling block. I would take the point of view that if the treatment is aimed primarily at terminating the pregnancy, that is an abortion and I would feel it is semantics to say otherwise but if the word isn't defined for the purpose of these discussions, their definition is certainly as good as mine but that's what I would call it.

Secondly, you were saying what do I think – what's the way to go forward. All I can do is reiterate that I feel some of the options outlined, such as an absolute ban on abortion or enshrining the C case judgment in the Constitution, I don't think they are satisfactory but I honestly don't think that I am in a position to advise you or any Member of either House as to what is the correct way of dealing with this sensitive issue. I would however feel that possibly the cat was let out of the bag in 1983 with the original one and maybe that wasn't the way forward really in retrospect.

Senator O'Donovan: As a follow up on that, it's obvious from what I am hearing, in the evidence that I have heard to date – I don't want to drag this out – that there seems to be several common denominators but one thing that comes across to me from all of you – you are the fourth witness – is that there is a need to categorise by way of legislation or constitutional amendment those exceptions that some people term 'abortion', others say … I think they use the term 'treatment' or 'medical procedure' to save the life of the mother where it appears at that juncture the lives of both parties are at serious risk anyway. That's an area on which I would like your view. Maybe it can be done by way of legislation or maybe it should be enshrined in the Constitution that there are five, six or seven known symptoms that may be added to.

Dr McKenna: Again, I don't want to .... I really don't think I am in a good position to give advice outside of my area and as to how best to proceed on this. That is something I would need to have explained to me in greater detail and I would need to think about.

Senator O'Donovan: A question I put to somebody else – this is my final point – is that, particularly in the last decade or so, there is an ongoing trend, somewhat like that in America, of huge medico-legal cases stemming up in this country. Obstetrics and gynaecology is an area that I am sure is not exempt from such claims. I wonder whether it would be much more secure for somebody in your position to say, 'Look this is spelled out clearly either in a constitutional referendum explaining A, B, C, D etc.' where the word 'abortion' can … that you're exempt from liability, so to speak, or else by way of legislation. Would you see that as a safeguard? I put this to you from your professional point of view rather than … I am not trying to entrap you into a legal ....

Dr McKenna: No, I appreciate that but I am afraid I would still have to say I don't know that my opinion is worth any more than anybody else's as regards how to move this forward. I really feel that, probably, the expertise resides in these buildings. Possibly I'd go further to say that you're to be congratulated in attempting to address this matter. If this is addressed correctly the body politic will stand to gain enormously and will claw back an awful lot of respect that people wish to have for their elected leaders. I wish you all the very best in how to achieve it.

Senator O'Donovan: On the one hand, we are learning a lot by meeting people like you and I think that we're probably going down the right road. We have a lot to learn as well. To move in any direction, either by way of legislation or referendum, without having this forum we would be making an error because we are lay people, by and large. Thank you.

Chairman: Before I permit further questions, can I summarise one point that seems to be clear from your evidence. You are happy to assist the members with your clinical experience, your experience as master of a very busy maternity hospital in Dublin, but you don't really want to be asked questions about legislative solutions. Is that a fair ....

Dr McKenna: I don't really think that my opinion is much better than anybody who you'd stop outside on the road and ask. If I thought I was going to be asked that I certainly could bring suggestions to you, but, at the moment, I really don't think that my opinion carries any weight whatsoever. I have never been involved in legislation.

Possibly just to clarify a point, you mentioned about medico-legal matters and obstetrics. We're not caught up in it. We lead the field by 20 lengths. It costs about £70,000 to insure an obstetrician/gynaecologist in this country. I hope that, possibly when you have managed to sort out this problem, you might turn your attention towards that one and help us a little bit as well.

Chairman: You will be glad to hear that Professor Bonnar raised that problem with me some time ago.

Deputy McDowell: Before you move off that issue, because I accept what is being said and I think it's fair, I would just like to make one point. I appreciate that I am skipping the queue a little bit but perhaps we can bring this one to some sort of conclusion. If we take the route of, let us say for the sake of argument, legislation, the major decision which the Members of these Houses have to make is the nature of the legislation. What I mean by that is whether it is prescriptive or whether it enables doctors to make decisions. That is to say, whether the Legislature goes about trying to define, as the Senator in front of me was saying, the circumstances in which doctors must make a certain decision or whether it simply says terminations of pregnancy may take place where a doctor is of the view that this is appropriate in the circumstances. It is fair to ask you whether you would wish to have the discretion.

Dr McKenna: I would certainly subscribe to the point of view that the taking of human life, under whatever circumstances, is an extremely grave matter. I see nothing personally the matter with you setting the framework and having each and every case reviewed on an individual basis with an answer, if necessary, within 24 hours. That can be arranged.

Deputy McDowell: I'm sorry I don't quite understand that. You're not suggesting that we set out in statute law the various exceptions, are you?

Dr McKenna: No. Well, I'm suggesting that a framework is set out under which, if a case comes up, it can be reviewed as a matter of urgency by a body of your nomination which could be judicial, medical or a mixture of both.

Deputy McDowell: I see. Thank you.

Dr McKenna: It was beaten out of me.

Deputy McManus: I would like to ask you about the Medical Council guidelines. I would like to thank you for coming before the committee. There was some concern expressed this morning by the master of the National Maternity Hospital in relation to the Medical Council guidelines. Are you satisfied that the judgment that you apply now in terms of termination of pregnancies to save women's lives, that is not in any way curtailed or constrained by the Medical Council guidelines?

Dr McKenna: I'm sure that what we do is within the spirit of the guidelines. I suppose I can't answer you specifically – are they covered precisely and exactly – but there is a difficulty in asking people in authority for permission to do things which you've got to do anyway. What do you do if they say no?

Deputy McManus: Is that your view in relation to legislation, or the lack of legislation at the moment – that you have to do what you have to do?

Dr McKenna: The answer to that is yes. We're not now going into the … we're staying well away from the foetal abnormality issue here. We are talking about the one or two women a year who will die. These are women who are so sick you can't actually get them out of the country. I am not talking about people who have, say, Eisenmenger's heart disease that are well enough to leave the country. I am talking about people who are in a bed and who are so sick that you can't move them.

Deputy McManus: In terms of general policy in the hospital, the old idea of the indirect and direct abortion was prevalent in terms of treating, say, ectopic pregnancies or cervical cancer. I take it that nowadays, in terms of dealing with ectopic pregnancies, you don't unnecessarily remove organs and that you use medication or the system of removing the products of contraception. There isn't an ethical issue in so far as it's what is appropriate for the woman, is that right?

Dr McKenna: Yes, there are no ethical restraints in dealing with ectopic pregnancy.

Deputy McManus: Very good. Could I ask you a more general question and I think you have raised very interesting issues? There has been a tendency with the presentations to us to give very much the doctor's perspective and that is only natural. You have actually widened it out to an extent to include the woman's perspective, for example, where there is a serious abnormality and the experience of somebody who actually goes abroad to have an abortion. That hasn't been dealt with in any way before. Most women going for abortions do not appear to seek medical advice, but do so, as you say, outside the loop. They go secretly, they come back and do not necessarily get any medical care afterwards. There is a problem there. Does it concern you that a large number, thousands literally, of women are travelling for medical treatment outside this jurisdiction and doctors here are not in any way dealing with this either to try and attempt to reduce the level of abortions or to counsel or to deal with the after care? If you are talking about referrals on an official basis, and I think it's a kind of compassionate approach, the logic is, eventually, that you cut out the travel, that you have a facility here, surely?

Dr McKenna: I accept the logic in that, yes.

Deputy McManus: Do you want to say anything generally about the situation?

Dr McKenna: Generally, I suppose that one reason why I would mention, particularly foetal abnormality, is because I feel that it would be irresponsible of me not to do so. The reason for that is that, in the Rotunda we operate a diagnostic amniocentesis service where we set out to provide women with information. So, we probably do more than just find these abnormalities along the way. We actually offer a service to people who are concerned, or who have grounds to be concerned, that their baby is or isn't normal. So, for me not to, as it were, represent in some way the voice of those people that have abnormal babies diagnosed I feel I would not be doing my job correctly. That is why I draw the distinction between

the small number who are diagnosed as having foetal abnormalities. In other words, I'm saying that's my business. I personally don't do it but that's what we do and we set out to do that. We set out to offer a service, whereas the 5,000 women who leave the country for a termination … they actually don't come near us. Consequently, whereas it is not something that I am in any way proud of and I think it is a national … is one of the figures that we should be ashamed of … but it isn't actually in my business. I don't see them, I don't deal with them. I hardly ever even have to deal with the complications that arise. So it is not something that impinges on me and I feel very comfortable in drawing a distinction because one is my business and one isn't. But, if you were to look at that from a moral or any other point, I can see that that is a fine line. That's a difference for Peter McKenna, but I am comfortable in dealing with it that way.

Chairman: Deputy Kirk.

Deputy Kirk: It strikes me as being a very useful exercise – our discussion so far today. If I might ask Dr McKenna – the issue of the special medical circumstances where the decision has to be made between the life of the mother and the life of the baby in the uterus, statistically how often does this decision arise from a professional point of view?

Dr McKenna: Well I don't think that that decision has ever … I mean if the mother dies, so too does the baby.

Deputy Kirk: Yes, but the decision has to be taken to terminate the pregnancy to save the life.

Dr McKenna: Right, okay. Well I would estimate that that probably arises once or twice a year in Ireland and there will be say 56,000 babies born in this country each year, so you are probably talking in terms of one in 50,000, one in 25,000. You are talking about a tiny number of cases each year.

Deputy Kirk: A total constitutional ban on abortion, from a professional point of view what are the implications?

Dr McKenna: Well the implications are that if you couldn't get those women out of the country, you would either have to break the law or let them die.

Deputy Kirk: In your opinion, is it possible to provide in a constitutional amendment for the special circumstances which both yourself and previous witnesses have referred to?

Dr McKenna: Is it possible to?

Deputy Kirk: To provide in a constitutional amendment.

Dr McKenna: I don't regard this problem as insoluble and I think that it has got to be solved. I just doubt my ability to offer you advice dealing in a matter outside of my area at the moment.

Deputy Kirk: You see, the committee has the difficulty, and it is a difficulty. At the end of the day you are the person or whoever will be making the professional decision, and that person has to make it in the context of the constitutional position that obtains at that particular point in time on the legislative position. On the basis of experience, there must be some views which have been formulated on the issue at this stage.

Dr McKenna: Well I suppose that … I'd still, I'm afraid, have to come back to what I've said before, that I'm not so sure I could offer you off the cuff advice as to how to frame such a statement.

Deputy Kirk: The problem, from the committee's point of view … we'll obviously have people from the legal ....

Dr McKenna: Yes.

Deputy Kirk: .... profession coming in here and they will deal with the constitutional, they'll deal with the legislative provision. They will say, the decisions have to be taken by different professionals in individual circumstances in maternity hospitals around the country, and that is a huge, huge problem and it doesn't leave the work of the committee any easier if they can't get at least opinions on the issue.

Dr McKenna: Well I think what you have seen, as I understand it, from all the expert advice that you have had to date is that: (a) these conditions do arise; and (b) how they should be dealt with, so I think that there could be no difficulty in saying that in a case that where the pregnancy was allowed to continue the mother's health was put at very serious risk or there was a threat of death to the mother, that under those circumstances the pregnancy is allowed to be terminated. Now that is putting it simply.

Deputy Enright: I ....

Chairman: Well I was going to ask Deputy McGennis and then Deputy Enright ....

Deputy McGennis: Thanks, Chairman. I suppose mine are, at this stage, more observations than direct questions but if I could make them, maybe there is space for some sort of response. Yesterday when I spoke, the first thing I said was that it was regrettable that we did not have a definition of abortion in the Green Paper. I have to say, by this afternoon I would be, maybe not as confused or maybe more confused. Like I said, sort of jocosely before lunch, when is an abortion not an abortion, and one would be tempted to say at this stage – it depends on who is giving … what witness is appearing before the committee. Yesterday the two specialists who spoke to us absolutely emphatically stated that the procedures they carried out were not abortions and were medical procedures. Now, the title of the documents we have in front of us are 'Medical Hearings on Abortion', and maybe we might need to amend that now to say 'Medical Hearings on Abortion/ Medical procedures' because if we decide – and I know you have made it quite clear that it is not an area you intend getting into but unfortunately it is one that we have to get into – if you were to put something as emotive

as a constitutional referendum or legislation before the people on abortion, you could nearly anticipate what the response is going to be but if you put that same legislation or that same proposal before people and you call it a medical procedure, it automatically changes, the response that you are going to get. If you were here today saying that there were absolutely no circumstances in which it is necessary to perform a termination or an abortion, but obviously in the context of a medical procedure things happen, as was said … I mean if I were to run by you there, one of the witness yesterday said 'You simply split the tube [and] … then nucleate the foetus, the placenta and suck it out.' That sounds very much like the kind of banners that would be outside the Dáil today ....

Dr McKenna: Well that is an ectopic ....

Deputy McGennis: .... depicting – I know it is an ectopic – depicting what we might, what I might understand is an abortion. So, my concern would be that if doctors differ, patients may die and, in fact, the person who was here before you stated that quite clearly.

It just happens, by co-incidence, that this day 22 years ago I was in your hospital giving birth to my second child. I was very lucky in that it was a healthy pregnancy and there were no problems but, as I mentioned to the doctor here this morning, if I had the kind of rare, very rare – and I would accept that they are extremely rare – conditions that were described by him and again, I think, by yourself to a lesser extent, then I would be in danger and could be in danger of dying if the doctors who gave evidence yesterday took the view that there was never a case for an intervention, which is a medical procedure which isn't an abortion … if you follow what I'm saying. So I think we already have a problem in that one side of the argument is saying 'This is not abortion', whereas maybe more openly and more honestly another side of the debate is saying 'Yes, it is. It is not direct abortion. It is not simply abortion to kill an unwanted foetus; it is there as part of a medical procedure', but I think we need to actually have that said.

Dr McKenna: Well I don't think I could say it any more clearly than I have done.

Deputy McGennis: Yes. Well then I suppose my only question to you is then when I asked one of your colleagues yesterday what he felt about people who would absolutely disagree with their view that it was never necessary to carry out procedures to save a mother's life – it is actually in print for us now; it wasn't this morning – he stated that they weren't obstetricians or gynaecologists probably. Now I mean this morning's witness was; you very obviously are again, and I think we have a lot of work to do.

I know the other question is not related to that, but I am very concerned about the medical issues around women's health and that if we start calling what I think I would understand to be a medical abortion, if we start calling it a medical procedure and if we then have an absolute ban – and I asked the first two witnesses and this morning's witness as well – and if we have this absolute ban on abortion, that in fact there would be a danger to existing practices. And I think that your colleague, who spoke before you this morning, stated in fact that already members of the medical profession feel exposed within the law. As I say, I do not know if those are questions or if it is just my observations so far which maybe you might like to respond to.

Dr McKenna: No, I can understand your confusion. The procedures, which I have referred to as abortion, may be referred to by other people as treatment. Now as I have said before, I think that if the treatment is to empty the uterus, I can't think of any more apt term to call that than an abortion. It doesn't imply that you want to end the life of an unwanted baby; it is simply a description of what you are doing. And it may be quite as simple, the difference may be quite as simple as somebody being able to say to themselves well there is no abortion in Ireland. That's, you know, where we can all rest assured in our beds at night. But I wouldn't take that point of view. I feel that if there is a problem, why not name it and address it and try to deal with it in a way that people can understand? I don't think that not calling it that really clarifies it. I mean one of the consistent threads that I do get in the mail is that I am 'muddying the water'. I'm only muddying the water for people who don't think clearly, I think.

Deputy McGennis: Just I suppose then to make the point again. If these hearings were called here medical hearings or hearings on medical procedures, then we might find ourselves in a different position because the very fact that we use the term 'abortion' means that, you know, nearly predictably, you're going to get a response which is negative. But if you were to have this debate around medical procedures which are necessary to save women's lives, in fact, it mightn't be so clearly ....

Dr McKenna: Well yes, I would agree. I think that nothing that's going to come out of this is going to really impinge dramatically on the 5,000 women who leave this country each year for an abortion. And I think it's possible people may have expectations of the findings of this that are different from what it could possibly find.

Chairman: Fortunately, Deputy, when the Government referred this document to us, it was described as the Green Paper on Abortion, not as the Green Paper ....

Deputy McGennis: We were told categorically yesterday there was no such thing in the terms of ....

Chairman: Well, not as the Green Paper on medical procedures. Deputy Enright.

Deputy Enright: Something we should do is thank you again for coming in, Dr McKenna. You are very welcome. On the very last point about the 5,000 people who leave Ireland annually, as you said, it's sad, tragic and it's really a national scandal as well that people feel they have to leave Ireland for one reason or another. We are supposed to be helping to formulate guidelines for the Government. We will report back to the Government with our findings and the Government is then obliged to consider whether or not to legislate, or whether to go for a referendum or a combination of the two. But one of the things I presume will be allowed is to put in some sort of a recommendation as to how, in fact, we can perhaps reduce the 5,000 people

who are leaving Ireland. We have skirted around it a small bit. Do you see any solution? One of the things that comes across clearly is that a lot of the people who leave Ireland and have abortions overseas are psychologically and psychiatrically affected for life. In fact, a lot of them have major problems later in life, and I think we should be pro-active in trying to see how we can maybe put forward some kind of viewpoint and some kind of help to try and assist those, whether through their ordinary GPs, the people they're meeting on a day-to-day basis, whether it can be an education policy and so on. There are a lot of reasons, social reasons are recalled, but they're very varied and I think there certainly should be some way we can devise to try and reduce that number. I'd like you to think about that.

Your colleague this morning – I'll be brief on this because it's something you may not wish to offer an opinion on. He dealt with the twelfth amendment of the Constitution Bill, 1992, which was not approved by the people. But he felt that that actual amendment was quite good. It was as follows: 'It shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life as distinct from the health of the mother where there is an illness or a disorder.' He felt it was in that area. Now, he said he hadn't thought it through fully as to how he might be able to come up with some kind of a suggestion that would be of help. I'd just like to know have you any views on how that can be done?

Dr McKenna: I'd have to say that's hardly – and I don't mean any disrespect to the person that phrased it – it's hardly a model of clarity and I had to read it several times, even recently, to decide what it actually did mean. It's hardly … it's not really punchy, you know, and what it's at, you'd have to think about several times. And that probably isn't the best way to get people's real feelings, I don't think.

Deputy Enright: Well, the Constitution now wouldn't be exactly … wouldn't read the same as a Jeffrey Archer novel, in fairness.

Dr McKenna: I appreciate that. Maybe I could come back to what you were saying earlier about ....

Deputy Enright: You see the thing is, if you know the Constitution – as you realise, we spoke about court cases earlier, the way judges interpret the Constitution and there are so many viewpoints for and against.

Dr McKenna: Sure.

Deputy Enright: That's why a lot of what goes into the Constitution on occasions people take their own meanings and that's why many constitutional cases arise. So that's why an exact ....

Dr McKenna: I appreciate that, but more and more people are communicating with each other informally in the written medium. And to expect somebody who can divulge their life in an e-mail in an instant to put aside some time to read that, you know it really appeals I suppose to maybe a slightly different generation. There's some effort required in understanding that from beginning to end.

But to come back to the 5,000, I don't think that there is any … on the horizon here, I don't think there's such a seismic shift anticipated that they would not be leaving the country and, consequently, it would make far better sense to try to reduce the numbers leaving. I think at the moment the ground is probably right to attempt to do that. There is increasing prosperity in the country, it can best be done, not just by throwing money at family planning services but by education, starting at a very early age, possibly late primary school and going into early secondary school. And I think that there are steps being done to do that already. But I think that needs to be encouraged. It needs to be fostered and people … the end point of that education should be measured against a fall in the number of people that are leaving this country for termination rather than make it that the sex education is simply an end to itself. I think if you started off with the premise this is why we are doing it, we're doing it to reduce these people, this is why we're spending money on family planning services, we're doing it to reduce the number of people going. I think that if you introduced it with that backdrop, I think you would find great support for it.

Deputy Enright: Can I just say this, and I'll be brief. Again Dr Keane this morning, in answer to a question, said that a lot of obstetricians and gynaecologists feel they're not protected by the law at present. And even though there is a discussion within their own code of ethics, that doctors feel they're on the wrong side of the law and that their own Medical Council is not on their side. Now there was an article by Mr Martin Wall in last Sunday's edition of *The Sunday Tribune*. I'm sure you read it because you were quoted in it. I don't know whether you read it now or not. It reads, 'Dr Peter McKenna generated much debate when he revealed in an interview with The Sunday Tribune that abortions were being carried out in Irish hospitals on women with rare medical conditions where a continuing pregnancy would endanger their life.' Now I listened carefully to what you were saying. I think that what you were saying certainly to me seemed eminently common sense and reasonable and fair. The article goes on:

> In a series of lengthy interviews in 1994 senior figures on the medical profession's governing body, the Medical Council, suggested that it did not believe that there were any circumstances in which an abortion would be required to save the life of the mother.
>
> After the publication of an ethical guide for doctors by the Medical Council in the mid 1990s, obstetricians considering carrying out abortions in Ireland were effectively warned that they would have to prove there was no other form of treatment available to deal with the medical condition other than a termination. Personal opinions would not be acceptable: doctors would have to produce hard scientific facts or face possible disciplinary sanction.

The area there … your Medical Council don't seem to have been supportive in 1994.

Dr McKenna: Again, I suppose it depends what you call what we're talking about, whether you call it treatment or whether you call it abortion. I mean I'm perfectly happy and I'd stand over it, that there was only one thing and one option in the cases to which we have been referring

this afternoon and this morning. There simply was no other option.

Deputy Enright: To conclude, and I will be brief. They say there are about 56,000 babies born in Ireland each year and one or two have these rare conditions. Is that the case?

Dr McKenna: That is all.

Deputy Enright: That is what you are saying – one or two.

Dr McKenna: Yes.

Deputy Enright: In the event of legislation being introduced, you would be happy if it was introduced just to take account of allowing people such as yourself to proceed with your work and your profession – if there was legislation to tie down matters in this area legally and properly.

Dr McKenna: Yes.

Deputy Enright: Thank you.

Deputy McDowell: I will be relatively brief. To start with Dr McKenna, could I ask you, maybe a general question. I think it is the stuff of popular belief in this city that the Rotunda is a more liberal, dare I say a Protestant hospital, and Holles Street would be a Roman Catholic influenced, more conservative hospital. Is there anything in that and are there differences in practice between the two hospitals that you know of?

Dr McKenna: Yes, there are differences in practice. There is a difference in obstetric practice, in other words how we manage pregnant women, which has absolutely nothing to do whatsoever with ethics. For example, it would be commonly known that the caesarean section rate in our hospital would be about 24%; it would be almost half of that in the National Maternity Hospital. This has nothing whatsoever to do with ethics. So, there are medical differences.

In the past I suspect there may well have been ethical differences, such as a different approach to, for example, female sterilisation. I do not think that difference exists at all at the moment. We do have an in-vitro fertilisation service and it is possible that the ethos of the board let that develop and let that grow up at a time when it may not have been able to do so in other hospitals. But, I have no doubt there will be little moral or ethical objection to that being done in other hospitals at the moment. There really is very little difference.

Deputy McDowell: But, in the area that we are basically dealing with here – you mentioned amniocentesis earlier, which is obviously one area which borders on it – are there any other areas of difference in terms of practice at the moment that you are aware of?

Dr McKenna: I am trying to think of some and I cannot really think of any. No. Is there something that you are getting at that I am not ....

Deputy McDowell: No, there is not. I wanted to ask you about one specific issue which I again mentioned to Dr Keane this morning. One of the options canvassed in the Green Paper is what you might call a liberalisation of the law to deal for example, with cases of rape and incest. I think it is generally accepted that people, women who have been the victims of rape are unlikely to present in the first instance to a hospital; they are more likely to go to a rape crisis centre or something of that kind. I asked Dr Keane this morning and he said that he had never come across a case in person ....

Dr McKenna: That is another difference between the two hospitals.

Deputy McDowell: That is what I was going to ask you.

Dr McKenna: We house the sexual assault treatment unit. I had actually forgotten that because I do not see that as an ethical consideration. The sexual assault treatment unit is there to gather forensic information for the Garda in order that they can effect prosecution. It is not really there as a long term counselling service to counsel women who have been raped. It is there to gather evidence. But, I did inquire, and, certainly, there have been pregnancies resulting from rape, not necessarily in women who have presented to us in the immediate, say, 42 hours after the attack when we could have got forensic evidence and also could have offered them post-coital contraception, but these are people who have come subsequently and who have been pregnant, so it does have ....

Deputy McDowell: Have any of those looked for either advice on or effectively referral for termination or, for that matter, even sought termination in the hospital?

Dr McKenna: Well, I can tell you with absolute certainty that none of them have been terminated in the hospital, but in formal discussions there are only two or three of these and if you can split three 50/50, one has decided to continue and two have decided to travel abroad for termination.

Deputy McDowell: What is you own ethical view?

Dr McKenna: On that?

Deputy McDowell: Yes.

Dr McKenna: Well, the difficulties of including rape as a reason for termination are well outlined in the Green Paper.

Deputy McDowell: Sure, yes.

Dr McKenna: One of the other questions that I asked is what is the length of time between a victim being seen in our sexual assault treatment unit and a prosecution being brought? The answer is that the time span has recently fallen from five or six years to two or three years. Now, what are you going to take as the evidence of rape? Are you going to take the doctor's word, are you going to take the garda's word, are you going to take the victim's word, or are you going to wait for the verdict of the court to come through?

Deputy McDowell: I think that is a fair point, Dr McKenna. As you rightly point out that is in the Green Paper, but I actually asked you as to what your own ethical view would be, assuming that it can be established that, say with some degree of certainty, the woman concerned has in fact been raped or been the victim of incest?

Dr McKenna: I would have to say that if it happened to a member of my family, whatever their wishes were, they would be effected. Whether they wished to carry the pregnancy or whether they wished to have a termination, that would be done. But, that, again, would, straight away, cut to the heart of the matter. If it was a member of my family I would be dealing with what I would regard as an absolute fact ....

Deputy McDowell: Yes.

Dr McKenna: .... and I would not be waiting for the court verdict. That is not quite the same in the generality ....

Deputy McDowell: Sure.

Dr McKenna: .... where, although malicious accusations of rape are unusual, they do happen, unusually, but they do happen and if this were to be the only criterion that termination could be allowed, one would regrettably be forced to the conclusion that they might happen more frequently.

Deputy McDowell: Yes, thank you.

Chairman: Are there any other questions? No. Dr McKenna, I thank you very much for your assistance to us today. Your evidence has been of great assistance to me and I am sure to the other members of the joint committee. I will suspend this session until the next witness takes his place at 4 o'clock.

SITTING SUSPENDED AT 3.48 PM AND RESUMED AT 4 PM

Dr Seán Daly

Chairman: We are now in public session and I welcome Dr Seán Daly, the Master of the Coombe Women's Hospital. You are very welcome Dr Daly to this meeting of the Joint Committee on the Constitution. We have asked you to speak to us because you are the master of one of the three great maternity hospitals in Dublin. I think you have been circulated with the brief book which you may have had an opportunity to look at. I want to draw your attention to the fact that while members of the committee have absolute privilege, this same privilege does not apply to you. The format of this meeting is that I will ask you to make a brief opening statement which will be followed by a question and answer session with the members. I invite Dr Daly to commence his statement.

Dr Seán Daly: I would like to thank the members of the committee for inviting me to talk to you on what I believe is a very important issue. I thought the Green Paper was a very good document which laid out the issues very well. It was unfortunate that there was no strict definition of abortion in the Green Paper but I am sure that is something we will discuss and I will be happy to discuss that with you.

In terms of abortion *per se*, I would see three broad issues. There is the issue of maternal illness in pregnancy, the issue of congenital anomalies that are diagnosed during pregnancy and, then, there is the issue of woman choice and abortion for woman choice. I think that these are very distinct.

I suppose my own area of interest in obstetrics and gynaecology is maternal foetal medicine. I have spent several years in the US doing a fellowship just dealing with women who are sick during pregnancy or who have pre-existing medical conditions coming into pregnancy and also dealing with foetal medicine, pre-natal diagnosis and therapeutics. I will leave it at that, if that is okay, and take questions.

Chairman: There is one question I would like to put. If you turn to page 127 of the brief book, you will see the letter from the Institute of Obstetricians and Gynaecologists. Are you aware of that letter?

Dr Daly: Yes, I am a member of the Institute of Obstetricians and Gynaecologists and certainly replied to the several drafts that Professor Bonnar sent out with suggestions as to how this submission could be changed. I believe the submission is a good one and I would certainly have agreed with it.

Chairman: I am dealing with questions by anticipation here but it is to clear up a matter at the outset. In the final sentence of the second paragraph:

> We consider that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example for social reasons and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother.

So there is a contrast postulated in that particular sentence and, indeed, I think it was postulated in your own opening remarks. My question is a different one – how do you characterise that essential treatment to protect the life of the mother? Can it amount to a termination of pregnancy in your opinion?

Dr Daly: Yes, I think it can. The medical term 'abortion' that I understand means the premature ending of a pregnancy before the foetus or baby is viable – that can happen spontaneously and, in general, we refer to that as a 'miscarriage' – but that whenever there is a medical condition that necessitates that the pregnancy needs to be ended before the foetus is viable, that is what I would consider an abortion. Now, certainly, there are different indications for it but, broadly speaking, I think that that is

what an abortion refers to. I think that if we go down the road of trying to slice up the term 'abortion', then we are only going to complicate things for ourselves even more. At the end of the day, we do need to be able to practise and if this committee, and ultimately if the country or however it is constructed, decides that there is never an indication for abortion or for the premature ending of a pregnancy, then I certainly believe that is going to make it difficult to practise in the current environment in which we practise.

Chairman: Thank you, Dr Daly. I call Deputy McManus.

Deputy McManus: Thank you very much for attending here today. I think it is very important for us in our work to have your kind of expert input. You cleared up the first question I was going to ask which was on definition. Could I ask, in terms of current practice and the requirements you have to be able to exercise clinical judgment, do you feel there is a need for legislation to clarify medical practice or to support it or to protect it and do you think that the medical council guidelines in any way affect your exercising of that judgment? Concerns were expressed this morning by the Master of the National Maternity Hospital in that regard.

Dr Daly: I think that the current practice … as we practise it at the moment, we do in general deal with the complications that arise. If we have a very bad high blood pressure problem during pregnancy, the treatment for which would be to deliver the baby or essentially to deliver the placenta, then we do practise that. Where it is going to get more difficult for us though is in cases of complex heart disease in the mother where, in essence, what we would be seeking to do is not to treat the complex heart disease but to end the pregnancy in order to reduce the risk to that woman. The medical council guidelines suggest that we cannot willfully destroy a foetus or a baby and, while none of us would wish to do that, ultimately that may be the result of what we do.

I think the whole issue of intent is an important one in that intent can be a double-edged sword. I could claim to be trying to do some heroic therapeutic intervention to a baby and, inadvertently, cause a miscarriage. I never intended to do it, but in essence I shouldn't have been doing it in the first place. I could get myself protected under the law by that. So it is a double-edged sword. Certainly none of us want to practice outside the law, nor indeed would we – those who are practising – feel comfortable doing that. That's why the onus is on you, I suppose, to come up with a wording which will allow us to practice in order to protect as much as we can the life of the mother and the child. I personally have … there is no problem in my mind that the life of the mother is paramount and that we must do what we can to ensure that the mother survives.

Deputy McManus: Could I ask you about the suicide issue? Now, a couple of doctors have made the point that they weren't happy with the X case judgment because of deficiencies in putting the evidence under scrutiny. But just leave that aside – that is not what I am concerned about. What I am concerned about is the issue of suicide itself being sufficient grounds to be life threatening and, therefore, grounds for an abortion. Do you have a view on that?

Dr Daly: I am not a psychiatrist so I would not claim to be an expert in the evaluation of a woman who was threatening suicide. I do believe that suicide is rare during pregnancy and I think there is very good medical literature to support that view. That's not to say that it couldn't be a genuine risk. It hasn't been an issue, to the best of my knowledge, in recent times and I don't know of any abortions that were carried out because of that indication in this country. Because it's not my area of expertise I suppose I find it a little more difficult to make a medical judgment about that. I would find it easier to comment on Eisenmenger syndrome or something like that.

Deputy McManus: In the area of grave foetal abnormality – I'm including the anencephalic foetus – do you feel that there is an argument for providing the facility for abortion either in this country or by way of referral to a specific unit overseas? Do you think that has merit, to explore that particular aspect of the issue of abortion, from your own experience?

Dr Daly: Yes I do. A lot of my research was on anencephaly and neurotube defects and I dealt with many, many women who had anencephalic babies, only one of whom I know had a termination of pregnancy. I think that women deserve a choice there, though, because ultimately being pregnant is a more dangerous time than not being pregnant and the reason that we justify that increased risk, albeit a small increase in risk, is because a pregnancy is going to result in the birth of a live baby. Where there's an anencephalic – or indeed where there are other conditions where it is clear that the foetus or baby is not going to survive – then I think it is difficult to ask a woman to continue that pregnancy if she doesn't want to. Having said that, many women in Ireland and many women that I have dealt with do want to continue the pregnancy. They believe this is the only time they have with that baby and they wish to continue the pregnancy and wish to deliver the baby alive, to have whatever time they have with it. But I would support the idea that there should be a provision for women who don't wish to do that.

Deputy McManus: Is the practice in your hospital at the moment to provide women with that information so they can make that informed choice for themselves?

Dr Daly: Where we diagnose an anencephalic we do discuss all the potential options for a woman. Now, as you know, it is difficult when you get into referral, but certainly we do provide as much information as we feel we can within the law as it exists at the present time and I think different people make different choices.

Deputy McManus: Okay, just one last question to ask. I am very concerned at the fact that we have such a high level of abortion in a country that claims that there isn't any abortion. It appears now that about 12% of pregnancies are ending in abortion. It does appear that in some countries where abortion is freely available, where there is an effort to reduce the level of abortion, they have

actually succeeded in reducing abortion levels, whereas in this country, where we don't appear to be able to face up to what's happening, the level is almost inexorably going up all the time. Would you comment on that? I mean, how do we deal with this in the sense that if we continue to export the problem, can we actually manage it and ensure that our abortion levels are reduced overall?

Dr Daly: Essentially, the vast majority of abortions are done because the pregnancy is unwanted – crisis pregnancy. By improving sex education, improving contraception – making it more widely available – we should be able to reduce the number of unwanted pregnancies and clearly all, or a lot, of the efforts should be put into that. This is a much easier problem to prevent than ultimately to manage. I think if that was grappled with more aggressively then we could reduce the number of women who would look to terminate a pregnancy.

Having said that, whatever is decided in terms of abortion in general, I do believe that we owe a duty of care as doctors and as public representatives – everybody – to the 5,000 women who leave this country for termination of pregnancy, whether or not that is specific services aimed at counselling women before they seek to leave the country, whether or not they are ultimately going to leave the country and come back. Frequently we end up dealing with the complications of termination of pregnancy and often the facilities in which the termination of pregnancies take place are not the best. There's no follow-up care and that's a real problem. So irrespective of what the country decides is going to be its law, we still owe a duty of care to people and at the same time we should be trying to minimise the number of crisis pregnancies by providing better sex education, by providing better contraception and by preventing the problem arising in the first place.

Senator O'Donovan: Just briefly, following up on the point made by Deputy McManus about the huge number of Irish women going abroad, particularly I suppose to Great Britain, for abortion, would you see that the introduction in whatever way, by legislation or over a period of time, of a liberal approach in this country similar to what happened in Britain would be opening the floodgates? Now, I make this point from listening to evidence that the 1957 Act in Great Britain actually didn't achieve what it set out to achieve in that in many respects it is seen as being too liberal and is being seen as a method of using abortion by way of contraception. I think one of your colleagues quoted that in some instances he saw the same woman come in for a third time. I think your predecessor here this evening said that this country … we have a Constitution – the people's Constitution – and that sort of seismic shift was the word used would be unforebearable either by way of legislation or a constitutional change at the minute. I am making the distinction of liberalism as opposed to say people with medical conditions, however grave or otherwise, or people who – I'm not sure what the medical term is – who maybe if they go full term the baby is not going to be born alive or will die on birth or whatever. One of the big worries I would have – I know we have a need to grasp the issues that are in front of us – but I would personally have a great fear that if we follow what Britain did we will actually open the floodgates and instead of helping the problem we would be creating a monster.

I make the point also that I have a teenage family ranging from 19 to 12 and my view is that most 12 and 14 year olds now have a greater knowledge of the facts of life and of these things then, say, when we were 16. I wouldn't see it as an excuse – and I am just asking you for your opinion – that there's a lack of sex education in this country and certainly I would say that situations like rape and incest are maybe in a different bracket. Surely the approach by people that they can get abortion on demand would be a very dangerous road to go down and I would like your views on that. Also, if we don't have a proper system of sex education here, which I personally don't agree from my experience as a family man, where can we attempt to redress the problem?

Dr Daly: Certainly I think that if we were to have legislation as existed or was brought into the UK in 1957 I think it would open the floodgates. I think that's right and I think that we would see a lot of abortions in Ireland for reasons that some of us might feel very uncomfortable about. Certainly in my own experience in the US where we didn't deal with general obstetrics and gynaecology we certainly would hear of the same people coming in again and again for termination of pregnancy and, expressing purely my own opinion here, I would have difficulty with that. When you do ultrasound at 12 or 14 weeks you can see a lot of the foetus or the baby and I would suppose not favour the situation existing here that exists in the United Kingdom.

Senator O'Donovan: Following on from that, would you accept by and large that with contraceptive methods in this country in the year 2000, in this millennium, we are as advanced as any country in Europe or in the States in the first place and, secondly, that the social stigma that attached to a girl becoming pregnant in the '50s and '60s has now evaporated more or less? In other words, it's quite laudable and actually there is a lot of support out there for a girl who decides to go ahead and have her baby and hold on to it. There's been a big shift in social attitudes in the last 20 or 30 years.

Dr Daly: I think there may have been a shift, but I think if it was as good as you're saying we wouldn't have 5,000 women going to the UK every year for abortions. We have the same contraceptive methods here as exist in any other country in the first world but clearly we still have a problem. That is not to say that it doesn't exist in other countries, it does. There are high rates of abortion in the UK and the US and similarly here, yet we have the same sophistication but we are not getting the message to the people who need it. While there may be a greater social acceptance of teenage pregnancies and pregnancies outside what we traditionally regarded as marriage and everything else, I don't think that, as I say … if there wasn't a problem then all these women wouldn't be seeking to abort pregnancy.

Senator O'Donovan: On a final question, would you accept or would I be fair in taking from your comments that you would not wish to see a situation in Ireland that currently exists in possibly Great Britain or in America

with what I would consider in certain instances a very liberal approach to abortion?

Dr Daly: Yes, that's my personal opinion only. Ultimately – and this is why this is so difficult – it's a huge grey area. Even the people who regard themselves as pro-choice ultimately become anti-choice at some gestation. People are pro-choice to eight weeks or ten weeks or 14 weeks or 24 weeks so, ultimately, at some stage during a pregnancy somebody is going to come and say you can no longer terminate a pregnancy. If you look at legislation throughout the world there are gestational age cut-offs in virtually every country so that even the most pro-choice people, ultimately, take the choice away. My personal opinion is that I would not like to see what exists in the UK and the US here and I do think it would be a huge shift for Ireland to move to that.

Senator O'Donovan: Thank you.

Chairman: Deputy McDowell.

Deputy McDowell: Thank you, Chairman. I really wonder, Doctor, what evidence there is for that. I was just looking at the Green Paper and the appendix which deals with the grounds on which Irish women in England look for abortions. It doesn't suggest the grounds are any different than they are for English women. It suggests that 99.7% are on grounds C and D which are the ones most capable of liberal interpretation, shall we say, and it suggests that 80% of Irish women seeking abortions have their pregnancy terminated by 12 weeks gestation and 67% of women have not had any previous live or still births. What I am getting at is when we say that the floodgates would open, have we any reason to believe that any of that would change if terminations were being carried out in Ireland as opposed to in the UK?

Dr Daly: My understanding of the floodgates opening would be that you would change a situation whereby women with significant maternal disease or women whose pregnancies were complicated by significant congenital anomalies had termination of pregnancy here and that if it was broadened that the floodgates would open in terms of the numbers requiring termination of pregnancy because, as you've just outlined, those two indications account for a tiny, tiny number of the abortions.

Deputy McDowell: What I'm really saying is that the floodgates are already open and that the suggestion that there would be any significant change by virtue of the provision of a facility here, there is no evidence for that.

Dr Daly: No.

Deputy McDowell: There is no evidence that practice would change if the facility were here rather than across the water.

Dr Daly: No, I was comparing to an indicated termination only.

Deputy McDowell: The reason why I intervened on that point is that this is an essential fact which I think we, as a nation, haven't come to terms with, that we do have a liberal regime. We just don't set the terms of it ourselves. They are set by virtue of the UK procedure and practice and by virtue of the '57 Act in the UK. Nobody that I am aware of in this country is actually suggesting anything that would be more 'liberal' than that. So there is no question in any sense really of the floodgates opening. If there are floodgates involved, they are already there and already open and they've been opened outside of this jurisdiction. Sorry that is a bit polemical, excuse me.

Has the practice in your hospital changed since 1983?

Chairman: Just one point. The session today has to close by 5 o'clock and I'd appreciate if all questioners respected that.

Deputy McDowell: I accept your chastisement, Chairman. Has the practice in the hospital changed since the '83 amendment was passed?

Dr Daly: No, I don't think so. I have only been master there for 16 months but I don't think the practice has significantly changed.

Deputy McDowell: So in that sense is this debate, or has it been, essentially academic? It hasn't influenced practice?

Dr Daly: No, I don't think it has influenced practice.

Deputy McDowell: Thank you.

Chairman: Feel free to ask any further questions.

Deputy McDowell: You have been crystal clear, you've given your injunction, Chairman.

Chairman: You have all made quite a number of statements at this stage and it is a matter of getting the questions dealt with. Deputy Tom Enright.

Deputy Enright: Thank you, Chairman. The figures in Britain since 1957 would indicate that about 5 million abortions have taken place in that time and in the United States since the Roe *vs* Wade case in '73 it was 39 million. They are alarming. World wars, famines, no matter what you say there is no loss of life in comparison to what we are speaking of here. There's never been any catastrophe even approaching those sorts of figures. Are the figures levelling out? Would you have any idea of what way those figures are? Are they going up or are they going down? You probably would not have the statistics.

Dr Daly: I wouldn't have the statistics.

Deputy Enright: I haven't either but those figures are alarming. In fact in both instances in both of those cases, the R *vs* Byrne case and the Roe *vs* Wade case, in fact both of those were rape. They're the reasons why the law was changed at that time. They were for rape but the main reason now for abortion taking place appears to be lifestyle and social reasons. You mentioned abortion at the beginning and said there were three issues, maternal illness in pregnancy, congenital abnormalities and abortion for woman choice. The third one does not arise apparently in Ireland at present. Would I be correct in stating that?

Dr Daly: Correct. It does not arise.

Senator O'Meara: The second one does not either.

Deputy Enright: Yes, but the third one would be the main factor for social reasons perhaps. Are you happy with the situation in Ireland as it exists at the present time if, in fact, the existing situation, your ethos, I gather from the speakers, is to treat the mother and child – that is the ethos of your profession. You also believe that perhaps the mother has to be given a priority on occasions. You are happy with that if that was tied down in legislation.

Dr Daly: Yes, I think that ultimately, in the coming years, we are going to be faced with more pregnancies complicated by maternal disease rather than less. There are going to more women who survive congenital heart problems, coming through getting pregnant, than there were 20 or 30 years ago. We are more likely to see complicated pregnancies as time goes on and I think that we need, within the law, to be able to treat that woman as best we can in order to ensure her survival. Ultimately, if she does not survive, the baby will not survive either.

It is all about risk at the end of day. Currently, and people can argue about the numbers, but broadly speaking, maternal mortality in Ireland is about ten per 100,000, so one per 10,000. If you have somebody who has Eisenmenger syndrome, for example, her risk of dying is 25% to 30%. So, you are now changing her risk from one in 10,000 to 2,500 in 10,000. We need to decide whether or not we believe that that is a significant change. If you do, then you need to try and manage that pregnancy as best you can. Ultimately, if the mother dies, the baby is likely to die. If you look at the maternal mortalities that are occurring at the moment, many of them are related, well, certainly a number which have occurred in the Coombe Women's Hospital recently, have been related to congenital heart disease. That is not to say that they would have definitely been avoided had there been termination of pregnancy.

However, there is a substantial change in the risk and I think that that is what we need to be open with our patients about. If a woman, fully informed, decides that she is happy to take that risk, then we will, of course, look after her as best we can. If, on the other hand, she decides that she is not willing to take that risk – and it is a very big risk – then, I think that there should be an option there for her to have a termination of pregnancy.

The other situation is the very difficult pre-eclampsia and those early pregnancy complications which can sometimes necessitate having to deliver. You are really trying to deliver the placenta but ultimately you obviously deliver the baby, or cancer of the cervix presenting early in pregnancy when clearly you have to do a hysterectomy. That is an early termination of pregnancy, be it at 12 weeks, and that is what we should call it. And while it is not … I can see where some people are differentiating that from other types of abortion but ultimately they are all early terminations of pregnancy.

Deputy McGennis: I am not even going to ask the question which I have asked everybody else because you have just answered it very clearly. Can I just ask two big questions about what you described as our duty of care to the 5,000 women per year who seek abortion outside the country, and I would fully support you on that? I think the two previous masters stated to us that they had not any incidences of cases where women presented in their hospitals seeking termination and in fact what seems to be the norm is that women either go to clinics here or they simply go to England or Northern Ireland uncounselled or unprepared and seek out an abortion clinic. I am just wondering if that has been your experience as well.

On the other issue of unplanned pregnancies or crisis pregnancies which either do or do not result in abortion – we have a very good report on crisis pregnancies – but I just wondered if there was any research in your own hospital. It seems quite obvious that we need better sex education and easier access to family planning, but I just wondered if within your own hospital there is any research which identified obvious reasons. Ignorance is cited in the report or failed contraceptive methods as the reasons for crisis pregnancies. Certainly in my experience as a politician the number of young women that would present and who actually did not expect – if you like that is ignorance – certainly did not expect to become pregnant, certainly puts lie to the case which was made several years ago about this being a career choice for young women. I do not think I ever accepted that and I do not think it is the case. I just wondered if there is any research within the Coombe Women's Hospital to suggest why we have the high level of not always unplanned pregnancies but pregnancies outside marriage.

As an aside to my colleague here about the floodgates, I think it is a bit disingenuous to say that if we had abortion available – the liberal regime which is available in the UK available here – it surely would not open the floodgates. Nobody can pretend that the number of 5,000, which is huge at the moment, that option is still only available to women who can afford to go to England. There would obviously, in my view, be a change if we were to look at or examine the possibility of providing a liberal abortion regime in Ireland. I think it is unlikely that that figure would decrease because those 5,000 women who are currently going to England ....

Deputy McDowell: I really do not want to get into crossfire between colleagues on the committee but I do want to make the point for the sake of clarity that I actually made the point that nobody was arguing for a regime as liberal as the United Kingdom.

Deputy McGennis: I am not saying you did. I am sorry, I did not mean that to be the point. It could not be suggested that the number would decrease if we had a liberal regime here.

Dr Daly: To answer your first question, I have not known women to come to the Coombe Women's Hospital seeking abortion. We do not currently have any research that has been done to try to find the reasons why crisis pregnancies have occurred. Apart from providing care for women who occasionally come back requiring additional care because of bleeding, infection or whatever, we would not in general come into contact with many women. Ultimately they come through later in their lives, perhaps, with pregnancies and attend the hospital … in taking their histories. One of

the changes that has occurred is that people are more open now and they are more likely to say that they have had a termination of pregnancy or whatever in the past. But we have never gone down the route of investigating why they chose to do that.

Senator O'Meara: I would like to take this opportunity to thank you for coming to speak to us today in what is a very illuminating and very useful exercise. In your opening statement you mentioned the three issues of maternal illness, congenital abnormalities and woman choice. The law allows hospitals to deal with maternal illness, as we know. However, it does not allow you to deal with congenital abnormalities. You were very compassionate, and I think it is obviously an attitude that everybody would share, in your response to the whole question of anencephalic babies, and you said that the choice is given to parents, the choice is given to mothers in that case. Would you like to see a situation where the law would allow you to deal with those specific situations, in other words, pregnancies which have no viability?

Dr Daly: Yes, I think I personally would. I think if part of your practice is the diagnosis of congenital abnormalities, it is difficult to bring a couple through that, and then walk away from it to a certain extent. It does place a considerable burden on them, if they choose to terminate the pregnancy, to go and try to find information to ensure that they get continuing good care. The difficulty with bringing in legislation for congenital abnormalities is where you draw the line. Again, while there are certain conditions that are clearly incompatible with life, there is a huge grey area. Then you get into quality of life issues, and it becomes very complex.

I personally believe it would be very difficult to bring forward a list that includes many more cases than anencephaly. It just gets so complicated. As we decode the human gene and prenatal diagnosis comes to the next level, we are going to be able to diagnose so many things. We can diagnose cystic fibrosis in pregnant women now. I see that some people would believe that here is an individual who is going at some stage to die, but ultimately we are all going to die at some stage, and I would be very uncomfortable about using cystic fibrosis and adding that to the list. There are very few conditions in which the foetus or baby is not going to survive, absolutely.

Senator O'Meara: I see the point you are making. You said, specifically in relation to the anencephalic baby, that a woman should not be forced to carry a pregnancy through against her will. It struck me that the same principle would apply, for instance, in the case of rape.

Dr Daly: It can ....

Senator O'Meara: Society considers rape to be a very serious criminal offence against the person on whom it is committed. In many cases – we know not in all cases – but in the majority of cases in my opinion a woman who becomes pregnant as a result of rape would consider that to be such a dreadful experience that she would not want to carry through the pregnancy. Having a law in this country which does not allow her to terminate the pregnancy in effect means the law is stating that she should be forced to carry it through. However, the choice is there in effect, in that we allow the right to travel abroad. You said it would be very difficult to legislate for foetal abnormalities, for instance. Would you agree that you are possibly introducing a principle which could be extended beyond foetal abnormality?

Dr Daly: It is a very difficult issue which the Constitution was unable to deal with and ultimately the Supreme Court had to deal with. I think that the principle of asking a woman to carry a pregnancy where the baby is definitely not going to survive may be different from asking a woman to carry a pregnancy where the baby is going to survive. There is a real difference there. That is not to have no sympathy with the woman who has been raped and finds herself pregnant, but I do think that there is a difference there.

Senator O'Meara: I have just one more issue to raise with Dr Daly. One of your colleagues in evidence to us today, in relation to the now famous figure of 5,000 – although I think some figures are up to 6,000 – Irish women who travel to Britain each year for an abortion, said that he does not see them, that they do not come to him. Of course, that is true. They do not come to him because these are women who choose to have their pregnancies ended. They are not women who choose to continue their pregnancies. We have heard comments about the situation in England, about abortions for social reasons, a comment I find quite offensive, particularly having studied this book, *Women and Crisis Pregnancy*, a study carried out on behalf of the Department of Health, which contains within it first-hand accounts by women – reasons why they have made the decision to have an abortion, reasons which are many and varied and could not be called social by any means. They were emotional, family, financial reasons. They were all sorts of reasons. I would encourage everyone, members of the committee particularly, to read what is in it, because there are heart-rending stories within that, and to use a generic term of having an abortion for social reasons is an insult to the very serious decisions that many women make every year.

One of the things that struck me out of the reading of this, which is very worrying, was the perception among women about the medical profession. This might be more relevant to general practitioners, but it is a point worth making in relation to the medical profession generally. Of the women who make a decision to travel for an abortion, only one-third would see it as relevant to have visited a doctor or a GP. That is very worrying. What emerges very clearly from the first-hand accounts – and they are verbatim accounts given in the book – is that many women do not see doctors as either sympathetic or relevant in the whole question. If we are to address the issue of how we should reduce the number of Irish abortions which, in effect, are being carried out in England, we have to look first and foremost at the reasons women give.

It seems that the medical profession might have to look – and I would ask you maybe to respond to this generally – at how they are perceived by women who find themselves in an unwanted or crisis pregnancy situation. It seems to me that doctors have a vital role to play in this whole area, and if we are to address the wider

issue of reduction of the rate of Irish abortion, then we must include doctors within that examination, and we must include the medical profession within that response. I am not specifically pointing to you in relation to that, or even to your profession of obstetrics and gynaecology, but rather to the wider medical profession. It jumps out so clearly in the book that women do not want to go to doctors. Some who go to GPs cannot bring themselves to mention the word 'abortion'. Clearly there is a severe problem there in relation to the perception of the medical profession and the relationship between the female population and the medical profession when it comes to this particular issue. That may have to do with our history and the fact that this has been such a hugely emotional and divisive issue, particularly over the last two decades. It is something I would like to see the medical profession responding to. Thank you, Chairman.

Dr Daly: I have not read the report. Clearly it is a very divisive issue and many people hold very strong views on it. If women feel alienated, that they cannot approach their general practitioner or indeed go to any doctor, I would agree that that is a real problem. Probably one of the better ways to address it would be to get doctors or physicians who are interested and want to provide that service to provide it in a structured fashion. One cannot ask everybody to do it because everybody will not want to do it, and if you do not want to do it, you are not going to do it well. I would agree, and I think that the third part of the submission from the institute clearly outlines, that obstetricians or gynaecologists and all doctors owe a duty of care, but some people find this area very difficult and there is no point in trying to force them to offer that caring approach if they do not feel they can do it. Clearly there is an opportunity to establish clinics that are staffed by medical doctors who have an interest in this area and who will help in a caring and compassionate way.

Chairman: Deputy O'Keeffe, I wonder would you share time with me in the sense that there is a 5 o'clock deadline.

Deputy O'Keeffe: I just want to touch on one area. Reading up the documents it appears that well over 100,000 women have had abortions in the UK over the last 30 years, giving rise to a rate of seven per 1,000 at the moment. I take it you accept those figures because apparently they are based on the number who give an Irish address.

Dr Daly: Yes.

Deputy O'Keeffe: The suggestion is that, in fact, the figure could be higher as some people don't give an Irish address for reasons of confidentiality. How then does the Irish rate, as it were, seven per 1,000 at the moment, compare with the rate in the UK or in continental Europe or, indeed, the US?

Dr Daly: I honestly don't know. Those statistics are not something that I have ever ....

Deputy O'Keeffe: If we were focusing on those, I gather it is up to 6,000 per year at the moment who go to the UK every year. Are we making sufficient funding available to address that issue? If sufficient funding or more funding were available, what should we be doing from the point of view of counselling in advance and, in particular, from the point of view of aftercare? Have you any expertise in that area?

Dr Daly: I think that all women should in the ideal world have some medical or nursing midwifery interaction before they would opt for a termination of pregnancy, that we should be able to provide that and that resources should be made available to provide that. That is important for a number of reasons. Some of these women will have medical conditions which would mean there are perhaps certain institutions that they might opt to go to the UK for termination of pregnancy that would not be ideal for them. We can't give good advice about the possible risks. The people who come back with problems afterwards are, in general, I think slow to access medical care. I think that if there were sufficient resources we should be trying to minimise the number of crisis pregnancies as we have discussed and to provide care for women who seek to terminate pregnancies in total.

Deputy O'Keeffe: I will hand over to you, Chairman.

Chairman: I think, in fact, the institute's submission referred to 'the intention of taking the life of the baby for social reasons' as distinct from essential treatment, but taking that widest category of abortion on demand or the right to opt for an abortion, as it is sometimes put, referred to gestation age cut-offs, I think in the United States the Supreme Court held in Roe *v.* Wade that in the last trimester it was only possible to carry out essential treatment to safeguard the life of the mother and, of course, that in a sense has been superseded by facts. Isn't that right because now you have delivery in the last three months in virtually all cases? To what extent will science resolve this problem in the future further back?

Dr Daly: Certainly viability is now down to 23 weeks in some centres, so that advances in neonatal care have changed that hugely. While it is difficult to see it getting far below that, I don't know what will be brought forward in years to come.

Chairman: Moving to the narrower question where you consider a specialty, foetal deformities. Your proposal there related to lethal foetal deformities essentially – not your proposal but your view, if you like, as to what should be permissible or open for consideration related to lethal foetal deformities. Is that correct?

Dr Daly: Yes, I think you get into a very grey area if you bring in legislation and the wording of it is lethal deformities or deformities that are invariably lethal, that is a very narrow band. If you use the term 'congenital abnormalities' some people would terminate a pregnancy for a cleft lip and palate which you can diagnose by ultrasound. Clearly, I think most people would feel very uncomfortable with that. I certainly would. The area of congenital anomalies is a very difficult one and is only going to become more difficult as our genetic knowledge on everything grows over the next five to ten years.

Chairman: Moving to the category which is referred to

in the institute letter which stems directly from your own work, there are three principal maternity hospitals here in Dublin. Isn't that correct?

Dr Daly: Yes.

Chairman: Yourself the Coombe, the Rotunda and Holles Street National Maternity. Complicated cases throughout Ireland would generally be referred to you. Is that a fair comment?

Dr Daly: Yes, complicated cases, be they maternal or foetal, generally come into one of three Dublin maternity hospitals or, indeed, to Cork or Galway, but I would say the majority of complicated pregnancies probably come into Dublin.

Chairman: Yes, but it's open for them to be referred to Cork or Galway which are university teaching hospitals as well, I take it.

Dr Daly: Yes.

Chairman: They are the medical institutions in this State where these matters are of greatest concern.

Dr Daly: Yes, I think if you work in these institutions you are much more likely to be dealing with complicated pregnancies and that, in general, for very good reasons and reasons that I would support in more peripheral units because of the availability of neonatal intensive care etc. etc. women are transferred to the bigger hospitals because the resources have been put in there to deal with the very premature babies and things like that.

Chairman: It was suggested by Dr Clinch yesterday in relation to Eisenmenger's syndrome that to consider the option of termination there would be unethical under the Medical Council guidelines. Have you any comment to make on that?

Dr Daly: Under the strict letter of the Medical Council guidelines, yes it probably would be. The issue with Eisenmenger's is whether or not a termination of pregnancy, early in pregnancy, is going to dramatically reduce the risk of death for the woman. I think there is a reasonable amount of literature to suggest that that is true and that while some people will argue and, indeed, I see in one of the submissions that the most recent paper from San Paolo shows that Eisenmenger's can be successfully managed. Two of those 12 women still died, there were three miscarriages, one of the babies died, so that ultimately the maternal mortality there was still 20% and if normally it is one in 10,000 that's a significant change.

Chairman: Would it be a fair summary of the literature to say that the earlier the intervention the more of assistance an intervention would be so to speak, that a late intervention may be neutral on the eventual outcome but that early intervention can sometimes help as in the literature on Eisenmenger's syndrome?

Dr Daly: There are no great studies on it but there is a reasonable body of expert opinion to suggest that an early termination of pregnancy is likely to result in a less risk of death for the mother than delivering at term.

Chairman: Dr Daly, I would like to thank you for giving us the benefit of your experience which is obviously very extensive in this area and we very much appreciate your help. I am now going to adjourn the committee until 10.30 a.m. tomorrow morning.

THE JOINT COMMITTEE ADJOURNED AT 5 PM UNTIL 10.30 AM ON THURSDAY, 4 MAY 2000

THURSDAY, 4 MAY 2000, 10.30 AM
MEMBERS PRESENT:
DEPUTY T. ENRIGHT, M. McGENNIS, L. McMANUS, J. O'KEEFFE, SENATOR J. DARDIS, D. O'DONOVAN, K. O'MEARA

DEPUTY BRIAN LENIHAN IN THE CHAIR

Dr Brian Denham

Chairman: We are now in public session and I would like to welcome Dr Brian Denham, who is a visiting paediatrician, to this meeting of the Joint Committee on the Constitution. Dr Denham, we have received your written submission which is at page 133 of the brief book. You will be glad to hear that the brief book has been tabled before the Houses of the Oireachtas and has absolute privilege.

The format of this meeting is that you may make a very brief opening statement elaborating on your submission, if you wish, which will be followed by a question and answer session with the members. I have to draw you attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you. I now invite you to make a brief elaboration of your opening statement.

Dr Brian Denham: Thank you very much indeed for inviting me to address you, Mr Chairman, and members of the committee. I am a paediatrician. I have been a paediatrician for 30 years and I have specialised in diseases of the chest of children, that is mainly diseases of the

heart and lung. On first sight one would think that is really a long way from any involvement with termination of pregnancy, and yet one does come across cases, and I thought it might be useful to your committee if I mentioned those.

As a paediatrician I am dealing with congenital conditions, that is conditions that children are born with and have throughout their lives. Much the most common, in my experience, is the problem with cystic fibrosis. Cystic fibrosis is a dreadful disease of childhood where the lungs, the liver, the intestine and other organs are affected. It is a very debilitating condition. The treatment is very intensive, requiring hours of physiotherapy, multiple medications, nebulisers every single day of the child's life. With very intensive treatment these children now survive to adulthood, although they did not when I was a medical student but it is a progressive and debilitating condition and eventually people with cystic fibrosis die from cystic fibrosis.

It is a genetic condition, in that once a family has had a child with cystic fibrosis there is exactly one chance in four that the next child might have cystic fibrosis. The condition is easily diagnosed by antenatal diagnostic techniques, so that families may be aware when they become pregnant again, if they have had a child with cystic fibrosis, of whether or not the next child is going to be affected. Of my patient cohort, approximately half of the families who are at risk of having a cystic fibrosis child seek antenatal diagnosis, they seek to find out. Some of those obviously go on to choose a termination of pregnancy and some of them choose, knowing the child has cystic fibrosis, to have the child.

It's often generally felt that choosing not to have a child with a severe disease like this is a selfish decision that the parents make because they don't want the burden themselves, but that's not my experience at all. It's a sad fact of life that if there are two children with this severe disease in the family, both children will do less well than if there is only one, just because of the burden of care the extra child throws on the parents and because of problems with cross-infection and drug resistance and many other things, so both children do less well. So, sometimes a family will seek a termination of pregnancy of a cystic fibrosis child just because they want to look after the child that they have – their living child – to the very best of their abilities. That is the commonest situation that I come across.

I mentioned two other conditions. One is children with congenital heart disease complicated by high blood pressure in the lungs. I believe this has already been fairly well addressed by my eminent obstetric colleagues because worldwide this is considered the mandatory indication for termination as early as possible in pregnancy, it carries a very, very high risk. A quarter of the … there are four paediatric cardiologists in the country, so roughly a quarter of the patients who have now grown up and have Eisenmenger's syndrome – congenital heart disease with pulmonary hypertension – would be ex-patients of mine, but they have passed out of my care by that time.

To bring your attention to the extraordinary wide range of possibilities, I mentioned this other thing, the acardiac twin pregnancy where there are twin babies in pregnancy, one of whom does not have a heart and when that baby dies the normal child dies, but this is truly rarer than hen's teeth. The patient that I know about living in Ireland was No. 6 in the world and I think there are less than 20 at the moment.

I really just brought those out to counsel you not to draw up a list of conditions where one can or should have termination and a list where one can't or shouldn't or may not because as soon as you make a hard and fast list, there is no doubt medical advances and medical progress will throw up another one that will make nonsense of your rules. I think that's all I would say at this point, Mr Chairman.

Chairman: Thank you very much, Dr Denham. Before the members put questions, there are just a few questions I'd like to ask that arise directly from the submissions that might clarify or speed the questioning. First of all, in relation to the acardiac twin pregnancy, which is the first matter in your letter, you mentioned that you sought to obtain a ruling from the Medical Council on that, but I think in fairness to the Medical Council their practice under the Act is not to give rulings. Isn't that correct?

Dr Denham: Yes, but they rule on whether or not you have behaved unethically.

Chairman: In fact, ultimately, the High Court in this country rules on that, I think. Isn't that right? The fitness to practice committee has a role there, but it is subject to confirmation in the High Court. Isn't that the strict statutory position?

Dr Denham: That's right, yes.

Chairman: So, the Medical Council are unhappy about giving advance rulings on any operation because ultimately their whole system is subject to review in the courts. In relation to that particular condition, is it correct to say that both will die in that situation?

Dr Denham: Both will die.

Chairman: Unless action is taken.

Dr Denham: That's right, yes. When the baby without the heart dies the normal baby dies. There are a few very rare survivors, inevitably severely handicapped. The release of the toxic necrotic tissue into the circulation severely damages the baby. Survivors are extremely rare.

Chairman: So, it is a struggle to secure the survival of one in fact.

Dr Denham: And inevitably handicapped, if survived.

Chairman: But both are doomed unless an attempt is there to save one in that condition.

Dr Denham: That's right.

Chairman: In relation to the second type of case, the Eisenmenger's complex, we had evidence yesterday from Dr Daly, Master of the Coombe, that early intervention in such an instance is a clinical option.

Dr Denham: It is. In my experience, most of my patients

with Eisenmenger's complex who find themselves pregnant because of the extraordinarily high risk the pregnancy poses … the literature is very variable, but you are talking about a mortality of roughly one third of all patients who go through a pregnancy, some people say much higher than that. Most choose termination early in pregnancy. I am in the very fortunate position in not having to advise them or refer them. I just have to say that pregnancy is a very high risk and if you do find yourself pregnant, you need to talk to one of my obstetric colleagues very early.

Chairman: Yes, but in relation to Eisenmenger's, I take it it is early intervention that is the clinical option that's canvassed.

Dr Denham: The earlier the better.

Chairman: I assume that, in a sense, the later intervention may not affect the outcome. That's the difficulty really, isn't it?

Dr Denham: In a patient who has got congenital heart disease of pulmonary hypertension – Eisenmenger's complex … the words are often used interchangeably … the actual word 'Eisenmenger's' means that the blue blood has started to enter the systemic circulation, so the patient has a blue heart condition. Pulmonary hypertension is just high blood pressure in the lungs and it's only when it progresses a bit further that the Eisenmenger's part comes out, but they are different ends of the one spectrum. All interventions of any kind in a patient with Eisenmenger's complex are risky and the more invasive the intervention … in other words, if you are talking about termination of pregnancy, late termination is much more risky than early termination. Carrying a baby to term is very risky indeed. Sadly, the most risky time is actually shortly after delivery, in the 48, 72 hours following birth. Tragically, these patients, when they do go through pregnancy, sometimes deliver and then collapse 24, 48 hours later and leave a baby an orphan.

Chairman: You have explained to us your experience in relation to cystic fibrosis, but you did recommend a solution as well in your submission, which was to restrict the Offences Against the Person Act in relation to its application in hospitals, which you listed as regional, university and maternity hospitals.

Dr Denham: Yes.

Chairman: I just want to clear up what hospital you are referring to there exactly. I take it the maternity hospitals would be the three principal hospitals in Dublin, first of all.

Dr Denham: Yes.

Chairman: The university hospitals would extend that to Cork and Galway.

Dr Denham: Limerick.

Chairman: And Limerick. The regional hospitals would be hospitals operated by the health boards ....

Dr Denham: Yes, and their agencies, major centres. What you don't want to see is the abortion clinic, in other words, a very small centre doing virtually nothing else.

Chairman: We heard from the Masters of the three principal maternity hospitals in Dublin yesterday and it would be fair to say that their hospitals are responsible for a great amount of the volume here. I think that's a fair assessment.

Dr Denham: That's right, half of all the deliveries in the country.

Chairman: About half of all the deliveries in the country. In relation to the medical conditions, I must say that the impression I formed – and subject to correction by the members on this – was that they certainly wanted that measure of clinical freedom there in relation to threats to the life of the mother. There was no question about that.

Dr Denham: They give their patients superb care too. I think we have got one of the highest standards of maternity care in the country. I would agree, I think to fetter it in any way would be a mistake.

Chairman: On the question of the scanning and congenital deformities, again I think I am summarising their position fairly in saying that they weren't prepared to go further than the case of the lethal abnormality clearly diagnosed from the scan. That, if you like, was the limit but you have opened a somewhat wider question. That was their position in terms of how far they felt they could go on that question at this stage. I am putting that to you.

Dr Denham: There is no termination of pregnancy available in Ireland for cystic fibrosis families at present. Any that need it travel overseas but there is an ante-natal diagnostic facility that is provided quite widely now in Dublin, Galway and Cork to detect whether or not a child is affected by what is ultimately a fatal disease, although it takes a very, very long time and requires an immense family effort. I cannot emphasise enough to the committee the burden of care that families of children with very severe chronic illness accept. The families are wonderful, the patients are wonderful but the treatment takes up so much of the family time and so much effort and goes on for so long that these families have no time for anything else. Our function as doctors is to support them as very best we can. For some families the idea of having another child with the same disease is just intolerable because they know what it will do to them and to their existing child. Some families accept it without too much anxiety. Either way, our duty as doctors is to support them and help them look after their children to the best of their ability.

Chairman: Thank you very much, Dr Denham.

Deputy J. O'Keeffe: Thank you very much doctor. Your evidence is very helpful to us but let me try and marry your medical expertise to the kind of constitutional or legal requirements we have to bring in recommendations on. Can I take it from your submission, indeed your evidence today, that you do not see any case whatever for introducing an absolute constitutional ban on abortion?

Dr Denham: I think that would be very unfortunate.

Deputy J. O'Keeffe: I take it that you would see it that, even as was evidenced yesterday, existing medical practice would be affected by such a constitutional ban?

Dr Denham: That depends on your definition of abortion – whether existing medical practice would be affected. I take it the masters told you it would be if there was an absolute prohibition.

Deputy J. O'Keeffe: Moving to the question of legislation, our basic law in this regard is the Offences Against the Persons Act, 1861. Do I take it that, in so far as there is legislation against abortion here, your view is that whatever treatment is necessary in relation to the life of the mother – if the life of the mother is at risk, there should be no statutory restriction on such treatment?

Dr Denham: Eisenmenger's complex is the condition of which I am aware and that I have dealt with where the life of the mother is seriously at risk from pregnancy. I would again strongly counsel against any restriction on medical intervention in that situation. I think it would put a lot of women's lives at serious risk.

Deputy J. O'Keeffe: Carrying that further to the question of a pregnant mother where there is a lethal foetal abnormality, what is your view in relation to the sort of legislative situation which should be provided for there?

Dr Denham: I don't deal with that situation at all, except in terms of cystic fibrosis families which is not a condition like anencephaly where the baby dies shortly after birth.

Deputy J. O'Keeffe: In relation to encephalitis ....

Dr Denham: Anencephaly.

Deputy J. O'Keeffe: .... the death of the baby is certain.

Dr Denham: In anencephaly the death of the baby is certain shortly after birth. Some of them live hours but frequently a very, very short time indeed. That's where the brain has not formed. I don't deal with that condition and I don't see mothers who are pregnant with that condition. The ones that I see are the more difficult situation, that is the families who have cystic fibrosis. Although eventually a fatal condition, with intensive treatment it is entirely compatible with survival up until adulthood – with intensive treatment. These families are hugely burdened and there is the one in four recurrence risk so that, as I said, about half of my patients choose to find out whether or not another pregnancy is affected or is not affected.

Deputy J. O'Keeffe: In some of those instances, having got diagnosis ....

Dr Denham: They go both ways.

Deputy J. O'Keeffe: .... there is a decision to terminate, is that correct?

Dr Denham: In some there will be a decision to terminate and in some they decide to carry the baby and look after it. When they do I continue to look after those patients. I don't hear about the ones who choose termination because that is done from the diagnostic facility. They make the diagnosis and they counsel them.

Deputy J. O'Keeffe: But under our existing law and medical practice, where there is such a decision to terminate ....

Dr Denham: It can't be done in this State.

Deputy J. O'Keeffe: That does not occur here?

Dr Denham: It does not occur in this country.

Deputy J. O'Keeffe: It is a question of the pregnant mother going to England.

Dr Denham: They all travel – either to the North or overseas. Even though termination of pregnancy is very restricted in the North of Ireland, this is one of the conditions that they would consider entirely acceptable to terminate.

Deputy J. O'Keeffe: The $64,000 question is whether it is your view that, in such a situation, there should be provision under our law for such a termination to be carried out here, provided it is carried out in a recognised maternity or health board funded ....

Dr Denham: I think it is very unfortunate that these families have to travel overseas – the ones that feel it is necessary for the life of their child and their family to terminate a subsequent pregnancy. That means that the patients who can avail of it are the patients who have the financial, educational and emotional resources to travel overseas. To a certain extent, the families with two and three and even four cystic fibrosis children tend to be in the poorer sections of our community where the educational resource and the knowledge and the financial resource to travel are not available.

Deputy J. O'Keeffe: Is that the only or the main area where you are suggesting that there should be statutory provision for termination?

Dr Denham: I have no expertise in other areas but you could ask every doctor in the country and nearly all of them would have knowledge of one or two conditions like this. There are other conditions of other organs and other bits of the body that … these are just the conditions. Cystic fibrosis is a condition I have specialised in and I have a great deal of knowledge about it. I would hate to start talking to you about dreadful liver disease or something which can be equally bad. I just do not have the knowledge base to advise you.

Deputy J. O'Keeffe: Therefore, do I take it that your viewpoint, from within your own experience and your general knowledge of the expertise of others, is that there should be some degree of flexibility in our laws, that where there is expert evidence available of these conditions, a provision should be made for termination to be available ....

Dr Denham: Yes, I ....

Deputy J. O'Keeffe: .... provided it is carried out in one of our recognised maternity or public hospitals?

Dr Denham: I have a great faith in the ethics committees of our hospitals. I think they have by and large run the hospitals very well, supervised what goes in them very well and I think if you said tomorrow that termination of pregnancy is freely available to anyone subject to the rulings of the medical ethics committees, I think you would find there would be very very few terminations and that they would be looked at very carefully by the hospital ethics committees. Without having to legislate for specific conditions, which is very difficult, I think the ethics committees would look at each case in great detail and ....

Deputy J. O'Keeffe: That would then allow the decision to be made by the ....

Dr Denham: By the clinicians.

Deputy J. O'Keeffe: .... medical ethics committee of each hospital.

Dr Denham: That's right. The decision, the advice would obviously come from the doctors looking after it and the decision would be supervised by the ethics committees.

Chairman: Senator O'Donovan and then … Sorry, Deputy McManus.

Deputy McManus: Thank you very much indeed, Mr Chairman, and thank you, Dr Denham, for coming here. I think it is very interesting that you presented a different perspective as a paediatrician to the matters we've been discussing, and you certainly opened up issues that are pretty large and complex. I appreciate that you are not directly engaged in advising or informing the parents about travelling to Britain or travelling overseas to have a termination, but do you feel, apart from the issue of class or people not being able to afford to go, do you think that it is creating difficulties for you medically or for obstetricians medically? It has been put to us that, for example, autopsies are not necessarily carried out and there is the issue of after care, that also the standards in some facilities are not necessarily top quality. Do you think that is a matter of concern?

Dr Denham: I'm quite sure it is, although I wouldn't have any knowledge as to how much of a concern. What is perhaps of concern is that the need to travel throws in a delay. There is absolutely no doubt that the emotional and other side effects following a termination of pregnancy – and consideration of a termination is one of the most anguished decisions any woman ever has to make – I don't think anybody is more aware of the fact that abortion is wrong than the woman who is faced with choosing between two wrongs. I think she is the person deeply involved, but there is no doubt that the earlier that decision is made, if they are going to get termination, the earlier the better, and the need to travel, of course, throws in a delay which adds to the trauma that these families suffer.

Deputy McManus: It would be clear that there would have to be a change of legislation, whether it is the way you propose or otherwise, but presumably there would also have to be a change in the Medical Council guidelines for hospitals and doctors to have that clinical judgment, the freedom of judgment.

Dr Denham: You are getting into very jesuitical arguments here, dancing on pinheads and what is an unborn and what is viable and what is not viable.

Deputy McManus: You mean ....

Dr Denham: .... but yes, I think the guidelines are reviewed regularly and frequently.

Deputy McManus: Okay. Maybe it is unfair to ask you this, but in terms of defining – you have mentioned cystic fibrosis but presumably there are other conditions that are equally worthy of scrutiny.

Dr Denham: An enormous number of them. It is just cystic fibrosis is the most common ....

Deputy McManus: Right.

Dr Denham: .... and Ireland has the highest instance of cystic fibrosis in the world, so it is a particularly Irish disease and one we need to take responsibility for.

Deputy McManus: So what you feel is rather than trying to prescribe a formula, you are saying leave it to the doctor – obviously with the woman – but leave it to the doctor and the ethics committee within the hospital to determine each individual case.

Dr Denham: Correct.

Deputy McManus: Okay. Well as someone maybe who has lived long enough to have had certain difficulties in the past with ethics committees on very basic issues like tubal ligation and even further back on family planning, why do you think that ethics committees can be entrusted with this kind of a role?

Dr Denham: There are clearly some hospitals, particularly those run by religious orders, that would find any form of termination of pregnancy totally unacceptable and I don't think it would be right to impose upon them a duty to do so. I think that whereas, you know, there are other hospitals, particularly the health board hospitals and things, where those restrictions don't apply. There is a wide variety. Obviously if a scheme is set up and one finds that there is a group of patients in desperate need of termination or not being offered, or indeed you find that there is one hospital that you might feel was abusing the system, that is a time to introduce some additional regulations, but I suspect to try and regulate it from the outset will just cause problems.

Deputy McManus: Well maybe that leads on to my last question. We have very excellent doctors in this country but inevitably they are not all 100% excellent all the time and certainly there has been a lot of concern, for example, in relation to the high level of hysterectomies in one particular hospital, where it would appear that a doctor was able to practise without any kind of regulation for

quite some time. Are there not dangers in the sense of putting these hospitals outside of the law in this particular area that we could end up with a bad doctor practising bad medicine without having the regulatory framework there to protect the patient?

Dr Denham: I think a regulatory framework is reasonable, in other words, a reporting system or something that would allow one to keep an eye on what's happening. I think that is very reasonable. I think a restrictive framework is what I counsel against, in other words, saying that you must act this way in this situation and not in another because the medical progress is occurring so quickly and so fast. I mentioned the case of the acardiac twin really just to show you how rapid medical progress is. We are talking about a very few cases in the entire world, but next year there will be something else available and sooner or later there will be an Irish patient who will need the intervention.

Deputy McManus: Thank you very much indeed, Doctor.

Chairman: Senator O'Donovan.

Senator O'Donovan: Thank you. I would like to welcome the doctor and to note that you are the sixth witness to appear before us and give evidence. In your submission that you've made, you have been very frank and you have put forward the most liberal view we have heard to date, that your option would be for I think, as you put it, the more liberal of the options in the thing, and I think that your moral courage and frankness must be appreciated in this respect.

Just a couple of things. Coming to cystic fibrosis, and obviously as a lay person I have some understanding of the serious nature of it and the huge encumbrance it is for both parents and the very debilitating effect it has on the person itself, would I take it from you in your answers so far that, would you think it more appropriate in such cases that termination or, to use another word, abortion might be the real solution in such instances? In other words, when you come across the situation say after three or four months of pregnancy that this situation exists, would you, in your professional capacity, counsel or advise, 'Look, you are facing a serious up-hill battle', and would you go beyond the word 'choice'? Would you be inclined to suggest?

Dr Denham: I think as soon as one suggests to a woman in that situation what they should do, you're … that's a very paternalistic attitude. I think all one can do is to tell them what is likely to happen. If we know a foetus is affected by cystic fibrosis, you can … they will already have a member of the family affected, so they know the work involved, and the only addition I tell them always is to consider how this is going to affect your living child, your present child. The additional burden of looking after another one, coupled with the problems of cross-infection and antibiotic resistance which hugely complicate treatment and make it much more difficult and much more expensive, means that it is a sad fact of life that where two children in a family have cystic fibrosis, they both live less long and have poorer quality of lives than where there is only one. Sometimes when people, a lay person says, 'Oh, I've been counselled to have a termination but I can't do that, it's a very selfish decision' and its because they're thinking of themselves, but if they bring their entire family into the picture and think about their living children and the rest, it makes it, it's frequently a very unselfish decision and made against the person's own inner desires and feelings. They may well want to bring this baby to term, despite the fact that it's severely ill, but they do not want to inflict their living child with the diminished quality of life that that would entail. It is a very, very difficult decision for any woman and I mean we support our families. We direct, we counsel them non-directively and support them to the very, very best of our ability whatever decision they make.

Senator O'Donovan: You mentioned, Doctor, that Ireland *per capita* has the highest ratio of cystic fibrosis in the world. In that regard, is that down to a certain maybe fettering of our religious beliefs or is it due to ignorance, or why are we out on a limb, so to speak, or have you any opinion to offer on it?

Dr Denham: We have a very high incidence of the cystic fibrosis gene. One person in 20 is affected by the cystic fibrosis gene. Somebody in this room carries the cystic fibrosis gene and if your partner happens to be the same, well then you're at risk of having a cystic fibrosis child. Now, we've got about the same genetic incidence of the disease as does Scandinavia and Denmark. It all boils down to a few randy Vikings who came over and spread the gene around. But in Scandinavia, of course, antenatal diagnosis and termination of pregnancy would be regarded as absolutely normal if a baby was known to be affected by cystic fibrosis. So, although in Ireland we've a lot of families with two and even three children with cystic fibrosis, that is unique in the world. Nowhere else in the world has that happened and this is why we have more of the disease than the other countries.

Senator O'Donovan: Next might I ask you, or is it possible for you … we've had a lot of interaction from the various questionnaires here and the witnesses about the definition of abortion *vis-à-vis* termination. I understood from some of the experts before us that they would see termination of a pregnancy in some of the extreme cases that you mentioned where … you mentioned one today and also this pregnancy that develops outside the womb and others. There are limited numbers of areas. Would you see any of those terminations as being abortion, because once abortion is mentioned for anybody on this side or for … there's an awful exclamation mark goes up as to … you're into the realm of abortion? But is there a definition of abortion in your view, or is there certain areas where termination is not abortion, or is there a defining line, or is it all abortion of some sort?

Dr Denham: I can't say. I'll consider the question but there's really no difference between termination of a pregnancy which happens to be outside the womb. I mean, there are one or two of those in the world that have gone to term and the baby has been delivered, so that you can't say it's intervention that was … that is absolutely indicated ....

Senator O'Donovan: One of the other expert witnesses

mentioned the seismic shift in Irish society, be it wrong or right. Having regard to maybe our religious hang-ups or background, would you consider that the option you promote – and I'm quite certain you do it with the utmost sincerity, etc. – that that would be acceptable to the Irish people at the minute, having regard to our existing Constitution and, be it wrong or right, there is provision in the Constitution? Could you see this seismic shift being evolved easily or is going to be ....

Dr Denham: Well, it's no doubt occurring. I mean when I first commenced practice in cystic fibrosis and when antenatal diagnosis first became available with the genetic techniques, very, very few families wished to avail of it. There's no doubt that as the years have gone by, more and more become aware of it and take it on board as being a reasonable option for them. At the moment, as I say, it's about half of all families seek antenatal diagnosis, families with cystic fibrosis. So, society is changing, and changing very fast and I've no doubt will continue to change.

Senator O'Donovan: Would you accept, Doctor, that there is a sort of a legal tight rope at the minute for people like you or others dealing with gynaecology, obstetricians, etc. in regard to the uncertainty that's there at the minute? You have, on the one hand, the shackle of the constitutional provisions and, on the other hand, maybe a law that's … we're primarily, apart from the X case, dealing with the Offences Against the Persons Act, 1861, I understand. Is there a quagmire of legal uncertainty existing for practitioners, leaving aside the ethical side of it? I accept that you've great belief in the ethical code, but is there a current quagmire of legal uncertainty pertaining to practitioners currently?

Dr Denham: Well, there is uncertainty. But I'm in the very fortunate position, you see, of looking after these families but not having to, even the ones that seek termination, not having to refer them. That is fortunately done by the diagnostic units.

Senator O'Donovan: And obviously in such situations, I accept you would not be at the coalface of the situation. In conclusion, I would just ask one final question. You may or may not be in a position to offer a view on it. I would sometimes see the concept of abortion with this *mens rea* or the mental view. It's like in the case of murder, where you intend to do something. Is there any possibility of a situation or common ground where you could define abortion, where some person of sound mind, sound physical health decides to go and say, 'Look, I do not wish to continue with the pregnancy for one reason or another'? At the minute, obviously they have to go abroad to have such an abortion. And the other scenario where in extreme medical conditions, some of which you've worked with and others have mentioned them, like ectopic pregnancies etc., that in these conditions where it would be more morally correct, so to speak, that termination would occur to save at least one of the lives. Is there … do you get the point I'm making that in certain instances I think there's a deliberate, if I could use that word, intention and the mind made up by somebody in full health to go and have a termination as against where persons who are in an extremely difficult medical situation have little or no choice? Can you see a difference in that sphere or ....

Dr Denham: I see your point, but I think I'll just say what I said before. I think it is the most anguishing decision a woman ever has to make and I do not think that anyone is more aware of the fact that a termination of pregnancy is wrong than the woman who is faced with two wrong choices.

Senator O'Donovan: I accept that, but the follow on from that is what one of your predecessors said yesterday, or perhaps the day before, namely, that he came across one instance in Great Britain where a young woman came in for the third time for an abortion out of her own free will – the liberal approach adopted in Great Britain. Surely, on the third occasion, or even the second occasion if it was so traumatic to make the decision, would she not have learnt the lesson? These are cases where, I understand, that the child in the womb and the mother were in perfect health.

Is there a danger abroad – I mentioned this word yesterday – of opening the 'floodgates', whereby a lot of people might say, okay, you are dealing with situations that are extremely difficult. They may say why not adopt the same situation that pertains in Britain under the 1967 Act or, maybe in the US, where abortion is readily available as a means of contraception?

Dr Denham: That is using abortion as a means of contraception, and I think that where it is widely used as a means of contraception, as it was in Hungary some years ago, I think it does, to a certain extent, undermine the morality of society. Certainly, I had one patient, a refugee from a middle eastern country who came in with a child that we were looking after in Our Lady's Hospital, Crumlin. When the junior doctor took the medical history and found that this woman had had six or seven terminations of pregnancy as a means of contraception there was a very uncomfortable feeling in the ward at the time that this was a very extreme way of dealing with contraception. When it is used in that way it does undermine morality and I would much rather see a good programme where unwanted pregnancies did not occur, as they have in Holland, which has a much lower instance of termination of pregnancy than we have in Ireland, even though there is a much more liberal regime.

Senator O'Donovan Thank you, Doctor.

Chairman: I call Senator O'Meara. I ask members to try to be brief with the remaining questions and to focus on the issues arising from the submissions.

Senator O'Meara: Very briefly, in relation to the last remark, one would only have to have compassion for somebody who found themselves in a situation where termination is the only choice that they have.

Dr Denham: Terrible.

Senator O'Meara: Dreadful. You said that we have the highest incidence of cystic fibrosis in the world. What numbers, how many babies are born ....

Dr Denham: In broad terms there is a thousand families with cystic fibrosis in the country at any one time ....

Senator O'Meara: There are ....

Dr Denham: .... and in broad terms there is another thousand who are either going to have a cystic fibrosis child in the near future or have had a cystic fibrosis member who died.

Senator O'Meara: So, per year, what numbers?

Dr Denham: We are only talking about 30 or 40 new patients every year.

Senator O'Meara: Yes.

Dr Denham: This will become very relevant, Mr Chairman, because the health board is on the verge of setting up a neo-natal diagnostic facility whereby cystic fibrosis would be picked up at birth as part of the heel, the Guthri test, that is checked on every baby at birth. When this happens, and it is likely to happen within the next year to 18 months, then diagnosis will occur much earlier and patients will be diagnosed at birth. That, of course, means that the family will plan their future at that time. It is unfortunate at the moment – sometimes you pick up a child with cystic fibrosis who is, say, six months or a year old and then you look at the other members of the family and you find that, lo and behold, the four year old with asthma, or who was thought to have asthma, also has cystic fibrosis and has had it without treatment all that time.

Senator O'Meara: My understanding is that with genetic advances, that with DNA coding and that, it is generally expected – maybe this is just a lay person's view through the media and so on – that we are looking at a situation where genetic diseases, such as this, will effectively be eliminated in a number of decades or will possibly be ....

Dr Denham: The only way you eliminate them is to ensure that people do not pass on their cystic fibrosis genes.

Senator O'Meara: I think it is worth just mentioning – there may be no need to mention it – but in relation to families where there is more than one child with cystic fibrosis, I think in general in this country we have had the view – possibly it is changing because the country is changing – where there has been a great welcome extended by families and by society generally to a disabled child or to a child which is not in medial or scientific language one would consider normal. There has been, I think our attitude in this country ....

Dr Denham: These families are wonderful.

Senator O'Meara: Yes, absolutely.

Dr Denham And the extended families are wonderful.

Senator O'Meara: Yes.

Dr Denham: Which is why we devote so much time to them and try and help them to the very best of our ability.

Senator O'Meara: And societal and community structure does support people very well.

Dr Denham: Yes. The schools are good, the health board structure leaves a lot to be desired still, but we are working on it.

Senator O'Meara: Working on it. Obviously, and from your remarks we know, and from remarks made by other doctors who have been here, that a number of parents are making a decision to terminate pregnancies, such as where cystic fibrosis is identified and in other cases where Down's syndrome is identified, for instance. So, parents are already making choices, in other words a choice is available. In the scenario you set out in your letter – I would like to thank you for it – as explored by Deputy McManus, you are looking at a situation where, in effect, an ethics committee in a hospital would be making that decision if one were to advance down that road.

Dr Denham: Well, the decision would obviously be made by the parents ....

Senator O'Meara: The initial decision, yes.

Dr Denham: .... on the advice of their consultant, and whether or not one proceeded would be in the hands of an ethics committee.

Senator O'Meara: At the moment it is not.

Dr Denham: At the moment it is not.

Senator O'Meara: At the moment the decision is purely in the hands of parents to do that. My reading of the Medical Council guidelines would be that if one were to allow for a situation of allowing for termination in this country it would cut very squarely across the Medical Council guidelines ....

Dr Denham: I think that is true.

Senator O'Meara: .... which talks about the deliberate and intentional destruction of the unborn where a mother's life is not in danger. Now, clearly, in the case of cystic fibrosis pregnancy a mother's life is not normally in danger.

Dr Denham: No, the mother's life is not in danger, but the family is in danger.

Senator O'Meara: And the mother's health is, strictly speaking, not in danger.

Dr Denham: No, but the entire family is in danger. The birth of a second severely handicapped child into a family frequently destroys that family and frequently breaks the family up. Even where it does not it throws such an extraordinary burden on the family that their life thereafter can certainly not be considered normal in any respect.

Senator O'Meara: But, medically speaking ....

Dr Denham: But medically speaking you are quite right.

Senator O'Meara: So, medically speaking, it would be the deliberate and intentional destruction of the foetus.

Dr Denham: Absolutely.

Senator O'Meara: That is fine, I just wanted to clarify that. Thank you, Chairman.

Deputy McGennis: My question has largely been answered with the last question. Thank you for your submission and for being here. You have recommended in your submission that we should go for the liberal option, but you have some safeguards. This would mean the option of permitting abortions where there is a congenital malformation. Now, you have dealt specifically with cystic fibrosis, because it is your area of expertise. You would not be suggesting that cystic fibrosis would be on a list of illnesses or congenital malformations where abortion would be permitted, I presume, because if that was the case, certainly the Masters who spoke to us yesterday expressed concerns about listing cases – this is even in life threatening situations.

What you are suggesting is that we would go for the most liberal regime and that the mother in consultation with her doctor would make the decision and then it would be up to the ethics committee of a hospital to decide whether that would be permissible or not.

Dr Denham: Well, they would obviously regulate the practice. Ethics committees in hospital do regulate the practice at present.

Deputy McGennis: It seems to me that what we would end up with would be a situation where an illness like cystic fibrosis came by way of, if you like, certification from the doctor who is treating the mother. Certainly yesterday, if not the day before, we discussed the position where 98% of the abortions which are carried out in the UK at the moment are done .... There are four headings, I think number three is the one which turns up in 98% of cases where the psychological welfare of the mother is cited. It may be stretching credibility a little to accept that statistic and people would maybe jump to the conclusion that the doctor who sees the mother in the first instance and the doctor who carries out the termination … are they absolutely convinced that is the situation and yet they certify it in a huge number of cases – I mean, five million abortions in whatever number of years on that basis.

Dr Denham: I do not have any knowledge or experience so I couldn't comment.

Deputy McGennis: Would you not feel that it would be highly unlikely that an ethics committee might overturn a request or a decision of the doctor and the mother for a termination?

Dr Denham: I do not think anyone is going to start doing large numbers of terminations of pregnancy in Ireland. I do not think anyone is proposing that, suggesting that or thinking of doing it.

Deputy McGennis: I suppose my main question is that you were not seeing it as part of a list but we are still going back to where it is the mother in consultation with her GP and then another authority makes the decision. Thank you.

Chairman: Just one matter. A reference was made by Senator O'Meara to the guidelines issued by the Medical Council but of course the constitutional framework here is more than a guideline and in a sense the proposal you have canvassed, if it is to be placed into the present constitutional context, could only refer to threats to the life of the mother. Is that correct?

Dr Denham: Again, you start to dance on the heads of pins, don't you, whether a threat to the family life and family structure is … and something that is going to adversely affect the health of an existing child is indeed a threat to the life of the mother or not?

Chairman: But by equalising the life of the unborn and the life of the mother in the Constitution, a very high standard is imposed – it's hardly dancing on a pin. It is quite clear in a way, is it not?

Dr Denham: Fairly clear and fairly onerous.

Chairman: The masters in their discussions with us on this question yesterday, in their evidence yesterday to us, raised specifically the question of the lethal outcome. That was specifically raised and they accepted there were wider questions beyond that but they seemed uncomfortable with them I have to say.

Dr Denham: I would agree I think. You know, most of my obstetric colleagues, when one comes to discussing the problem of cystic fibrosis, are uncomfortable. It is a very difficult area and there are no easy answers. I cannot tell you what is right or wrong any more than I can tell an individual patient what is right or wrong for them because what is right for one family is wrong for another. As I said before, we counsel them non-directively and we support them to the very best of our ability whatever they decide.

Deputy Enright: I would like to join with the other speakers in thanking you for coming this morning. In regard to a woman who is expecting, who is pregnant and expecting a baby whom you have diagnosed as suffering from cystic fibrosis, is that normally a difficult pregnancy for the mother physically, as distinct from mentally?

Dr Denham: No, the pregnancy is completely normal.

Deputy Enright: Completely normal?

Dr Denham: Yes, no difficulty whatsoever with the pregnancy or delivery.

Deputy Enright: You mentioned the actual physical problems associated with cystic fibrosis – the problems of their lungs, the problem of breathing difficulties, the amount of medication they have to take regularly, the level of physiotherapy that is required. Those are all physical – what is their mental capacity? Can you give me an idea of, say, ten patients who suffer from cystic fibrosis? Are they below average intelligence ....

Dr Denham: Their intelligence is normal, the brain is not affected. The lungs, the liver, the intestine, the salivary glands and the reproductive tract are all involved … and the pancreas – many of them get diabetes, they get liver failure, they get lung failure, they have severe digestive problems. It is not uncommon for a patient with cystic fibrosis to be taking well in excess of 100 tablets every day as well as all of the physical therapy but their brains are normal. If well looked after and well treated, their quality of life is very good for many years but eventually deteriorates and it is a very bad disease.

Deputy Enright: Certainly they are individuals who actually are fully aware of their surroundings when they are born?

Dr Denham: Completely normal.

Deputy Enright: Thank you very much.

Dr Denham: Thank you.

Chairman: Dr Denham, I would like to thank you very much for coming today. I appreciate you have a very busy schedule like many medical men and women and you are very good to assist us. You can read a lot in the newspapers these days about how politics are held in a certain way by some sections of the population but you will be surprised to learn you are being a bit of a politician yourself coming here today and I think that is the most important thing about citizenship.

I really do want to thank you very much and I want to take the opportunity at this stage to thank all the members of the medical profession who have helped us. It has been very enlightening to us as a committee and I'm sure to the general public and your assistance as doctors and as citizens of Ireland is very much appreciated. Thank you.

Dr Denham: Thank you.

Chairman: We will suspend the session for five minutes and then we will take Dr Anthony Clare.

SITTING SUSPENDED AT 11.38 AM AND RESUMED AT 11.45 AM

Dr Anthony Clare

Chairman: We are now in public session. I welcome Dr Anthony Clare of St Patrick's Hospital to this meeting of the Joint Committee on the Constitution. We asked to meet you, Dr Clare, to see whether you as a psychiatrist could throw some light on this question of abortion and the procedures associated with the care of maternal health in pregnancy. The format of the meeting is that you can make a brief opening statement on that issue, if you wish, which will be followed by a question and answer session with the members. I have to draw your attention to the fact that while Members of the committee have absolute privilege, that same privilege does not apply to you in your spoken utterances here today, although a transcript will be prepared and when published will enjoy absolute privilege. I now invite you, Dr Clare, to make your opening statement.

Dr Anthony Clare: Thank you, Chairman, and thank you too for sending me the briefing documents which I have to say I found extremely helpful, though if anything they served to deter me even further from coming here seeing the complexity of what's involved.

I should say at once that I am uneasy as a psychiatrist and as a man involved in these discussions. With regard to the role of the psychiatrist you'll see why when I discuss how psychiatry has been caught up in the issue of abortion. This is, if you like, an opening statement. As a man I find it a difficult situation because this is one of those few but crucial decisions that in the end women make, too many of them I'm afraid unsupported by the men who have put them in the position they find themselves in in the first place. While I know there are those who argue that liberalising abortion if anything serves to let many men further off the hook, I think that in the briefing documents, for example, there are some very fine statements concerning the need to put the whole issue of abortion in a much wider context of personal responsibility, greater sexual and personal and psychological education of young men and young women – boys and girls indeed – before we get to some of these difficult issues. So I would like to say that has really been my reluctance. So you have invited me here, which I must say I appreciate, but if you wondered why I hadn't put myself forward in the first place, they were among some of the considerations.

Psychiatrists in this country, as you know, have been caught up in this arising out of the X case very largely, where the issue of suicide became almost – well it became the definitive issue in relation to Ms X. This was somewhat unfortunate because, of course, her suicidal statements, as I understand it, arose out of the context of her pregnancy which was, as reported, the consequence of force and an involuntary act on her part. That raises the issue of whether that would have been a better reason to argue the termination than the much more tenuous and difficult issue of suicide.

The literature on suicide and abortion, which I, with a colleague, Janet Tyrell, in 1994 reviewed for the *Irish Journal of Psychological Medicine* is pretty miserable. It is a rather sparse literature compared to that on the psychological consequences of abortion. Many of the studies are faulty in terms of their sample selection and the absence of any appropriate control groups and in overall design. Many women, for example, up to 40% in some highly quoted studies, supposedly refused abortions

have actually gone off and had the abortions elsewhere depending on availability. Nonetheless, these caveats notwithstanding, suicide rates in pregnancies are low, certainly lower than in non-pregnant women.

These findings are in the main derived from studies in countries in which legal abortion is available and one of the studies quoted in your briefing document, I think Louis Appleby's retrospective studies spanning ten years found that the risk of suicide in pregnancy in the UK was one sixth of that expected for non-pregnant women. He actually put figures on it. A total of 14 pregnant women committed suicide during 1973 to 1984 compared with an estimated and statistically expected 281.5. That gives an overall observed to expected ratio of 0.05% or, to put that into simple figures, pregnant women had one twentieth of the expected rate of suicide. That's led to the statement that in fact pregnancy protects women from suicide, though no one would advise that as a treatment. The mortality ratio for teenage pregnant women was 0.28 so that, although at low risk compared with teenage non-pregnant women, this group did carry a risk of suicide five times greater than that for pregnant women as a whole. What we are dealing with, very, very small numbers and a very small risk.

There is, however, just to complicate it, strong suggestive evidence that the provision of abortion has in some jurisdictions resulted in a drop of suicide rates in pregnant women. For example, the study of Weir between 1943 and 1960 found 66 women had committed suicide who were pregnant as against Appleby's 14 in the 12 year study he had and that was a change from 59 per million births to 1.9 per million births. People have argued as to why that is and there are a number of reasons but they're all probably social. There's been the change in attitudes to single parenthood, change in attitudes to illegitimacy or births outside marriage and, of course, there's been the development of legal abortion.

Nonetheless it is also difficult to show evidence of suicide following refused requests for termination and much would be made of that and has been, particularly in the context of the X case where, as you know, it all revolved around the danger that the girl refused abortion would kill herself. It's very hard to find this kind of work properly studied because most jurisdictions that carry out decent medical research happen to be the same jurisdictions that have legal abortion. One study in Sweden between 1938 and 1958 found three cases of suicide registered in people who had been refused abortion, none over the next 20 years. There are a number of other studies but I have to say that one's got to be very careful about how you interpret them, so that suicide as a consequence of termination being refused is a low risk but it's not an absolutely non-existent risk. It can and has happened.

The second point I'd make as a psychiatrist, just because it'll come up, is that much is made often of the psychological consequences of abortion. We looked at that, its effects on mental health. Most studies do not find increased morbidity following abortion but, again, there are difficulties undertaking this research and, for example, the present predicament we face is that we've no idea what kind of psychological morbidity follows in many Irish women who go for abortion because they drop out of sight once they've had their terminations. It's not something that they're necessarily going to discuss in great detail with their doctors. Much of the evidence is anecdotal. Many psychiatrists, such as myself, will have seen women who have got guilt and regret, which is particularly activated often when they become pregnant again, perhaps in a stable relationship or whatever, and they do recall their termination and abortion, but that's anecdotal. There are after all 5,000 a year and there are many, many other women, presumably, out there who have made that decision in the most difficult of circumstances and lived with it.

Surveys in the United States suggest little evidence of any pyscho-pathology in over 20 methodologically sound studies. Psychological distress was generally greatest before abortion and the instance of severe negative responses for most abortions was low but there is a caveat that has particular relevance to Ireland and that is those women who have strong cultural and religious distaste for abortion often are those who show, understandably, the most psychological distress following abortion. That would fit after all and there's what I heard Dr Denham say, which I think is important to re-emphasise, and that is for the overwhelming majority of women who take this decision it is a very painful one. As you are agonising over how to do it without too much trauma, that is to say how to legislate, women are deciding about their pregnancies. It is not a case of which is going to be the one without any trauma. There's going to be trauma whichever they do and, therefore, to find psychological distress following abortion is not surprising. If you weren't to find it it would confirm the views of those who say 'there are women who without thought enter into it'. There's evidence here. You can interpret it in both ways. I don't think it helps people towards a decision as to whether they do or do not legalise abortion.

What about psychiatrists predicting suicide? Well, you'll be told, perhaps to your alarm, that psychiatrists are not very good at predicting suicide. I say to your alarm because, of course, under mental treatment legislation psychiatrists are permitted to detain people against their will on exactly that prediction. Now they will argue that they're dealing with potentially mentally ill patients whereas most of the 5,000 women who go to the UK for abortion are presumably mentally healthy, but I have to say we are not terribly good at predicting suicide in the mentally ill either. If I tell you that the problem is, you see, suicide is a rare event. In Ireland it is about ten to 12 per 100,000 or 1 per 10,000 of the population. If you were to increase the rate here a thousandfold the risk would still only be about one in ten and that, as statisticians will tell you, while it might sound a much higher risk, is still a relatively low probability.

Even in illnesses with a high lifetime rate of suicide – 15% in disorders of mood, 10% and rising in schizophrenia, 18% in alcohol dependence – the greater likelihood, as you see from those figures, is non-suicide. I think Michael Kelleher predicted that for every 100 cases of suicide predicted the prophecy was wrong 97 times. Now in the case of the Mental Treatment Act we accept that rather poor score rate because to save three from killing themselves, which is after all an irreversible decision, we're prepared to be wrong quite a few times to err on the side of caution. As you know the Legislature at the moment is trying to see how that can be circumscribed with even tighter laws and appeal tribunals and so on because they

recognise the deprivation of somebody's liberties as a serious matter, but most societies accept that to protect people from killing themselves requires that kind of intervention in the case of mental illness.

So you're dealing with a very low prevalence of suicide anyway – a state of pregnancy which tends to protect and, if anything, to reduce the risk still further but not eliminate it, doctors, psychiatrists, poor at detecting those who are going to go on and kill themselves and a situation we have arrived at here in Ireland where as a result of a particular court interpretation we're almost at a situation of regarding the psychiatrist as equivalent to the obstetrician and the general practitioner and the patient as somehow deciding whether a termination should take place.

The last point I'd make is I have actually worked in a number of jurisdictions. I worked as a locum in Bermuda. At the time I was working there psychiatrists did have a say. The problem with that was it was wide open to abuse, very understandably. To see women reduced to the situation of having to plead suicide to get an abortion, say in the case of severe congenital malformation or incest or rape, I thought was demeaning to women and to psychiatrists. I've worked in the United Kingdom. I've heard already here today but often in discussions this issue of women and abortion and the extent to which if you liberalise you can lead to a situation where some women regard it casually. This is a difficult area because you're talking in general about women as a man which is, I think, given history a dangerous thing to do. The fact is, however ....

Deputy McManus: That doesn't stop them.

Dr Clare: .... that there will be some women … of course … I mean we're dealing with a general population. You see when you talk about abortion on demand, for example, that is to say that if a woman decides she does not want this pregnancy she terminates it then you're dealing with the general population. In the general population women, like men, are going to be right across the spectrum of all kinds of things, health and illness, personality order and disorder, sensible and silly. It would be a very silly doctor, it seems to me, who'd put his hand on his heart and say every woman who has had an abortion in a very, very liberal climate, as in Britain, thought about it very seriously. I would have had a number of impulsive, disordered rather unloved young women with poor self-esteem, for whom an abortion … yes, I have seen such women have three, four or five. It is part of their appalling self-esteem really that they would regard themselves so poorly. Overwhelmingly, the vast majority of women, even in the United Kingdom, where I felt the participation of doctors was very largely signing a form, they still, it seemed to me regard the termination of their pregnancy with significance and the work of Kumar and Robson, for example, looking at women who subsequently became pregnant and how they coped seems to bear that out.

So, if I were to summarise, I would say that the only real reason that I am here, I think, and that you will find psychiatrists involved in this, is, in a way, because, I suppose we have been drawn in to try and get people off the hook over this issue of a danger to the health and life of a woman who is pregnant and wishes to terminate the pregnancy, so who better than to get the psychiatrist to tell you that if this is refused, this woman will kill herself. Well, no such statement can be made with any great safety, whether the person making it is a psychologist, psychiatrist or a general practitioner. Then one has to really stand back and say 'Why have we got ourselves in this situation, why are we asking that women should mount this argument?' That takes us back to some of the issues you have heard from other medical experts.

Chairman: Thank you. Just one or two short questions and then I will ask the members. In your review of the literature, I was not quite clear – are you discussing the condition of pregnancy of itself as a contributory factor to the suicide?

Dr Clare: That is a very good question. In most studies of suicide in pregnancy, no real connection, no direct connection can be drawn. You are looking at two events, if you like, two phenomena and assuming certain kinds of connections. You are quite right, there may be many reasons why those very very few women kill themselves in pregnancy. It cannot be immediately assumed that it is because they are pregnant. They may be deserted, they may be going through other turmoil. I am afraid the studies do not allow that kind of subtle clarification because, after all, if you are studying suicide, the person you really want to inquire of is already dead.

Chairman: Yes, indeed.

Dr Clare: Their precise state of mind at the time is unclear, so the assumption is that the pregnancy is connected. But it is, again, and there would be those who would insist, rightly, that you do not immediately assume such a connection.

Chairman: But the most obvious assumed connection that has arisen in controversial court decisions would be the connection between a person who has been raped and the anticipation that would then be formed on the basis of that.

Dr Clare: That is right.

Chairman: Is there any literature on that specific issue?

Dr Clare: There is and it suggests that women who have been raped, refused a termination and gone on to have their babies, their suicide rate does not appear any higher than pregnant women in general or pregnant women seeking terminations for other reasons than rape. The problem is the numbers are tiny and the studies are difficult because many, many women in that situation will have gone on to have terminations anyway. It is very hard to find a jurisdiction other than our own, I suppose, where such a situation can arise. It is very hard – either you find a situation where termination is just out of the question anyway or you find it where it is so legalised, that example you have just given, it just would not arise. That would be one of the reasons people would be terminated if they requested it.

Deputy J. O'Keeffe: I would like to express my thanks

to you, Dr Clare, for a very fascinating submission and also for the clarity of your thoughts and the way you have expressed them. Could I bring you into territory which it is our job to enter into and this is the legislative and the constitutional conclusions one has to draw, or we will have to be drawing, from the submissions that we are getting. As you know, there was a proposal before the people in 1992, the 12th amendment to the following lines: 'It shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life, not being a risk of self-destruction.'

Now the background fact is that the 12th amendment fell at the referendum hurdle, in fact by two to one. My recollection is that in fact it was opposed by what I loosely call those on both sides of the divide. You are sitting in a front bench Senator's chair.

Dr Clare: I will move back if you like.

Deputy J. O'Keeffe: Putting on a parliamentary hat temporarily, can you be of any assistance to us, firstly from the constitutional point of view? Do you have any suggestions as to what steps, if any, might or might not be proposed from the constitutional point of view and, in doing so, could you also deal with what in fact is the main constitutional proposal in the options presented in the Green Paper, that there should be an absolute constitutional prohibition on abortion? Could I ask you to address that aspect?

Dr Clare: I found the briefing documents, as I say, extremely helpful and of course, the Green Paper, in laying out the seven options, even more helpful, together with the commentary, which, because I am not a lawyer and these are, in the main, constitutional issues, I found helpful too. My understanding about the absolute constitutional ban, leaving aside, for example, the acceptability of it, is that it does not seem to apparently be workable because of distinctions that moralists might make about indirect and direct abortion, for example, whether that would be legally or constitutionally safe to implement in an absolute constitutional ban. Anyway, to judge from opinion surveys and general viewpoints, I do not think there is support for an absolute constitutional ban. That is why we are agonising here. There is acceptance that a simplistic, absolutist view on this is no longer really tenable and if you want evidence for why it is not, it is in the case of the 5,000 people who each year cross the Irish Sea and they are an important constituency.

Option two, as I understand, is similar to the 12th amendment which was discarded in 1992. Option three, retaining the *status quo*, leaves us where we are and it leaves the courts, as I understand it, to resolve such issues that relate to medical treatment.

Option four, one of the interesting elements in the discussion about that, a *status quo* and restatement of prohibition, was that it actually laid out a possible way in which psychiatrists might participate, a kind of approval committee to which the doctor and patient would be referred for approval, tightly controlled legal circumstances, I think it is called. While it may … it certainly will not appease those who oppose this particular justification anyway but it carries, I think, the grave problems that it encourages ordinary women to have to declare suicidal impulses. Then you have the disagreeable situation of doctors clashing. I have already indicated to you the difficulties here of predicting suicide. It is almost at the level of opinion. A great deal of interest would be taken, I think you will agree, in the composition of any group that would be making the judgment. I can think of two psychiatrists in this city who hold quite divergent views on the subject and certainly if one of them was on the appeals committee, I think the woman should think of another reason for seeking termination whereas if another one was on, the suicide threat would be taken at face value.

Option five, as I understand it, would make suicide threats virtually the only way to obtain a legal abortion and I think that suggests that the 5,000 women who are really serious about this, who are crossing the Irish Sea, are all suicidal and nobody would suggest that for a moment and, indeed, the proportion of them who are must be relatively small.

Option 6 refers to pre-1983 and I am not sure that constitutional lawyers see that as a runner, which leaves option 7. This would permit abortion on grounds beyond those events but, of course, everything implicit in what I am saying is that X was a bad reason. I can understand it. If you have laws structured in certain ways, people are going to utilise them as best they can. In the case of X it was an intensely emotional situation, but the suicide threat overwhelmed the original issue of how the poor young woman became pregnant in the first place.

I heard references when I was listening to Peter Denham giving his evidence to the fact that the Masters – as I understood you to say – were reluctant to think in terms of lists, which rather cut the ground from under me in a way because, first of all, I take what they have to say very seriously. After all, any termination that is going to occur at any hour in the jurisdiction of the Republic of Ireland will occur in, I assume, approved and appropriate hospitals, so they are key people and the staff, if you staff those hospitals, are key people, yet it does seem to me that the ordinary person in the street thinks this way. They think that termination in the case particularly of a young woman raped or pregnant as a result of incest … Incidentally there are some very insensitive statements in your briefing documents by some people that rape rarely leads to pregnancy. I do not know where these statements come from.

Sexual intercourse may in many instances rarely lead to pregnancy, but fortunately it does, but in the case of rape, sadly – and the Balkans is a very good example – rape only too frequently leads to pregnancy, so I think that is a kind of an escape. It is interesting how people try to escape from realities. Rape can lead to pregnancy and someone has got to make a decision. Do you, largely a male establishment, insist that women carry through to term a child conceived through rape? That is a decision. There are those – I respect them – who say absolutely yes, the foetus is an innocent in this and the adult woman has to bear with the consequences of something forced on her. I think many people find that unacceptable, and I would be one of them. Notwithstanding all the difficulties that you have very well laid out and how you establish

rape and assault, I do not think that is beyond the wit of a legal system that has sophistication and sensitivity. I will leave it at that.

I heard Peter Denham on severe congenital malformation and the issue of cystic fibrosis and major risk to physical-mental health. I make that point because I remember at the time of the X case discussing with a number of senior lawyers how unhappy I was about the issue of suicide being used and how really it seemed to me to be a kind of escape from a much more human view of human life. I heard Peter Denham articulate it, and he started to talk about things that you and I can readily understand – impact on a woman's ordinary basic functioning, her sense of herself and her life, family life. A lawyer, who is a judge, with whom I discussed this, said, not unreasonably, that it starts to make things so much more loose. Well, that is the way human life is, it seems to me. If you want to make it really tight, then okay, make suicide your one criteria, and watch the 5,000 go to 4,999 or whatever it is. I just think nothing will change except you will have another tremendous controversy and another vote and then you will have a piece of legislation that will make not a blind bit of difference.

On the other hand, the moment you start to extend, as it is put here, the X case options, then, yes, people will say you are opening up the sluice gates to abortion on demand, but in truth are you not trying to find a situation – to answer your question – where you will have legislation for the termination of pregnancy in certain defined situations, which would include major risk to physical-mental health, pregnancies arising out of rape and incest, sexual assault? Then you would have to discuss with doctors in areas other than mine, and far better qualified than mine, the rare but difficult situations in which women seek termination on medical grounds.

Deputy J. O'Keeffe: I am glad you went over the course so comprehensively. From your reply, you would favour a constitutional-legislative framework which would permit termination here in this country in the circumstances which you have defined.

Dr Clare: Yes, I would. I am a realist, however, and you must bear this in mind – though I notice it discussed almost nowhere, so that there is at times a sort of Alice-in-wonderland feel about the discussion about termination in Ireland – that you, very understandably, want to circumscribe termination in Ireland more strictly than it is in the United Kingdom. I think that is a general actual wish here in Ireland. We do not like to see abortion on demand. I do not think there is much support for that. However, that will mean, of course, restrictions in terms of, say, ethics committees deliberating, certain kinds of monitoring. It also means – I know my Ireland – that terminations occurring in the Rotunda, or the Coombe or Holles Street, will be surrounded by immense publicity, controversy, disagreement. This is not going to go away. Indeed, it will stir it up again. I have heard references to seismic shifts, and I have no doubt they are occurring, but these seismic shifts are slow seismic shifts. The fact remains that most women, it seems to me, confronted with a choice between seeking a termination in an Ireland that permits it under reasonable restrictions, with all the dangers of loss of confidentiality, controversy, public discussion, being outed, and going, as they go at the moment, in relative anonymity and privacy to the UK, will continue to do so. So I do not see that this, for the moment at any rate, is going to significantly reduce the numbers. That is the first point.

The second point is – I do not think it is incompatible with what you're trying to do and I understand the Masters, or one or two of them had some interesting views on this subject – it is a great pity that at the moment that great number of women each year is lost to us as a research group because we do not have a direct referral to the UK. We cannot even go that far that we can accept if women are going to seek termination in the UK that we might have a much more structured relationship with the UK such that we could gather much more fundamental data about their mental states, their physical states, their attitudes, their choices, their circumstances, their situations than we can at present. I would not like to see that lost because I do think that over the next ten years we are going to still have a very steady and full stream of women to the UK, whatever you decide to do.

Deputy J. O'Keeffe: The very last point I want to put to you, Dr Clare, is that some of the doctors indicated that in fact the 1983 amendment of the Constitution did not affect obstetrical practice in Irish hospitals one iota, that it had no effect whatever, that irrespective of that amendment the numbers going to the UK have increased year by year. Do I gather that, to a large extent, you are saying that, apart from the benefits that would be available for research, irrespective of what constitutional or legislative proposals might emerge here, the actual practice will not change to any great degree, the practice of people going to England if they want to have an abortion with a greater degree of confidentiality than they perhaps might feel would be available here?

Dr Clare: That is my opinion. You would have to ask women. If and when legislation is designed, it would certainly be interesting to ask women, perhaps hypothetically, if they were in a situation where they were seeking termination, which jurisdiction would they seek it in. That is all I am saying. I do not know the answer, but I would be interested to know what women think. Having seen it much discussed, what I have seen is how we might legislate, what kind of circumstances, what kind of controls, what kind of supervisory committees, medical representation, psychiatrists making statements about suicide, but what I have not seen is what do women themselves feel. They choose the UK because termination is not available here, but not just for that reason. Not only is termination not available here, but there is no controversy, they have anonymity, they have got privacy. I have grave doubts that any of those things could be protected in an Ireland where, for all the seismic shifts, there is still a very strong body of opinion that would support an absolute ban. There is still a substantial minority of people, and there is still a very deep gut feeling about termination which, seismic shifts notwithstanding, I do not think is going to go away. While one bit of me, the constitutionalist, feels that if we think something is right we should ensure that it is legally available in Ireland and appropriately so but another bit of me knows that we are neighbours to a country where there is a very liberal

regime, and it does provide, as I say, anonymity and confidentiality.

Deputy McGennis: It is a bit disconcerting when a psychiatrist anticipates your question and I think has answered it. In your opening submission you made reference to the X case and the Supreme Court decision and again in responding to Deputy O'Keeffe's questions about the seven options which are dealt with in the Green Paper you dealt with option seven in great length and that was what I wanted to bring you back to. I think you are saying, very honestly and in a way that probably hasn't been said before, that the risk of suicide or a psychiatric condition being used as it is – and I think I would agree totally with you – and the countersigning by the two doctors in the UK situation … in our own legal situation where suicide is … if you want to get a termination or an abortion then that is the way to go. What I wanted to ask you, and as I said I think you have certainly addressed it in your response, is in option seven where abortion for women pregnant as a result of rape or incest … I think you actually said in your submission it would have been far better if the judges had made, and in fact they couldn't because of the law, but if the decision had been made on the basis of the crime and what the girl, the young teenager, went through at the time. Could you just expand on that in relation to your own work and also is it too much to ask you would you support a provision, either a legal provision or a constitutional provision, for a termination where it is obvious that it is established that it is rape or incest and there has been force. We have, as you would have seen from briefing documents, a submission from a colleague, Fred Lowe, who deals with the area of rape or force. That is the area I am interested in.

Dr Clare: I can answer the last question quite directly. Yes, I have no … yes, I would feel that … I really do feel it repugnant as a man … I feel it repugnant that we would live in a society where someone who is raped or who has been forced, and we have seen such terrible cases, that may be part of a seismic shift since 1983, who would be made pregnant as a result of consistent, persistent or even one off sexual abuse in a family or by a stranger is forced then to undergo … to carry that pregnancy against her will. Yes, I find that repugnant. You put your finger on it. The reason the X case went the way it did was that that was the only way, it seemed to me, the compassion of the Supreme Court could be expressed was through this interpretation. I think the psychologist at the time was exposed to very understandable scientific criticism but we all knew what was going on. What was going on, I felt, was a compassionate response to an appalling situation and I felt the Irish people felt the same. It wasn't her suicidal statement, it was really the way she became pregnant.

Yes, I would … I do … your documents were really … I cannot compliment you enough on this. I felt not only would you lay out an option and you would lay it out such that just as one was feeling this is the solution you then laid out very clearly the problems and, in relation to this one, there is this issue – what do you rely on in terms of a woman saying she's sexually assaulted. Does she have to go through a whole gamut of a Garda investigation and virtually … and how long would that take? Then right at the other end of the spectrum you say, do you take the woman's word. I think here I would fall back on, listening to Peter Denham, and hearing in this Chamber a great statement about again the doctor-patient relationship. I do trust that in most instances it can be abused but I do trust it, and I think arising out of that decision … out of that medical recommendation concerning a pregnancy and how it arose I would probably find that sufficient. Others, lawyers may argue about that and there may be other ways around it but in answer to your basic question, yes, rape, incest, there may be other sexually related crimes relating to a pregnancy that would be part and parcel of such a reason for termination … legal termination.

Deputy McGennis: So there is a need for honesty which in fact is what we have found since the first day of the hearings …… even definitions, we had no abortions on Tuesday which became abortions on Wednesday and we now have maybe a need to be honest about why in certain circumstances abortion may be permissible and let's not maybe pick the opt out of threat of suicide.

Dr Clare: Yes, I would say to you though I do respect people who take a very … I understand where they are coming from but I don't agree with them and in the end, of course, that is the problem here, we are not going to get complete agreement but I don't argue out of bad faith. I think the people who argue very strongly against abortion … I understand their position. Even the way somebody asked very recently the question, are you in favour of … God, I hate the whole business and I want to listen very strongly to the people who have to do them, obstetricians and gynaecologists. I do not have to do an abortion, I do not have to commit a termination so it is easy, it might seem, for me but I don't think it's easy for the women and I don't think it's easy for the doctors. I think it's best to talk about this as a discussion as far as possible, though I did get a little emotional about rape and incest but I don't think one should. I think one just should say the situation of a woman and what she is describing and is that a reasonable reason for a termination. In answer to your question I am saying yes.

Deputy McGennis: Just very briefly, my follow-up question was, without obviously going into any kind of detail, the cases which you would be dealing with, where you had somebody who has suffered incest or rape, leaving aside whether they have had a termination or that they had gone through with the pregnancy, what would be your experience of people who had suffered that? What is the ongoing prognosis for most … well, certainly for the people you are dealing with? What have they suffered, what are the effects and ....

Dr Clare: Marese Cheasty and myself studied a sample of adult women attending their general practitioners for any reason at all. I was interested to take a sample away from psychiatry and talk to women going to their GPs for anything and we looked at the extent to which they reported to us in a gentle research atmosphere their experience of sexual abuse in their lifetime and we came up with alarming figures whichever way you defined it. If you defined it that they had been raped, there was around

3% which is an astonishing figure. I mean this is a random population virtually … as random as you can get of going into the community and doing it. If you took any kind … at the other end of the extreme … of sexual interference or exhibitionism or whatever or a distressing kind it was around 33%, so that is the range. When we looked at the women who had been raped or seriously sexually interfered with the consequences for them over their adult life, which we were able to track through their records and so on, were immense. These were women who would have had a lot of difficulty in their personal sexual relationships and were much more likely to be using or had used psychiatric drugs or to be in touch with psychiatrists or doctors with whom many of them, they were small numbers who would not necessarily have discussed their sexual abuse.

It makes people like myself look back over 30 years and think of all the patients I have seen, certainly in the first ten or 15 years of that 30 years who almost certainly would have been abused and neither I nor they discussed it or knew about it. I think that has been such a revelation to people right across the board that none of us can feel untouched by a certain guilt at our inability to either discover this or face up to it or do anything about it. I think that undoubtedly has affected my own judgment about the issue of termination in such instances, not because I think it is a solution to the terrible abuse but I don't want to see added to the terrible abuse further abuse or forcing women against their will to sustain pregnancies in such dreadful situations. None of the women in that particular study had been, as far as I can remember, pregnant arising out of their circumstances. I am not absolutely sure of that but I have seen, of course, in my clinical situation women who have carried to term babies as a result of rape either within or outside of marriage and, of course, I didn't touch on it in my discussions with you but in the paper with Janet Tyrell we looked at the consequences for children who are born in an unwanted situation. They are not inconsequential.

There are some quite interesting studies, most of them from eastern and central Europe where they have done more research on this, looking at the impact on children who came from pregnancies where termination was refused. There are issues of self-esteem, mental health, psychological and physical development that differentiate such children from children of wanted pregnancies. That is another area completely. It doesn't have a particular bearing on this but it bears out the question you are asking me about the consequences of abuse and sexual assault.

Deputy McManus: Obviously, you are dealing with individuals but it has, I think, informed you in your views about society generally and I am interested in this point that you are making that women may still choose to go to England. Even the experience of the last few days, for me has been salutary. I certainly expected there would be more publicity outside, in terms of the pro-life movement, the Youth Defence movement. I had not expected – but I should have thought of it – that every person coming here to make a presentation was male. It reinforced in me a recollection that the world is still dominated by men. I recall back to the times of contraception issues when women had to struggle very hard to be able to win the right to control their own fertility and that it was a time of conflict, but it was a very good thing that that change occurred in Irish society.

I would like you to respond, or to elaborate a little bit on the point you were making that the alternative route of going to England will continue to be attractive even if, in some way, we provide a restricted abortion here. Do you not feel that we have moved, in terms of facing up to our responsibilities, that there has always been the conduit of going to Britain for all our problems, certainly our major problems from emigration to unmarried mothers? Is it good for us, rather than seeing it in terms of opening the floodgates that we can actually see it as an opportunity to mature?

Dr Clare: Firstly, your comment about men. I have no doubt that one of the reasons I certainly did not volunteer or did not approach you to come and talk to you was the feeling that I am another of these men. My wife would disagree with that. She would say, 'You are perfectly entitled to give your view as much as anybody else'. And she would also point out that the gender divide on termination does not split necessarily always the way you think. Not every woman is a liberal and not every man is conservative, if we use these rather crude terms for a moment. Certainly within the medical profession some of the strongest articulated voices on the question of termination and against any liberalisation are women. But I take your point that so many of the voices that one hears expressing views of one kind or another on the issue of termination are men. I accept that, but short of surgery, a man is what I remain.

Deputy McManus: You know that is not what I am getting at.

Dr Clare: On this issue you may be right, you may be right. But I would be very careful before assuming that because we debate in this Chamber so quietly and people are so reasonable and discussing the issues so non-emotionally that you might be seduced into thinking that the steam has gone out of the issue. Because when I read your briefing document – and I did, right through – I was struck by this – the full extremes are there and articulated very powerfully.

I think those people who feel that Ireland is the last decent bastion of civilised sense when it comes to protecting the unborn, are waiting. I have been in the United States which has had, after all, termination for a long time and feelings in certain states run very high. People have resorted to physical violence, terror and intimidation. With due respect to the Celtic tiger and great changes of an astonishing kind in people's moral and intellectual positions, I still feel this one touches something very, very basic in the heart of every Irish person. I think that is why the debate here in Ireland is sometimes the most thoughtful, the most serious as well as the most appalling and disagreeable. It is because it matters.

I once took to task somebody who said, 'Here we are in Ireland whingeing on on abortion and there are so many much more important things'. Well, I am not so sure there are, actually. I think the termination of human life is a very important thing and I think that is why we are here. It is the beginning and the end of it all, and I would be very doubtful that the strong feelings that were aroused by previous amendment discussions have

completely gone away. That is the point I am making.

So, I am saying that you face a dilemma that short of a liberalisation equivalent to that in the United Kingdom, which after all is a boat or plane away, we will have, if we move beyond the current constitutional and legal situation, we will have surely a situation here where termination of pregnancy will still be more restricted, more monitored, more supervised than in the United Kingdom. That is what I am saying, and secondly, I think that even in the hospitals from which these doctors come there are staff who will have very formidable positions indeed and these staff will, obviously, have to have opt-out conscientious clauses and they will still see termination as something they will wish to oppose.

Where I am probably with you at an intellectual level is … yes, conflict, as I am often saying as a psychiatrist, is not necessarily a bad thing. So, you may be right, Ms McManus. You may be right that we are in for a storm, but a cleansing storm. But I think you might be wrong if you are suggesting that somehow, as a result of the many changes we have seen over the last ten years, that the debate on abortion may be entering calmer waters. I would not be so sure.

Senator O'Meara: Thank you, Chairman. Could I thank Dr Clare for his presence here today, for a very illuminating and quite different perspective than the purely medical perspective that we have had so far. As non-medical people and non-lawyers coming to the discussion I think it is extremely important that we look at this because the issue of abortion is not just a medical issue, obviously. We know that the women who travel to England do not travel for medical reasons, except for a very, very small number whom we have heard about.

I do not know if you are familiar … there is a summary of this study by Mahon, Conlon and Dillon in the briefing document, in the context of the Green Paper and the verbatim interviews, the words of the women themselves, not only in relation to abortion but in relation to decisions to take adoption or lone parenthood as choices are extremely illuminating and certainly do confirm what you have just said, that the whole issue is extremely charged, extremely emotional and for the vast majority of women extremely traumatic as well, in terms of the decision that they make.

Two issues – one, in relation to studies of the rate of suicide among pregnant women, perhaps the only illuminating study that we could do would be to look at the potential for suicide among teenagers who have been raped and who are being prevented from leaving the State or who have been prevented from having a termination, because these are the only cases that have been before the courts and they are very hard cases. Hard cases make bad law, of course, but these are the only cases in which the Supreme Court has illuminated the issue in law. In the absence of legislation, that is where we are … two teenagers who have been raped and are pregnant and are prevented from having terminations, threatening suicide. They are the circumstances which we have been faced with. And that is not an illumination, in my opinion. I do not think by any reasonable and objective standard that is an illumination.

You are absolutely right in what you said and I totally agree with you that you cannot have a situation where a woman who has been raped is being effectively told to continue with a pregnancy. That is not reasonable or not human, in my opinion. Nor is it right – and personally I feel that this is what came into play in the X case in particular – that the State should tell any person, any woman, and particularly a teenager, that she should carry on a pregnancy which has resulted from such an appalling act. And that, I think, is what when faced with … that we could not have and I think the public reacted to it in exactly the same way. One might recall – I certainly do recall very clearly – a cartoon in *The Irish Times* at the time, 'internment Irish style', showing the figure of a child holding a teddy-bear with barbed wire all around the borders of the country. That is not what we want to achieve. The result of that has been, it seem to me, the overwhelming vote for the right to travel. So, we don't want abortion in Ireland, but we are happy to have the right to travel to England. That, I think, sums up our approach in this country.

When he was here yesterday Dr McKenna, Master of the Rotunda, who had direct, hands on experience of the X case said, when I discussed it with him in more detail, that he was very surprised at the Supreme Court judgment and felt that to uphold the right to travel would have been the decision. Of course, if you look at the wider issue, possibly – I am just going to put this to you – upholding the right to travel really solves that problem. It does, in effect. To get away from the medical and wider issues, it allows us to allow a raped teenager to end her pregnancy, if that is what she wants to do, her parents and her family want her to do and is considered to be the right thing to do. We will allow for cases of foetal abnormality, for dreadful situations and for every case enunciated in this book and the many other thousands where it would be very, very difficult to turn around and tell a woman, 'No, you shouldn't travel' or 'You can't travel.' We, effectively, let ourselves off the hook on that.

I would take a different view to my colleague, Deputy McManus, on this and she knows that. I don't think that we in this country are ready at all, by a long shot. I think that having the right to travel there and as long as we have a legal framework which ensures that women with severe medical conditions are allowed to be treated properly by our obstetricians in our hospitals, that, effectively, deals with the situation for us. I also agree totally with you, by the way, that even if we brought in a limited abortion regime in this country – a legal framework – that women would still travel to England for precisely those reasons that you talk about, for confidentiality in particular. So, I actually think that psychologically – for want of a better word – this is where the country is at. One of my colleagues said yesterday that we do have abortion, we have abortion in England and we have the right to travel, so, effectively, we are part of that liberal abortion regime. Can I put it to you that by retaining the right to travel we have solved our problems?

Dr Clare: I would remind you that I am in one of the two Houses of the Oireachtas of a free and independent State which drafts its own laws for its own citizens. What you have described is, I understand, a very practical solution, but the Supreme Court, the courts and the Oireachtas of this State feel that we need to have some law on termination. Either it should be completely banned or we should permit it in certain circumstances.

Be very careful, what I was saying was … I wasn't saying that it is or isn't right that we should be deliberating and that at some point there should be a constitutional or legal framework. I wasn't saying that is not right, that's why I am here. I am merely saying that it is separate from the problem of 5,000 travelling to the UK, that we are not changing our legal and constitutional framework to sort of stop them going there; we are changing it because we think it is the right thing to do.

I think that over time, of course, people will alter and change their views as societies develop. That was the disagreement with Deputy McManus, if disagreement it was – it was an exchange of opinions really because neither of us can be sure of this – but I don't think it is necessarily going to change things overnight and the feeling I get from these documents and discussions with people of various kinds is that there is no appetite here for an unrestrained abortion … abortion on demand. There are some people who argue it … Lawyers for Reform, I think, argue it here, but my impression is that that would be a very difficult one to argue and that, therefore, we will have a more restrictive position.

In answer to you I would say that, all right, you may see it as a solution, but it means that if we never move, the situation is that for a woman to terminate her pregnancy she has to go to another country to avail of medical facilities – whose quality is very variable – where there is very little in the way of post-termination counselling and where the society, ours, never really in the end faces up to the fact that a very significant number of women are opting out of our current legal structure. I think that's … I see that it is reflected in your efforts. That's not really acceptable, that it is really a blight on our sense of ourselves as a legal and mature society that we have not brought in, in other words, certain kinds of legal changes because of a kind of geographical arrangement that we have with a country whose position on abortion we strongly disapprove of and yet whose facilities we avail of.

So, I am distinguishing … Please don't think that because I think it may not in the short or even medium term have an effect on the number of women who seek termination in the UK … I don't think that that is a good reason for not sitting down and looking and seeing can we construct a legal and constitutional framework whereby abortions that the majority of the Irish people feel should be permissible here can be permissible here.

Chairman: Of course, to go down that road would require revision of the current constitutional framework, apart from anything else, and that, in turn, would require a fresh consultation with the people on the question.

Dr Clare: Is that inevitable?

Chairman: That is inevitable if you seek to extend the categories; you would have to have fresh consultation with the people. In the political tradition to which I belong it was your heart surgeon … you looked into your heart and decided what the people wanted, rather than consult a psychiatrist.

Senator O'Meara: I thought it was your former leader, de Valera.

Chairman: I enjoyed very much your analysis or interpretation, which was made as a citizen, rather than as a psychiatrist, I might respectfully say – I found it very stimulating for that reason – of where the Irish heart lay in this matter, if you like. A lot of the discussion was taken up with restrictions and whether you can have restrictions and if you have restrictions, where they are, but there is a more general question that wasn't touched upon much and I'd be interested in your view on it. We have a rate of abortion in this country. The statistics are a little uncertain because of where they take place. Is there any practical measure we can take to reduce the rate of abortion?

Dr Clare: I think there are a number. The first thing .... It is part of a larger argument that I make in relation to a number of issues that confront this society – I am thinking of things like drugs and alcohol, sexual relationships, the relationship between the sexes, non-sexual relationships between the sexes, bullying, violence in our society and so on – that it does seem to me .... I am often asked to go and talk to schools – that we really need to take a complete look at how we teach human behaviour. It is often called civics or ethics. Business studies touches on it, but it really is surprising that my children who have been educated here and in Britain can get quite detailed biology instruction – indeed go on to take the leaving certificate in it – and yet human psychology is not touched on. So, if you want to discuss with children issues like bullying or sexual relationships, it is in an artificial setting, somebody comes in from outside or there is a special … there is a little circle around it … or drugs or alcohol. Of course, they are all related to each other. Many of the teenagers who get pregnant get pregnant while they are intoxicated, particularly in Ireland where teenage drinking is a phenomenon well worth reviewing in this Chamber and the other one.

That would be the first thing I'd say, that we really do need … this is where I would suggest that some of the people who feel so forcefully about abortion would really need to take a step back and look at the issue of sexual and human relationships and how we help parents in Ireland develop a reasonable degree of personal responsibility in our young adults, which is lacking, particularly I am afraid in young male adults. Hence, we then end up with this situation.

My wife said to me that in all the discussions about abortion you hardly ever hear men mentioned other than when they are drawing up the laws. All these pregnancies occur as a result of men being involved, but, of course, by the time a young woman or, indeed, often a married woman or a woman in a relationship gets pregnant men are so settled in certain kinds of ways that I am afraid their role subsequently in many instances … I risk the opprobrium of John Waters but, in many instances, they reflect badly on men.

The second thing is that perhaps we need to take a look at what kind of .... This is where I would like to have heard the obstetricians and gynaecologists, in particular. I'd like to have a look at the kind of counselling that is currently available. I would strongly support the issue of non-directive. I know there are arguments about this but, if we really want to influence termination rates, then we must be able to have as open a discussion with women –

pregnant and non-pregnant – about the issue of pregnancy and dilemmas and difficulties as we possibly can. I cannot understand how a psychiatrist, for instance, could argue that you can do that in a setting where one of the options is completely ruled out or cannot be discussed or is completely not on. Particularly since, in practice, it's on across the water.

There are other areas no doubt but those would be two areas that I think, regardless of what you decide to do in your constitutional deliberations, politicians, in consultation with teachers, parents and doctors, really do need to take a very, very cold and careful look at how we educate our children in personal social sexual relationships. At present I am afraid we do it by default. That is no criticism of Ireland as I am not terribly sure it is done terribly well in many jurisdictions.

Chairman: There are two practical points arising from that. I take it from what you are saying that fostering a responsible attitude to sexual relations is a desirable common good – the desirable element of the common good.

Dr Clare: Absolutely.

Chairman: It is something that, as legislators, we should foster in any way we can. In the case of other countries, are there any particular approaches towards this problem? Cultures vary enormously, I appreciate that.

Dr Clare: That is the problem. People will discuss a culture like Holland, Norway, Switzerland, Britain or the US. I think it is difficult. The more I look at, say, the Dutch, who are very interesting on issues of sexual education, the more you see that you can't really separate it from a lot of other Dutch views on personal responsibility in all sorts of areas. We can learn, perhaps, technologies, ways of incorporating some of these ideas and that is reasonable. It is right that we should look at how other societies handle such issues as sexual education, personal responsibility and issues of drugs and alcohol but we must evolve our own response. We can learn but you are right.

A very good example of that is a culture that we talk about so often – the UK – but there are differences. The family structure is different. I worked there for 19 years and it is very similar in lots of ways but there are interesting differences. The extent to which adolescents are either, it depends on your views, liberated or ejected from a close family structure is more apparent there than here. Therefore, in a sense, adolescents over there often have to stand on their own two feet even earlier. That has its hazards in the UK.

Here there are hazards because we think that, because so many of our adolescents are still within the family home, that, somehow, they are protected – they are still children. We have to look at all of that. I notice how easy it is to think in terms of 14, 15 or 16 year olds as children and, therefore, we have to be careful how we educate them sexually. However, several of the cases that provoked the constitutional issues concerned very young adolescents. There is a sexuality out there, happening anyway. The signals are there for us that we need to take a much more systematic approach to the issue of sexuality then we do.

Chairman: Do you think that, in your own clinical experience, there is an increase in personal irresponsibility because we haven't been able to cope with the decline in the intensity of religious practice in Ireland?

Dr Clare: That's a very difficult one. Situations change and whether things are worse or better I don't know.

Chairman: I am not making a judgment about worse or better in putting that question.

Dr Clare: Are teenagers more irresponsible?

Chairman: Yes.

Dr Clare: If I compare my teenager's life with my life as a teenager, there is certainly .... This is a much more open society with many more opportunities for good or ill. There are less structures and there is less hidden, in certain ways. However, that means you've got to educate your adolescents in a sense to be more streetwise. For example, you and I will know that, when we were growing up, the issue of drugs in Ranelagh or wherever would never have occurred to any of us. Now you'd be a foolish parent indeed to take that view, not to engage your teenagers in at least a discussion about soft and hard drug use. That's in 25 years and that's what I really mean.

The problem is that I go to schools and parents of teenagers say to me things like, 'What should we do? Should we discuss drugs? What should we do about alcohol? What should we do about sexuality?' They are not asking me what should they do about educating their kids about business studies or geography, they are asking about the most fundamental aspects of their children's lives and I realise that we have failed them. Schools, doctors, politicians and society have failed parents. We have changed the society. None of these people individually had too much say in that – societies change in complicated ways – but we have left them adrift. Abortion, teenage pregnancy, drug use and alcohol abuse are the final consequences of a kind of *laissez-faire* attitude to how young people in Ireland are helped to grow up.

Chairman: In a way that was what my question was directed at – that with the decline in the intensity of the traditional practised religious beliefs there isn't an alternative code or standard. That really was the ....

Dr Clare: That's true, you are quite right. I would not, and neither would you, feel that there's any prospect, even if there was a desire, to return to a society which was largely one of controls and circumscribed prohibitions. That is no longer a situation but that itself is an interesting development we have to take on board.

Chairman: One other issue arising from your response to that basic question is about non-directive counselling which is permitted under the legislation as it operates here in this State. Are you suggesting we should, perhaps as an experiment, invest more widely in that to see whether that, as an exercise, would yield more information about how we can tackle this problem of the rate?

Dr Clare: I would think that in any constitutional and/or

legal development, you would need to take that very strongly into account – that just changing laws and regulating constitutions is insufficient. You are going to have to put in place the bones of that which you regret is not in place at the moment. That is to say where women can have an opportunity. I accept what you say about it being constitutionally available but it has got to be very widely available and publicised and the bullet about women then choosing to go to the UK and seeking information as to where safely to go also has to be bitten. That's the point – that after the non-directive counselling there has got to be some kind of guidance as to where they can safely go if they still opt for termination and, hopefully, fewer of them would.

Chairman: Dr Clare, thank you very much for your contribution. It is very much appreciated and thank you for your assistance. I know you have a very busy schedule. Members found your contribution very interesting. Some of them had to leave because they had other engagements after a number of days of very difficult hearings but I very much appreciate your assistance. Thank you very much.

SITTING SUSPENDED AT 1 PM AND RESUMED AT 2.30 PM

Dr Michael Solomons

Chairman: We are now in public session. I would like to welcome Dr Michael Solomons to this meeting of the Joint Committee on the Constitution in its consideration of this issue. Dr Solomons, we have received your letter, which is at page 179 of the brief book before you, but I think you may need a copy of the Green Paper as well to assist you. Do you have one? You have a copy of it, have you?

Dr Michael Solomons: It is here, I think.

Deputy McGennis: It is, yes.

Chairman: Your own letter is at page 179 of that book, but your own letter, at page 179, actually refers to the Green Paper and I am anxious that you should have a copy of the Green Paper as well before you. I will arrange for it to be provided to you.

In the meantime I shall tell you that we have received your letter, which has been circulated to the members and, you will be glad to learn, it has also been laid before the Houses of the Oireachtas so it enjoys absolute privilege so you can never be sued in respect of your letter.

The format of this particular meeting is that you may make a statement elaborating on the letter, if you wish, which will be followed by a question and answer session with the members. I have to draw your attention to the fact that while the members of the committee have absolute privilege, this same privilege does not apply to you in your utterances here today, and I would ask you to elaborate on the letter which you wrote to us which is at page 179 of the book before you.

Dr Solomons: Now Chairman, please may I start by saying I am a bit deaf so I had to strain to hear what you had to say. It is not your fault. I gathered it all but I don't want to miss anything important.

Chairman: Yes, very good. Can you hear me more clearly now perhaps?

Dr Solomons: Yes.

Chairman: I am leaning into the microphone more and I hope members would do the same when questioning Dr Solomons. What I indicated to you is that your letter has been circulated to the members of the committee and ....

Dr Solomons: I did understand.

Chairman: Oh you understood that. It is just you had to make an effort and you don't want to be making that effort as we progress to more difficult topics. Well would you like to elaborate on the letter which you wrote to us?

Dr Solomons: Well the first paragraph is clear, I think, and the second, my reasons for opposing options one to six, inclusive, because I think they are unrealistic in the Ireland of today. The present situation, as far as I can see it, involves a large degree of irresponsible sexual activity amongst the unmarried, and especially teenagers. There is inadequate sexual education and family planning advice. The young especially are subject to peer pressure and the media in many cases do not help to give younger persons a balanced view of sex – journals, television, advertisements. If I were a young person and didn't have any parental guidance or spiritual guidance or didn't assimilate them, I would believe that the way that one is, that the public is exposed to a great number of partly erotic or certainly very suggestive pictures. I think it is very tricky for the young.

On peer pressure, there seems to be quite a degree of conversation amongst the young, suggesting that going to bed or say having intercourse is the thing to do and is worth trying out. These features associated with I think the poor availability of good information, and especially if they are, if the tendency to sexual activity, which seems to have increased in recent years amongst this younger age group, if it is to be contained and put into a more favourable situation such as marriage or, probably more important, taking precautions against contracting disease and, on the subject of today, becoming pregnant when they don't want to … and we have these approximately 5,000 Irish women going to London for an abortion and that it is another reason why I feel the first six options don't seem to understand the problem of these young women. Even if I am not keen on, and would not approve of abortion on demand, I would certainly emphasise the essential nature in this abortion question of preventing pregnancies, and also, as a male, I don't think enough emphasis

is being put on the responsibility of men. Women have abortions, men don't, and a number of those of my sex do not seem to realise that the woman carries the baby and all its consequences unless the man or the partner is extremely supportive, which is not the case in every instance. Coming to the reason why I would support option 7.

Chairman: You wouldn't object, Doctor, if I led you on that perhaps in relation to option 7? I could summarise what you said there if you like, because I have the Green Paper before me.

Dr Solomons: Sorry?

Chairman: I could assist you on option 7 perhaps. In setting out your letter you make the point in relation to option 7, that is to say, permitting an abortion on grounds beyond those specified in the X case, that you agree in the case of a risk to the physical or mental health of the mother but you would put in the word 'major' before 'risk', a major risk to the physical or mental health of the mother. You also agree in a case of a woman pregnant as a result of rape or incest, and you also agree in the case of congenital malformations, with an additional wording to read, 'Congenital malformations incompatible with an acceptable quality of life'. Then you disagree with abortion for economic or social reasons or on request. I think that's essentially the substance of what you're saying in relation to option 7. Is that a fair summary?

Dr Solomons: Yes.

Chairman: Would you like to develop that perhaps in a few words?

Dr Solomons: I think I'd like to say that before all this arose it may be relevant to say that I was an assistant master in the Rotunda hospital from 1948 to 1951, and I saw far more problems in obstetrics then than occur today. I think it's worth mentioning that in those three years 12,000 deliveries occurred. It's much higher, it's nearer 20,000 now in a three year period in a Dublin maternity hospital. Of those 12,000, 23 women died and 800 babies died. So I have been brought through, or brought up with the major problems and I'm delighted to see they have improved so much since. One of the other cases which was very significant of the times was that a 26 year old woman, on her sixth pregnancy in hospital, became blind as a consequence of hypertension, high blood pressure, and complications. That wasn't enough; her husband combined to bring her back to hospital within a year pregnant again.

Since then I've been associated with the Irish Family Planning Association. I've written a book on sex education which was subtitled *Facts for Adults.* In those days – this was 1963 – you had to be very careful who you were writing to and what you said. Incidentally, contraception could not be mentioned in that book, so we are advancing. Then my next effort was almost 30 years later, when I had retired and decided I wanted to say a few things about abortion Bills and related matters. These factors all combined to make me very conscious of the importance of women's health being a priority for all men. Women, too, I think, certainly must retain the right to choose, not just to do with whether they require or wish for an abortion, but I think they are entitled to discuss the matter with a doctor, say, their general practitioner, then to be referred to a panel of doctors, possibly devised by the Department of Health who would assess this individual. This may take an awful long time, even if it comes to fruition, because there are so many women in this position. The committee or the assessment group would include a gynaecologist, psychologist and a social worker at least.

Then my dream is to have in cases where abortion is approved – and there aren't many cases where it's necessary for medical reasons – that there could be hospitals which would designate departments to dealing with these cases, staffed by consenting conscience agreeable doctors and nurses and that any procedures in these hospitals should be recorded and reports submitted to the Department of Health for assessment each year.

I am reminded of the time in my general hospital in Dublin when I wanted to do … carry out some female sterilisations, tubaligation. I was in two hospitals – one was staffed by a great character who said, 'You're not going to do that in my theatre'. At the other hospital, I spoke to two theatre sisters, both Roman Catholic, and their view was that if I thought it was practical and indicated that I should speak to the parish priest and if I got his approval, they would consent to provide nursing staff and theatre facilities by nurses who had no objection in conscience to sterilisation. So sterilisation has come, contraception has come. I don't want abortion to come *ad lib*, but I do want some more understanding of those cases, such as are listed under option 7, which would include the X case, the C case, and I can foresee other cases in the future where there will be similar or comparable situations where a young woman is suffering and is not being treated with any – I'll be careful about this – Judaic or Christian understanding. I feel that there are future events which would necessitate the adoption of option 7.

I see the other options as not facing the realities of this country and while I respect moral scruples of every other religion, I do not necessarily agree with them all. The Jewish aspect may be a bit relevant. First of all, the term 'unborn' has no place in Jewish doctrine. When I was writing my book I looked up Thesaurus about 'unborn' because I thought it was an over-used, unsuitable word for this question of pregnancy and abortion. Thesaurus names this term 'unborn' as being equivalent to unconceived and unbegotten. And here we have discussions widely using this word, the 'unborn'. We had one of the doctors in recent days speaking as emotively as, I think, opponents of the whole principle of abortion follow, speaking about the deliberate killing of the child, sorry, the deliberate killing of the unborn compared with the incidental killing of the foetus – by incidental meaning following as a result of the necessity of treatment of the mother – you have this histrionic approach to words. Admittedly in all good controversies you have good actors. I think that unborn just does not have a place in, say, acceptable literature today. Let us get back on track.

Chairman: I know the members were very interested in the Hebraic and Jewish tradition – you are referring to the old testament writings, I presume, and the Talmudic

doctrine built on it, but what expression is used, I was going to ask you myself?

Dr Solomons: May I continue with one other item?

Chairman: Yes, of course.

Dr Solomons: In Hebrew or Judaic doctrine, the sanctity of the mother is always above the sanctity of the child. Then, coming to the stage of the situation of abortion, abortion is not permitted by Jewish law, but it is permitted if expert medical opinion decides that the continuation of a pregnancy is dangerous to the life and the health of the mother. So, there are other aspects of this abortion question that I feel I wanted to put in place. May I have a pause?

Chairman: Yes, of course.

Dr Solomons: Hopefully to answer anything.

Chairman: Do you want some water?

Dr Solomons: Yes.

Chairman: I will let the members ask questions in a moment.

Dr Solomons: Please, if any questioners will remember my hearing. I have got hearing aids and they are working very well with you.

Chairman: Yes. It is important to speak close to the microphone. I call on Senator O'Donovan.

Senator O'Donovan: I welcome you, Doctor, today and I have listened with great interest to what you have just outlined. I will be quite brief. I have just, I suppose, two questions. Having regard to your phenomenal record and length of service in your career, would it be fair to say that in the late 1940s and early 1950s there was abortion of some sorts in those days, in other words, termination to protect the sanctity of the mother in difficult situations?

Dr Solomons: If I was associated?

Senator O'Donovan: No, not you personally. The reason why I am putting this to you is that I have learnt this week from a number of speakers, you know, I had this naive and, I suppose, simplistic attitude that, you know, where there was an ectopic pregnancy or where there was cancer or where there was a serious risk maybe due to high blood pressure or heart disease of the mother, that such medical intervention or terminations was not, in fact, abortion, but listening to most of the experts here during the last two days, including today, it would appear that any intervention, medical or otherwise, was, in fact, abortion of sorts. I am just anxious to know that whatever about since the 1983 Act and all this concern that has erupted in the last 20 years approximately, going back, say, to the 1960s or maybe even the 1950s, was there intervention then of a similar nature?

Dr Solomons: You mean on stated medical grounds?

Senator O'Donovan: Yes, not deliberate abortion, but in instances where the health of both were at risk, but particularly that if intervention did not take place, the mother would possibly also die.

Dr Solomons: Yes, I am sure it did. As a student or as a recently trained, recently qualified graduate, I did see similar cases, certainly in the Rotunda. All of stated medical grounds, stated to the class – which in those days we had 50 plus in the residencies, students and postgraduates all having the situation explained to them – so it was this abortion as a reason for improving the health of the mother, or at any rate of improving at least and hopefully curing, abortions were carried out.

Senator O'Donovan: I note that you say in your letter … in many ways some of the points you are making are not at great variance with other points being made by other obstetricians and masters of the various hospitals we have met, but I note that you state, that you use the words, which is interesting, 'major risk' to the health. In other words, it is not something that would be done lightly.

Dr Solomons: Major risk?

Senator O'Donovan: In other words, where there is a major risk to the health of the mother.

Dr Solomons: It must be a major risk.

Senator O'Donovan Yes, that is what I understand.

Dr Solomons: Yes.

Senator O'Donovan: Also there are probably some grey areas indeed, but I understand that you would not wish to say abortion for either socio-economic reasons, whatever, or on demand?

Dr Solomons: I qualify that slightly. I qualify it by saying that there are some cases where I do think compassion and understanding and a feeling of what the patient or person is going through needs to be considered. One example that I remember in my own case, a mentally handicapped couple where the woman became pregnant and had her baby, which because of the mental state of the parents of that child – both of them in their teens – the mother, the grandmother of the child, said she would look after the child, which was fine, or fine at birth. I do not know what happened afterwards. That was the history. The mother came with the girl to me and said: 'Look, I want you to do something about this. My girl is not responsible for her actions. She had a baby with the boyfriend a year or so ago. She is pregnant again and I cannot look after two babies of my own child indefinitely and I cannot let this go on.' That is the type of case that I would view with very great sympathy and understanding and I believe that there must be others that are unforeseeable that may arise which would come into the acceptance of option seven.

Senator O'Donovan: Thank you.

Deputy Enright: I join with the Chairman and Senator

O'Donovan in welcoming you to our meeting this afternoon. You speak about women's health being a priority for all men.

Dr Solomons: What being a priority?

Deputy Enright: Women's health. I think you made a point that it's important.

Dr Solomons: Yes.

Deputy Enright: Can you elaborate on how you can achieve that, to try to get that across because you've written books, you say, going way back 40 years ago and I think it's something that every department of health and other departments would be anxious about. It's much more difficult to achieve … it's impossible to achieve as far as I can see to date anyway.

In your letter here to us on 25 November last, you referred to option 7 about inserting the adjective 'major' before 'risk'.

Dr Solomons: Yes.

Deputy Enright: Then you speak about a woman who wishes to choose, that she goes to her GP and then to a panel of doctors, perhaps a gynaecologist, a psychologist and a social worker – that's the panel you referred to. In the event of such a procedure being adopted, are you satisfied that there would be sufficient safeguards in that instance, with those panels set up, that you wouldn't have a situation arise as has already happened in both the United Kingdom and in America? That is the one concern so many people have; there is a lot of concern here in Ireland that what was intended in Britain … one of the main reasons, there were four reasons given for allowing abortions in Britain and one of them was because of the psychological damage to the expectant mother. Do you think that there are safeguards in the way you are proposing to set this up to ensure that you wouldn't have, after a period of time … that the panel becomes something of a rubber stamp in a lot of hospitals? That is the concern of a lot of people. I'd like to thank you for your very forthright views here today.

Dr Solomons: Coming back to the last one, there would have to be very strict controls and that's why I mentioned the Department of Health. I think there must be. You could get some rogue gynaecologists – sometimes I've been called a rogue, not a rogue gynaecologist but a rogue – and I'm sure there are some individuals, not specifically in Ireland but anyone who would take up the question of abortion as some way of money-making rather than as purely … professional attitude to the matter. Admittedly, it's not a pie in the sky but it's a little shaft of light in the sky that I can see. How it should be matured, I don't know. I'm just putting this project forward but I can see your point which is very valid. You don't want things getting out of control and I haven't gone far enough to see how I would devise the situation except I would insist on control in such a way that the British attitudes or British situation regarding termination of pregnancy, abortion, whatever … nobody wants to see that here.

I think also there is the point that the Irish medical population is pretty wary religiously, morally, spiritually, medically of doing abortions – let's say not on demand but without too much supervision. I don't think there are enough gynaecologists in Ireland who would be prepared to take this job on irresponsibly. In other words, they would insist on being agreeable about the subject and they would like to know it was being done to control the number of women that might be approaching them for abortion. In other words, the Department of Health must have a place. I'm not so sure about other bodies. Medical bodies, some of them, they're not quite so impartial about important judgments as I would like them to be.

And your first point, I've lost it?

Deputy Enright: Well, basically you put forward a view about … some of your opening remarks referred to responsibility on the man, the woman carries the baby and all of the attendant responsibilities and you said that women's health should be a priority for all men which, unfortunately, in the facts of life it is not. I'm probably being very … to ask you to try and outline how that can be achieved, I don't think it would be possible or perhaps you have a different view. Could you give us some suggestions as to how … we, as a committee, will have very little role in that but I think it would be of benefit to have your views as somebody who has been involved in writing text books and everything else on this issue?

Dr Solomons: I think education is the answer, education. Let parents do their best to ensure that boys have a proper regard for girls and not think that they should be put up against a wall or put into bed at the slightest drop of a … I won't say 'hat' but you understand what I mean. I think a lot can be done by parents if the parents are fit to tell their children, not only fit but if they are competent and un-shy in talking to children.

I think the role of school education is vital. Again, are you going to get the right teachers or instructors, that people are not going to be hectoring but will be sympathetic towards the problems of puberty and adolescence? I think those are the bases and also try and tell them not to believe everything they see in journals, films, advertisements nor to view the fashion pages of periodicals as the way that most people dress and live and show their attitudes towards friendship. So, I'd like to start with those ideas. Parental guidance and then education and also marriage counselling can help. So many men – I won't exclude myself – had a very … had a shy attitude towards women in my student days. I remember my brother was a much more lively character than I was and, although I became the gynaecologist and he was a dermatologist, he would go to the university dances. While I had a lot of enjoyment in many ways, I remember him saying 'why don't you come and make up a party or come in our party to the dance, you can always be platonic?'. This, coming to me, indicated that I was very slow to mature and to understand what was going on. I'm telling you a life history now which is probably quite out of place.

My father was a gynaecologist, I became one, my cousin senior to me was one and now I believe – even if my wife might not completely agree with me – I've got a fairly reasonable attitude as to how women … how valuable they are, how they should be respected and

should not be ignored. They are looking after the young family, the husband isn't. So, the husband should realise that he's got a good value wife or partner – whatever – and treat her with the respect and love that her efficiency and companionship demand.

Deputy Enright: One final point. In regard to, we'll say, unwanted pregnancies, particularly among young people, have you given any thought to, say, both the question of drink and drugs nowadays? One can have education and excellent homes. I think you are correct in what you say about parental responsibility – I think that is very, very important – but with a lot of young people drink is a factor nowadays at a much younger age than heretofore. Similarly, I think drug taking is a factor as well.

Dr Solomons: Yes, I think those are relevant, but then drugs of various sorts have been taken for years and people have drunk an awful lot in the past, before you and I were born.

Deputy Enright: And will after us too.

Chairman: Are there any further questions?

Deputy McManus: It is not a question. I just can't let the opportunity go by. I am one of the first generation of Irish women who were able to truly avail of contraception and it is in part at least thanks to you and to brave people like you because the medical establishment was certainly not in the forefront in enabling women to achieve certain rights. So I just want to thank you for the work you have done over your life.

Dr Solomons: Thank you very much.

Chairman: Well, Dr Solomons, I would like to thank you for taking the trouble to write to us and to come to us here today in our consideration of what, as you say in your letter, is a very difficult subject. I think all of the Members were very impressed with the experience that you brought to bear from what has been and, please God, will continue to be a good life and a long life. Thank you very much.

Dr Solomons: Thank you very much indeed and thank you to the committee and everyone who listened.

SITTING SUSPENDED AT 3.12 PM AND RESUMED AT 3.20 PM

Dr P.J.K. Conway

Chairman: We are now in public session and I would like to welcome Dr P.J.K. Conway to this meeting of the Joint Committee on the Constitution. Dr Conway, we have received your presentation, which has been circulated to the members, and I think you got a copy of the brief book ....

Dr P.J.K. Conway: I did, yes.

Chairman: .... which your letter is contained in.

Dr Conway: That's right.

Chairman: In fact you'll be glad to hear we've tabled that before the Houses of the Oireachtas, so your letter has absolute privilege. In relation to the presentation, the format of this meeting is that you may elaborate on the submission if you wish and that will be followed by a question and answer session with the members. I want to draw your attention to the fact that while members of the committee have absolute privilege, that same privilege does not apply to you in your utterances today. A transcript will be prepared and that will enjoy absolute privilege. Perhaps you will elaborate on your submission and explain it to the committee.

Dr Conway: I suppose I better explain who I am myself.

Chairman: Yes, indeed. You can state your qualifications and your experience before we get at that.

Dr Conway: I'm originally from County Meath, Ratoath, a village. I qualified from University College Dublin in 1965 in medicine. I did one year's law in UCD after that and decided I wouldn't go any further as I didn't see any future in combining the two. I did a diploma in public health, again in University College Dublin, and membership in the Royal College of Obstetricians and Gynaecologists in London. Recently I have gone to America and I have qualified as a practitioner and as a consultant in fertility care, or it's more popularly known as natural procreative technology in this country. The certifying board is the American Academy of Natural Family Planning.

My position is fairly simple. I did six months obstetrics and gynaecology in Holles Street as senior house officer in 1967 and I was very taken with the intellectual and the medical approach of Professor Ciarán O'Driscoll, whom I would say is probably the pre-eminent obstetrician this country has ever produced. He is about one of the few world class people that we have. We have a few others in other fields, in literature, in athletics – Ronnie Delaney – and so on. Dr Clinch would probably be the next after him as an eminent obstetrician. I then went to England, as was the normal thing at that time in Ireland. There were very few jobs in Ireland in obstetrics and gynaecology and the future didn't look very good so I went to England as was normal practice because there was nowhere to train in Ireland at the time.

I went to the Leicester Royal Infirmary and I did six months. I moved from there to the Newcastle Royal Victoria Infirmary in Newcastle-upon-Tyne. I happened to arrive

in Newcastle when the law changed. The Abortion Act of 1967 was implemented from 27 April 1968 so it was practised for the last six months of 1968. For me coming from somewhere like the National Maternity Hospital where the whole approach was to look after the mother and her unborn child as one of the questions we were often asked when we came into the hospital when we were starting was 'how many people do ye see in the bed?' and, of course, everybody would say 'one'. Professor O'Driscoll would say 'no, there are two, the mother and her baby'. I went to England and the whole outlook was so totally different. The only thing … I learned nothing over there certainly for that time except the six reasons why an abortion should be carried out and who should do it and why they should do it.

The people you would meet in the out-patients, the people you would meet in the gynae-wards were almost to a woman young women, all under 24, many of them quite young, 17, 18, 19, in perfect health, beaming when they came in with perfectly healthy pregnancies and perfectly healthy babies, in for an abortion. For me coming from Holles Street this was just unbelievable. This was crazy. It was standing the world on its head. It was a total contradiction. It was against everything that I certainly did in medicine. I certainly wasn't in medicine to act as judge and jury as to which baby should die and which should live. That just wasn't my scene and my views on abortion crystallised very rapidly then. I got back to Ireland for six months and then after six months recuperation if you like working back again in Holles Street I went back to England, to Stoke-on-Trent. I was a bit older at this stage and a bit more mature and I could take it a bit better and not get involved in it, but observe it and do other work.

When you introduce abortion, you introduce it for everybody. The person that accepts and clerks the woman that comes in, in the admissions office, she is involved. The person in the outpatients who sees the woman and her baby is involved. When they come into the hospital, the person who gives them their meals is involved, the house doctor who checks their hearts and lungs is involved. The attendant who wheels them down to the theatre for an anaesthetic, the anaesthetist and the person who does the deed – everybody is involved. It undermines everybody. It undermines a core value and that is a respect for basic human life. It undermines society too. Society's attitudes change. It undermines the whole lot of us and we are all involved, even if a small number want it. It is not a thing that is democratic. It is not a thing that lends itself to voting majorities, it is a core value and it should not be interfered with.

Our obstetric care in this country, certainly for the last 30 years, is probably the safest place for the mother and for her baby, in the whole world and I do not think anybody would dispute that at the present time. If you change it, I guarantee you that will change. Why? When I was in England there were still many obstetricians who would not do abortions. Go to England now, they are all doing them because the ones who would not do them in the past have got out. Why? Because they are not let in, because the people on the interview boards and so on do not want them because they will not do the dirty job.

Irish Maternity was one of the benchmark papers written by Professor O'Driscoll and John Murphy in 1982 in the Irish Medical Journal. It was written on a review of maternal deaths from the National Maternity Hospital in Holles Street from 1970 to 1979 – 74,000 mothers. There was 26 or 27 maternal deaths and the conclusion of the review of the paper was that abortion would not have saved a single woman. Their second conclusion was, and it holds just as true today if not more so, their second conclusion was that public health progress and medical progress in the future will reduce maternal mortality further. Furthermore, they stated that in their view, abortion may – they used the word 'may' – abortion may have had an indication in the past but events have put that aside, that there is absolutely no reason for it whatsoever now, in terms of the mother's chances of death.

The number of mothers dying in that Holles Street review was 3.7 out of 10,000. The advances have been made. A review of 223,000 births from the three Dublin maternity hospitals, from 1980 to 1989, the number of mothers who died was 1.7 out of 10,000 and from 1990 to 1998, the number of mothers dying in the three Dublin maternity hospitals is down to 0.8 out of 10,000, that is one mother out of 10,000 from all causes. That includes causes that are unrelated to pregnancy. One in 10,000 – who needs abortion to save the mother's life? The reasons that have been given in the past, or the reason that the cases have come up recently, that have hogged the headlines, the X and C cases, both young girls, both alleged rape, both unmarried.

Might I just digress there, and of course the unmarried mothers and the young mothers are the fodder for the abortion clinics. Eighty per cent of all the young girls that go to England from here are unmarried and young. They are vulnerable and are not being supported. The people that are sending them to England, that are counselling them – counselling is a laughing word for me, counselling … because I know I can counsel somebody, somebody has a medical problem and if we get three different doctors counselling them, the same patient will decide to do three different things. Counselling is a joke.

Just getting back to the two, the X and C cases. They bring no credit on the legal system. If the people involved in that were judged the same way as we are judged as doctors, when things go wrong and we are hauled up before the courts and so on, they would be judged as being highly negligent, highly negligent. Their judgments were totally flawed and totally wrong, based on the medical evidence that was presented. In the first case, there was no medical evidence – a psychologist was used. In the second case, one psychiatrist gave his opinion and the other psychiatrist verified that the girl was capable of giving evidence but no other psychiatrist was asked to corroborate or agree with the first psychiatrist. I know myself the consultant who was looking after that second girl, the C girl, he was never asked for his opinion and it would not have been the opinion that was given in the court.

Suicide, I better talk about that because it is another one. The chance of suicide in pregnancy is 20 times less than in a woman of the same age who is not pregnant – it is 20 times less. So, pregnancy, rather than giving rise or leading to a suicide, has the exact opposite effect. Now, where is the evidence for that, am I thinking of that off the top of my head? I am not. The Institute of Maternal Health in Minnesota in 1967 – Minnesota is where the Mayo Clinic is – they give a figure of the chances of suicide

in pregnancy of one in 90,000. The conclusion they gave at the end of the study was that they could see no place for killing a baby in treating depression or threatened suicide. What they advocated was psychiatric treatment and rehabilitation and not the killing of a baby or the termination of a pregnancy or induced abortion or whatever it is.

Louis Appleby, in a leading article in the British Medical Journal – and Britain, as you all well know has a culture of abortion where abortion is now normal, as it is in most of the western world, unfortunately – Louis Appleby also gave a figure of one in approximately 100,000 as the chance of suicide. If you look at the study from 1980 to 1989 from the three Dublin maternity hospitals, there were two deaths out of 223,000 births in depressed women from overdoses from tablets. Both were already attending psychiatrists. Both had already delivered, both had already gone home, and it was some time after the pregnancy.

Again, there is a one in 110,000 chance of suicide, yet here in Ireland we have had judges deciding that two young women were going to commit suicide so they should be sent for an abortion. A recent paper from Finland has shown quite emphatically that the chances of suicide after an induced abortion, not a spontaneous one, is six times as high as in a normal woman. In other words, multiply 18 by six and that tells you how much more likely a person is to have a suicide after an abortion than after a normal pregnancy. Suicide is a joke, as far as I am concerned.

I will answer any questions after this. The only other thing is that the one thing with the abortion issue is that those who want abortion – and there are people who want abortion, there are colleagues of mine who want abortion – are masters at muddying the waters and bringing in things that have no relevance whatsoever to the discussion, for example, ectopic pregnancy. I guarantee that that will be brought in. There is not a country in the world that regards the treatment of ectopic pregnancy as abortion. The only time I ever heard it was from a few people here in Ireland. It is just nonsense. I think I have nearly said enough.

Chairman: You have made a submission. You have very forthright and strongly-held views on that. That is clear to me. There was one matter I wanted to bring you through. Do you have that brief book we sent you?

Dr Conway: I do.

Chairman: Could you turn to page 127. It is the letter from the Institute of Obstetricians and Gynaecologists. You are a member of the institute, I take it?

Dr Conway: I am, yes.

Chairman: And you were involved in the consultation process?

Dr Conway: I certainly was, and held very strong views, yes.

Chairman: The first paragraph of that letter refers to the Green Paper. It says:

> We welcome the Green Paper which provides a comprehensive, up to date and objective analysis of the issues arising in the care of the pregnant woman. Our expertise is in the medical area and our comments are confined to these aspects.

I take it, on the first paragraph, you might not have been happy with all of the expressions used in the Green Paper.

Dr Conway: No. The definitions are unclear. They would facilitate muddying of the waters to a great extent. They are not clear. On induced abortion or direct abortion, there is a difference between the indirect killing of a baby and the direct.

Chairman: In fact, in a way you are anticipating the second paragraph.

Dr Conway: Sorry.

Chairman: No, I am not criticising. The second paragraph also addresses in a way with that question, because that is the crucial paragraph in the institute's letter. It says:

> In current obstetrical practice rare complications can arise where therapeutic intervention is required at a stage in pregnancy when there will be little or no prospect for the survival of the baby, due to extreme immaturity. In these exceptional situations failure to intervene may result in the death of both mother and baby. We consider that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example for social reasons, and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother.

I take it that is an expression of your distinction between the direct and the indirect. I do not want to take you short on this. Take your time looking at it, if you wish.

Dr Conway: There was a lot of discussion on that. On some things there was no problem whatsoever. For example, the place where I work, Portlaoise, is a small hospital, a primary hospital. The major areas where we would see problems like that, but they are not problems, would be in severe toxaemia where it is life-threatening to the mother. I will explain that. You probably know it already.

Chairman: We know that from the ....

Dr Conway: I have been working in Portlaoise for the last 20 years. In that 20 years, we have transferred three mothers who would fit that bill, three out of 24,000 births, roughly. That is all. We have transferred others who would not fit that bill. I can give you graphic detail of the three if you wish because ....

Chairman: Where do you transfer them to?

Dr Conway: To Dublin, to Holles Street, the Coombe or the Rotunda.

Chairman: To one of the major maternity hospitals in Dublin.

Dr Conway: Yes, tertiary hospitals. Each of the three were

delivered eventually between 24 and 26 weeks pregnancy. They were delivered because of the severity of the disease. If they were not delivered the mothers would have died. They would have got an eclamptic fit and died and, of course, the babies would have died too. That is normal treatment for severe eclampsia. We have also transferred others who might be 28 or 29 or 30 weeks with severe eclampsia and, again, the treatment for that condition – there is only one treatment for that condition – is to deliver the baby or else you are going to have a dead baby and a dead mother.

Chairman: Everyone who has spoken to us confirmed that and the circumstances of ectopic pregnancy have also been outlined to us.

Dr Conway: Ectopic is just a red herring.

Chairman: The key problem we have is that the masters of the tertiary hospitals came in and talked to us yesterday and they suggested to us that there other conditions, very rare indeed, related to heart and liver conditions which did require, in their view, direct intervention. The Master of Holles Street instanced a particular case in connection with a liver disorder in that connection. I have to stress that all the masters were at pains to emphasise that these were very unusual circumstances and had given them a great deal of trouble. Clearly you did not have any experience of that kind of case in Portlaoise.

Dr Conway: No.

Chairman: Apart from that, the various points you made very strongly and cogently were in fact made by the previous witnesses, although I would say you have put a very strong emphasis on one side of the line, if you like, but those various points about the suicide question and also the question of the limited categories extending themselves have certainly been made.

There is just one point. I take it your experience in England in 1967 had a very strong influence on the formation of your opinion on this matter.

Dr Conway: Of course it had. It had a huge impact. You are obliged to crystallise your own views on the situation and on the problem very rapidly, and you meet lots of other people who will just roll along with the waves, very nice people and then, suddenly, they are involved in abortions.

Chairman: It has been canvassed before us that there are certain very limited categories where abortion would be desirable and it has also been canvassed before us that the experience in the United Kingdom with the 1967 Act was that once you introduced the limited category, you were really on an escalator at that stage.

Dr Conway: I think you have got plenty of examples since 1967, since the British one came in. You've got the French change of law, the German change of law, the Italian change of law, the Spanish change of law, the Portuguese, the American 1973 ....

Chairman: But on the other hand ....

Dr Conway: England is just one of a long series.

Chairman: There are substantial differences between what was introduced in those different jurisdictions. For example, the United States, as you rightly say, went for an even more open-ended approach as a result of the Supreme Court decision than the United Kingdom and in Northern Ireland. Then in the case of some of the continental countries, the tendency was more to limit in terms of gestational periods I think. Is that correct?

Dr Conway: The number of abortions on young people from the various countries from the Eurostat statistics … the latest one I have is for 1990 but it hasn't changed much since. Denmark is at the top, 37% of all pregnancies are aborted, Italy are not far behind with 30%, the United Kingdom come with 24%. Germany don't give a figure because it has changed since they unified. It has gone up since the unification of Germany. France is in the 20s. They are all much of a muchness.

Chairman: I think before unification Germany had a rather low rate compared to some of the other countries.

Dr Conway: They had 12. Our current figure is, I think 11.2%.

Chairman: I think the German constitutional court had recognised certain rights in the unborn at any rate unlike, say, the constitutional arrangements in any of the other European countries.

Dr Conway: I don't know but they are doing a heck of a lot of abortions in Germany now.

Chairman: Are there any members who would like to ask questions. Deputy Kirk.

Deputy Kirk: Thanks Chairman. I join with you in welcoming Dr Conway here. With regard to the constitutional position in relation to abortion in this country at the present time, how do you view it, if you view it as unsatisfactory, how do you feel it should be remedied and do you think this issue should be looked at from a constitutional point of view combining it with legislation or, the alternative, just constitutional, or alternatively legislation?

Dr Conway: I would not really be an expert because I am not a legal man as such. I think the situation should be as it was before the X and the C cases that the status at that time … that the baby needs protection and it needs it very urgently, because once abortion starts, it starts as restrictive and then it just becomes on demand, as it has in every single developed country in the world. There may be one or two exceptions like Malta that doesn't have abortion yet but there aren't many. Spain and Portugal are going down that road now pretty fast. I think the baby requires full protection with the mother. Both of them require full protection. I don't think there should be any abortion in at all, that's my view, because it is not necessary. The evidence isn't there for it. The three masters were giving their own opinions. Two of them are very young men. They have only taken up their posts relatively recently. They may change their tune as they get a bit more into their jobs.

Senator O'Meara: Thank you Chairman. I extend a welcome to Dr Conway. You mentioned the masters of the hospitals. There was something we discussed yesterday with the masters which I want to raise with you, the question of foetal abnormality, specifically very severe foetal abnormality where no chance exists of the foetus actually having an independent life, in others words where it has encephalitis. It was put to us that in a number of cases, because of amniocentesis and the diagnosis of encephalitis during the pregnancy, that a number of parents are taking the option of having those pregnancies terminated in England. The view was put to us that there is a case to be made for having a facility to terminate those pregnancies in this country, in other words in the maternity hospitals, the justification being that these pregnancies, these foetuses have no independent life and that the parents should be given the choice and in many cases are already taking the choice of ending those pregnancies. What's your view on that?

Dr Conway: I'll answer it with a recent lady of my own that I have managed. A 34 year old expecting her first baby, she booked at 18 weeks and the scan showed she had an anencephalic baby.

Senator O'Meara: No brain.

Dr Conway: That is no brain and no head. I explained to both parents that there was no prospect of life and so on and I explained also that the safest way for the mother … the safest way for her physical and mental health, to manage her, was to let the pregnancy continue until she went into labour and delivered and that's what happened. She delivered and her baby lived for a couple of minutes, was baptised and she and her husband held the baby afterwards, after the nurses had put towels and so on, and they took photographs of the baby. They have a baby that is theirs, that has a name, that is buried and they can visit the grave. They would have no guilt. The people who are more likely to become depressed after an abortion … one of the groups that is at high risk of depression after an abortion is people who have induced abortions because they have an abnormal baby.

Senator O'Meara: Is there evidence to support that?

Dr Conway: There is, yes.

Senator O'Meara: Would you ....

Dr Conway: Secondly, it is more dangerous. Most of these abnormal babies that won't survive after birth are picked up after 16 weeks, at a time when it is quite dangerous to induce abortion physically. There is a paper from America, reported in the *New England Journal* of America in 1996 which states categorically that the maternal mortality is higher in those who are induced to get rid – I am using the term of people who do not want the baby – to get rid of a baby who is abnormal than if they are allowed to go and have a natural pregnancy and a natural delivery.

Senator O'Meara: It was put to us yesterday that the situation you have outlined does happen where a number of parents would choose to continue the pregnancy for all the reasons you have outlined but some don't. The point was put to us, quite strongly, that where a parent chooses to terminate a pregnancy which has no end viability that there are medical reasons for post mortems and so on to be carried out which would be important for the future medical treatment of any future pregnancies that woman might have. Can I put it to you again, what is your view on a choice which would be taken by parents where a pregnancy has no viability?

Dr Conway: I think I gave you my view already, that in my view it would be far healthier for her to carry on her pregnancy both physically and mentally than to go to England and have an abortion and I would give her that strong advice ....

Senator O'Meara: Right.

Dr Conway: .... and I would have no doubt most of them would accept that advice.

Senator O'Meara: Can I take it that in the case, for instance, of rape where pregnancy occurs arising from rape that you think .... Would it be your view that the woman who has been raped and who is pregnant as a result of it should, under the law, carry her baby to term?

Dr Conway: My view on rape is very simple. The number of people who get pregnant as a result of rape is 0.6%.

Senator O'Meara: Some women do I think you will accept.

Dr Conway: Yes, of course, I said I did accept, 0.6%. If you had looked at the medical literature as I have looked at it in this particular field there is very very little written on pregnancy resulting from rape and what happens to it. There are two American papers, one of them is taking a sample of the whole of America on rape victims who became pregnant and there wouldn't be many. They looked at them and they found that about half of them, even in the American culture, continued on with the pregnancy to term and the other half opted for abortions. Doing an abortion is hardly treatment for violence inflicted on a woman. Getting rid of an innocent third party is hardly good treatment. Doing an abortion, as I said already, you are compounding the chances of suicide sixfold on top of trauma you have already dished out, or that the person has already had. I would not favour it at all. I would not recommend abortion for somebody who has been raped.

Deputy McManus: First of all, Dr Conway, can I thank you very much for coming here today to give us your views on this very complex issue. I would like to just go back to where you started. You were speaking about Dr Ciarán O'Driscoll and I think you are absolutely right. I concur with your view that he was very innovative and very progressive and a major figure in the whole area of obstetrics. Even a doctor as eminent as he .... Some of the practices and developments that he is responsible for have now been superseded. I think particularly of the management of labour. I suppose he is a good example that medical practice does not stand still. It keeps moving forward all the time and changes.

We have received presentations from the three masters of the maternity hospitals in Dublin and it is clear that there is a general view between them that there are certain rare instances where abortion is necessary to save the woman's life. Now, you are in a situation where you are referring patients, from time to time, to these major hospitals so I presume that you have a certain confidence in relation to the kind of tertiary care they provide. There has been concern expressed that if there were an absolute constitutional ban on abortion that this kind of protection for women, where their lives are at risk, would be compromised. When you are saying that there needs to be added protection, are you arguing for a constitutional ban on abortion and if you are, how would you see that impacting on the kind of care that patients receive at the moment in maternity hospitals in the major tertiary care units.

Dr Conway: As things stand at present, it has not impacted at all. As I told at the very beginning, the mother and baby in Ireland is safer than anywhere else in the world so it has not impacted at all. I do not know what your question is, so be clear.

Deputy McManus: It was raised here by the masters.

Dr Conway: I do not care what was raised. I was not here.

Deputy McManus: No. Well, maybe I could explain to you what my concern is. The question was raised – and it was only cited as a possibility and a concern by some of the masters – that if there were, in the Constitution, a total ban on abortion, which is one of the options that is being put forward, and we have to look at all seven---

Dr Conway: Which I support, I might add.

Deputy McManus: Yes. Well, that is the first answer that I was looking for, that you do support the constitutional ban on abortion.

Dr Conway: I do. Yes.

Deputy McManus: Well, the second question is that since you take that position, how do you answer the concern being expressed by the very eminent people who are now following in the footsteps of Dr Ciarán O'Driscoll, who have raised this as an issue with us?

Dr Conway: Well, two of them are very new. One of them is in the job since, I think, the first of January and the other is in the job just over one year. That is two of them. The third person I know because he was in the athletic club with me, the older man, the fellow that is there. None of them, I can tell you … I do not look at any of the three of them in awe. Each of the three have still to earn their spurs. They have not filled Professor O'Driscoll's boots yet. At the end of their seven years perhaps they might have. So, that remains to be seen.

The rarities that they are talking about, what are they? How often do they occur?

Chairman: Very, very infrequently, on their evidence. I think I have to say, in fairness to them, that they did not come here just on the basis of their own experience but reflecting on the practices of the hospitals that they were in, as they saw it. They did, I think, make that clear to us in their evidence.

Dr Conway: Can I get back to the active management of labour? It is still being practised and it is still very much being practised. So, it has not gone out the door.

Deputy McManus: No, I did not imply it had gone out the door. What I was saying is that the practice has developed and moved on and I think that would be generally ....

Dr Conway: Moved on where?

Deputy McManus: Moved on for the better.

Dr Conway: I am working in obstetrics. It has moved nowhere. It is still being practised.

Chairman: Dr Conway, I would like to thank you .... I am sorry, there are further questions.

Deputy McGennis: Just a very brief question. I would like to welcome Dr Conway as well. I have read your submission and, obviously, your views are held very passionately and I respect that. You have said, and it is in your submission as well, that your experience in England certainly, to quote you, 'was profoundly shocking, horrifying and disturbing' and I can see how that would be the position. I would not like to have had to be in that situation.

Can I refer you to a point you made in your oral submission and which runs through your written submission? It is to get from you an understanding of .... Your submission refers quite a number of times and you did again – now I know you put it in a particular perspective – to unmarried mothers. You did mention that you would fear that they were the fodder for these abortion clinics. That is clear. I would ask you – and I am sure it is not in terms of the treatment you would afford to anyone, regardless of marital status – do you have a particular view in relation to unmarried mothers because you actually describe them under the heading 'Why is There a Demand for Abortion?' You say, 'There have been many serious adverse social changes in Ireland' and you mention unemployment, drug abuse, alcohol and they are quite obvious. You mention specifically unmarried mothers in that context. I would ask if you could just expand a wee bit on that. Would you draw a distinction between unmarried mothers where it is a planned pregnancy and where there are unplanned pregnancies? I am sure you have experienced … certainly as a mother of three … and you must have come across also quite a significant number of unplanned pregnancies among married mothers. I am a wee bit concerned and I would like that you would expand on your view in relation to unmarried mothers because it forms quite a significant part of your written submission.

Dr Conway: The only reason I speak about unmarried mothers is because of the nature of my job, because I

come in contact with them. It is not for any other reason. It is because we meet them all the time.

Deputy McGennis: But surely, in your professional capacity what you are meeting is mothers, as distinct from whether they are married or unmarried.

Dr Conway: Of course, yes.

Deputy McGennis: That is why I wonder why you draw the distinction between unmarried mothers as distinct from the mother and baby who are the two patients, as you described earlier, that you are looking at in the bed. Why do you make any reference to marital status?

Dr Conway: Very simple. The problem with unmarried mothers … the problem with unmarried pregnancies is one, they have less support. Very often they do not have a man with them. They do not have two people. A child needs two people, usually, to grow up. Secondly, as I said already, 80% of the people who are sent to England for abortions are unmarried. They are not married. There are very few married sent to England for abortions.

Deputy McGennis: I hope nobody is sent.

Dr Conway: Counselling, in my view, is a dirty word because counselling means a whole lot of different things to different people. You can counsel a person to do what you want them to do, very often.

Deputy McGennis: Would you accept that under Irish law, as it stands, it is illegal to send anybody – in my understanding – for abortion.

Dr Conway: I am not going to get into the legalities of it. I will stick to what I know.

Deputy McGennis: But if you have a knowledge of that, I would have thought because of your passionately held view, that would be something you would take action on.

Dr Conway: On what?

Deputy McGennis: If you knew that people were being sent for abortion.

Dr Conway: Maybe I have used the wrong phrase. People are going to England. I don't know who is sending them. Somebody is arranging it and sending them there. I am not, but somebody is.

Deputy Enright: First of all, I'd like to join with the other speakers in thanking you for attending this afternoon. I read your paper, which you submitted and which is very detailed and comprehensive. We have had some eminent witnesses. Perhaps they have or have not earned their spurs yet – I don't know – but I am sure they all got their appointments on merit and I am sure they will, over the years, perform very, very well. We also met Professor John Bonnar and Dr James Clinch who would be very experienced people.

Dr Conway: Very.

Deputy Enright: They are not young people; they have been in this profession all their lives. One of the points made by Professor Bonnar .... Unfortunately, you do not have copies of what they said. I appreciate that if you had, it would afford you an opportunity, if you were asked a question, of considering it. I quote very briefly from page 24 of the report for Tuesday, 2 May. In the course of a very long outline of facts … statement, Professor Bonnar said:

> There are other situations and I have personally had to deal with these because I have had a special interest in gynaecology malignancy. A mother, for example, may have cancer of the cervix and she may present in the first half of pregnancy, she may present at 12 weeks, and often this masquerades initially as a threatened miscarriage. Then we find to our great consternation that there is a cancer there and we have got to go ahead and deal with that, we have got to treat it. I have had to do the operations. We have got to remove the uterus. That means certainly the life of the baby cannot survive. I think we are doing the same procedure as we would do if she wasn't pregnant. So what I want to make clear to the committee is that that may have to be done.

So, in that instance ....

Dr Conway: That's no problem. I'd fully support that, 100%.

Deputy Enright: You would feel that it would be in order to have an operation ....

Dr Conway: Of course.

Deputy Enright: .... and terminate ....

Dr Conway: As it always has been here in this country, it has never been any other way.

Deputy Enright: There was an article in *The Sunday Tribune* last Sunday – I do not know whether you read it – in which Dr Peter McKenna was mentioned. I will quote again briefly:

> There is a recognition, by and large, that in some very rare situations the health of the mother can only be guaranteed or ensured by the pregnancy not continuing. These are very few and far between, but in those situations you simply cannot allow the mother's pregnancy to continue and her to die as a result.

These are cases where ....

Dr Conway: I gave three examples that we have had of mothers whose pregnancies were less than 28 weeks. In the last 20 years, out of 24,000 deliveries, we transferred three mothers to Dublin because, whatever chance the babies had of surviving, they had none in Portlaoise because we don't have intensive care and ventilators and so on. They were all sent to Dublin and they were all delivered because that is the treatment for the severe disease that they had. You deliver them and the baby takes its chances, but when it's that immature you don't expect the baby to survive. It would be a miracle if it did. I fully agree with that. We all do that and have done it

ever since I have been a consultant and since I have been involved in obstetrics.

Deputy Enright: Bluntly, it is ending the pregnancy.

Dr Conway: Of course, it is, but that's the treatment. If the disease is very severe at 24 weeks, that's the treatment. If the disease is very severe at 28 weeks, that's the treatment. If the disease is very bad at 30 weeks, that's the treatment … or 40 weeks, that's the treatment. If you don't do that, you end up with a dead mother and a dead baby. That's the treatment. It just happens that it has moved back a few weeks here and there.

Deputy Enright: But it results in the termination of a pregnancy.

Dr Conway: All pregnancies are .... This is where we have to be very clear on terminology. It's not an induced abortion. You are not doing this with the full purpose of killing the baby. You are doing it with the purpose of treating a particular disease. You know that the baby's chances of surviving the treatment are small, but, at least, the baby has some chance. If you don't do that, you'll end up with a dead mother and a dead baby.

Deputy Enright: Okay, I'll take that a stage further then ....

Dr Conway: That is the treatment, whether it is at 24 weeks, 25, 26, 30, 40. That's the treatment.

Deputy Enright: Can I ask you this then?

Dr Conway: Yes.

Deputy Enright: What I'll do is just tell you what Dr Keane said to us in regard to this.

Dr Conway: Yes.

Deputy Enright: It was in response to a question from Senator O'Donovan, who spoke earlier, dealing with a pregnancy where a rare problem had arisen. The X case had also been dealt with. In reply Dr Keane said at page 50 ....

Chairman: I appreciate that you wish to put this matter but it is important because the next witness will have to conclude by 5 p.m.

Deputy Enright: This is my last question, Chairman. Dr Keane said:

> In answer to your question, we, as medical practitioners in this country, are governed by the Medical Council and we do feel somewhat exposed in the field of obstetrics and gynaecology that we are not protected for these already mentioned rare cases because technically any form of termination of pregnancy or abortion is against the law of this country and, therefore, despite the serious considerations that are given to these individual cases, the technical termination of pregnancy that we occasionally and very rarely, thankfully, have to perform … we are technically on the wrong side of the law in doing so and we feel exposed in that area.

In performing these procedures which you feel totally justified, both morally and medically, in performing, do you feel that you are on the wrong side of the law, as mentioned by Dr Keane?

Dr Conway: No, not at all.

Deputy Enright: Do you think that that requires to be in any way placed as a safeguard for you in performing these procedures?

Dr Conway: I would be loath to tamper with the law because you don't know what side effects you are going to have, e.g. all the abortion laws right through the western world were all supposed to be restrictive, but look at what has happened. I would not tamper with the law at all because you don't know what is going to come out of it. I'd be very slow to tamper with it.

Deputy Enright: Because you are happy with the way it is?

Dr Conway: No, I am not happy with the way it is because the two judges have put the kibosh on it really.

Deputy Enright: Let me ask you this then. If in fact there is an absolute and total ban on abortion .... You are in a situation where abortion is the wilful taking of a life ....

Dr Conway: Is the direct taking of a life. You have to be very clear about terminology. A total ban on the direct taking of the life of the baby, I would fully subscribe to that, yes.

Deputy Enright: And in the medical situations that have arisen.

Dr Conway: Dr Keane would be seven years as Master of the National Maternity Hospital. He is very unlikely to come across a lot of these problems because they are so rare.

Deputy Enright: Correct.

Dr Conway: I don't know what problems he is talking about, so I am not privy to that. I know about Eisenmenger's and the evidence there is .... There is nothing in the literature that supports a case for terminating there, nothing.

Chairman: There are no further questions?

Deputy Enright: No.

Chairman: Thank you very much, Dr Conway, for giving us your assistance. I regret to say that there seems to be some conflict of opinion on that last matter you mentioned, but I thank you for coming to us today and giving us the benefit of your views. I think the one thing I took very strongly from what you said is that, as you say, the introduction of any legislation in this area, in whatever form, constitutional, statutory or otherwise, is fraught with difficulties and interpretative difficulties further on.

SITTING SUSPENDED AT 4.20 PM AND RESUMED AT 4..25 PM

Professor Eamon O'Dwyer

Chairman: We are in public session and I would like to welcome Professor Eamon O'Dwyer, professor emeritus of obstetrics and gynaecology at the National University of Ireland, Galway, to this meeting of the Joint Committee on the Constitution. We received a submission from you, Professor O'Dwyer, on 16 October last year and that has been circulated to the members. The format of this meeting is that you may make a brief opening statement if you wish and that will be followed by a question and answer session with the members.

I want to draw your attention to the fact that, while members of this committee have absolute privilege, this same privilege does not apply to you in your utterances, though your submission has been laid before the Houses and has absolute privilege and the transcript of what you say will also have absolute privilege. I'd ask you to address the members.

Professor Eamon O'Dwyer: Thank you, Chairman. I am hoarse because I have been up since 6.30 a.m. I had to come up by train as my wife would not let me drive. Let me introduce myself. I am a medical graduate of University College, Dublin, and a post-graduate trainee in Dublin, London, Liverpool and Manchester. I am a fellow of the Royal College of Physicians of Ireland and of the college of obstetricians of London and have a law degree from the national university. I was a consultant obstetrician in the National Maternity Hospital before I went to Galway where I have been professor of obstetrics and a consultant between 1958 and 1993.

I was a member of the council of the Royal College of Obstetricians at the time when the Abortion Act was being enacted and I remember all the terrible anxiety that my colleagues in the United Kingdom had at that time. They were assured that this was going to be very limited abortion on very strict criteria where two doctors, acting in good faith, were necessary to predict that it was essential. Everybody knows what has happened since then.

I was a member of the Medical Council here when it was first set up – for its first ten years. I was chairman of the national council of post-graduate medical and dental training. I am a life governor of the National Maternity Hospital. I am the second chairman of the Institute of Obstetricians and Gynaecologists. I was a member of the EU hospitals committee and a member of the EU advisory committee on medical training and I was external examiner in many universities in Ireland, the United Kingdom and abroad. That's me.

I'd like to say something by way of opening because I have read about it, and I have read about it in the papers since, about this thing called Eisenmenger's complex or Eisenmenger's syndrome. This is a very rare, dangerous condition which leads to sudden death in people, be they pregnant or not. I have searched through the literature and between 1945 and 1990, I think, 1995, I counted 151 cases of Eisenmenger's in pregnancy recorded in the world literature. That gives an idea, I think, of the rarity of the condition. In the last report on maternal deaths in the United Kingdom, Why Mothers Die, covering the period 1994 to 1996, in over 2 million births there were seven cases of deaths from Eisenmenger's syndrome, not six. When one searches through the report, you find another one tagged on somewhere. Of those seven, four of these women died when the pregnancy was allowed to continue and three died when the pregnancy was interrupted in the early weeks or months, hardly supporting the contention of my colleague on the northside of Dublin who said that there were conditions whereby by not allowing the pregnancy to continue we could guarantee or ensure the life of the mother. Unfortunately, that isn't so. Abortion does not ensure the life of the mother in Eisenmenger's syndrome.

Now there is another series, the biggest one in the world, which no one seems to refer to at all, and that comes from South America. During a period of a few years ending in 1995, I think it was, in the university, the cardiac institute of the University of Sao Paulo in Brazil, this team of workers looked after 12 women who had Eisenmenger's syndrome in 13 pregnancies – that's the greatest single number ever recorded anywhere. Now of those, all right, mortality was 23%. Three of them died, but who died? One woman who refused hospital treatment, one woman who neglected to take her treatment when the baby was delivered and got a clot and died, and one woman who died from causes unknown, as they had no post-mortem examination. Of the women who went through the regime in the hospital, where they had intensive care ante-natally during labour and post-natally, of those nine, all of them survived.

Now that is never recorded in the literature. When people talk about Eisenmenger's syndrome, they think 'Oh, terminate the pregnancy and that will be the answer to it'. It is not the answer really. I think if one were prepared … incidentally in the report in the United Kingdom the committee was very critical of the seven cases of Eisenmenger's. They said that anaesthetic services were inadequate in four, and cardiac supervision was inadequate in others. They made the point that termination of pregnancy is not without risk in Eisenmenger's syndrome, that's termination early in pregnancy – abortion, if you like.

And the other thing, they said that all these people should be delivered in tertiary cardiac centres, as there was in Brazil. Now here in Dublin, one would say 'Well also there's a tertiary cardiac centre in the Mater and there are three tertiary maternity hospitals and if they were to marry together and give round the clock supervision for seven or eight months in pregnancy in the puerperium, the results should be much better, so I am not a pessimist.

I wouldn't quarrel with the people who take the opposite view or different view, and say that you have to interrupt the pregnancy. That's their view and I respect that view, but there is another side and I think that it is only fair to be objective.

Chairman: No. No. Thank you. That is extremely helpful actually. I want to thank you for your assistance and for

the fact you took the trouble to write to us and to come to us today. In fact, Dr Daly discussed this very issue yesterday because I put the question to him, the Master of the Coombe, and he said … I put the question to him that Dr Clinch on the previous day had expressed the view in relation to Eisenmenger's syndrome that to consider the option of termination there would be unethical under the Medical Council guidelines, and had he a comment to make on that, and he replied that:

> Under the strict letter of the Medical Council guidelines, yes it probably would be.

And he said:

> The issue with Eisenmenger's is whether or not a termination of pregnancy, early in pregnancy, is going to dramatically reduce the risk of death for the woman.

His view was that there was 'a reasonable amount of literature to suggest that that was true and that while some people will argue', and he referred to the submissions, he said:

> the most recent paper from San Paulo shows that Eisenmenger's can be successfully managed.

He, in fact, believed that two of the 12 women died rather than three, and he took that:

> there were three miscarriages, one of the babies died … ultimately the maternal mortality … was still 20% and [he made the point that] … normally it is one in 10,000 that's a significant change.

And of course you're, and he made the point you are assessing risk there then rather than anything else, but I take the point you're making.

Professor O'Dwyer: I am sorry to interrupt.

Chairman: Yes. No, but I thought I should put that to you so you get an opportunity to comment on it.

Professor O'Dwyer: The other point is that the figures, as quoted, for maternal mortality with Eisenmenger's is between 30% and 40%, but the cases, it is a sum of cases from the year 1945 onwards, and there have been enormous advances, as everybody knows, in intensive care in the last even ten years, so what might have been 40% in 1945 or '50, one wouldn't expect it to be anything like that now.

Chairman: Deputy McManus.

Deputy McManus: First of all, professor, we are very grateful to you for coming here and appreciate that you have travelled a fair distance to make this presentation. In terms of the various issues that have come up, obviously the one that you've referred to has been one of quite great significance where the three masters of the Dublin hospitals did refer, from their own perspectives, to the practice, and certainly all of them referred to the practice of terminating pregnancies in the rare cases where a woman's life was endangered and using the term 'abortion' – certainly, I think, Dr McKenna used it and Dr Daly.

Even though we have at the moment an amendment to the Constitution, it would not appear that the practice, the medical practice has been altered as a consequence of that constitutional amendment, but I don't know that you are aware that when the constitutional review group looked at the Constitution – and this is the expert group – they did state … and I'd just like to quote so that you can maybe comment on it … and they were looking at the question of whether to put a constitutional ban on abortion. I notice you have a wording here which would render, which would in effect be a ban on abortion:

> If a constitutional ban were imposed on abortion, a doctor would not appear to have any legal protection for intervention or treatment to save the life of the mother if it occasioned or resulted in termination of her pregnancy.

That is something that Dr Bonnar didn't necessarily agree with, and I don't expect everybody to agree with it, but would it be of concern to you that the expert opinion of a group established by the, in fact, by the Oireachtas to look at the possibilities of what might happen in certain conditions, that there was a view that this would impact directly on the clinical judgment of doctors being exercised as it is exercised at the moment?

Professor O'Dwyer: Well, you see, there is another view expressed by no less a person than Mr Peter Charlton, senior counsel, in his textbook *Offence Against the Person* which was published, I think, eight years ago, and he says intent is the important thing, explicit intent, and I think that in my submission there is ....

Deputy McManus: Well ....

Professor O'Dwyer: If a doctor, for example … I have no problem, if somebody has cancer of the neck of the womb earlier in pregnancy, I would have no problem with doing a hysterectomy even though that's going to terminate the life of that baby. If somebody has cancer of the breast, I would have no problem in recommending that she should have intensive chemotherapy if that seemed to be the right thing to do even though that again would carry the risk of causing foetal abnormalities or, indeed, of killing the baby. I see no problem in that, and I don't see any legal problem either. You know, the Constitution group had their view, but it was only a view of a group of people and the legal side, as Peter Charlton assures us in his book, is that in this jurisdiction doctors would have nothing to fear, so one can't have it both ways. I'm going with his advice. I have nothing to fear because it has been the practice in this jurisdiction before the 1983 referendum and after the 1983 referendum.

You see, my interpretation of the reason for the 1983 referendum is different from some people. I think the genesis of it was to give the unborn child the protection of citizenship which it didn't have unless it was born, and the second reason was to protect the 1861 Act, the Offences Against the Person Act, so that it would not be struck down by legislators in the future. To me, those were the two reasons for the 1983 referendum and it was tragic that the Supreme Court should have decided, as it did in the X case, on what many people would say were faulty grounds, but they did decide, and that has got us into the problem we are in now.

Deputy McManus: Do you not accept as legislators that

no matter what – I mean there may be a whole range of opinions on the Supreme Court judgment – that it is the judgment of the Supreme Court and that one has to accept that that is the supreme judgment, so that you can't unravel that or roll that back and that, in fact, if anything the fact that we have an amendment now of the Constitution has, in certain ways, opened up possibilities for women to access abortion which weren't there before?

Professor O'Dwyer: I accept that this is the law of the land. One can't roll back the Supreme Court decision by legislation, but you can roll it back by constitutional referendum.

Deputy McManus: But this was put to the people that they would reject the X case decision of the Supreme Court. This was put to the people in 1992, and the people rejected it for a variety of reasons, I have no doubt. But that has already been done and has been rejected by the Irish people.

Professor O'Dwyer: Well, I think that the 1992 referendum was a double-edged sword, if you like – you vote 'yes' for the referendum and if you vote 'no', we'll give you legislation. That's what Mr Reynolds told us. There was no doubt at all about it in his mind, and I have it in writing somewhere. You either accept this referendum and if you don't, we'll give you legislation instead. Now the people didn't want the legislation. They didn't want the terms of the 1992 referendum either. They want a referendum that will roll back the decision in the X case, and whether they decide to do it, or to accept a referendum or not, once they've given their choice … you see, under the Constitution, people are always free to decide. Article 6 of the Constitution says that the people are sovereign. In all matters of national importance, the people's voice must be heard. When the people drew up the Constitution ....

Chairman: Under God, I think.

Professor O'Dwyer: Under God, yes. But when the late Éamon de Valera and his friends drew up this Bunreacht na hÉireann, they didn't put in Article 6 for nothing.

Deputy Enright: Or Articles 2 and 3 either.

Professor O'Dwyer: But Article 6 does say that in the final analysis the people have the right. Now, it seems to me that in all matters of common good, or whatever it is, it seems to me that the question of life and death is something so fundamental that the people ought to be given that choice. They ought to be given the right of determining one way or the other, and if they in their wisdom say 'yes', that's fine. Then if they reject a referendum that would be on their side, the whole thing is put to bed and done with for ever, we would hope. But until they're given that choice, I think, of a constitutional plebiscite, if you like, I don't think that this question of abortion is going to go away. It may be put ....

Deputy McManus: Just one last question, if I may. I think you'd have to recognise as legislators – certainly I would see, and I think everybody else would see who's in this job – that I have a duty to protect the life of men and women when that life is put in danger. Now, it is clear from the advice that we've received that the treatment that doctors are giving at present – and this has if anything been reinforced by the three masters – the treatment to protect the life of women would be put at risk with the proposition being put to the Irish people, if it were passed, to have a ban on abortion.

Professor O'Dwyer: With respect, I couldn't accept that and Doctors Clinch and Bonnar would be in the same boat as I am. We don't think … . you see, when I'm talking about abortion – and I notice that Senator Dr Mary Henry had difficulty with the term 'abortion' – abortion to me, when I use the word 'abortion', I'm talking about the deliberate intentional destruction of the child in the womb. I'm not talking about anything else. If I treat somebody and the baby dies, it's unfortunate, but it happened. That's not abortion. All I'm against is, if you like, the deliberate taking away of the life of the baby in the womb, and nearly all of those are for social reasons. But leave that aside, I'm against that; I'm not against anything else.

You talked about women being put at risk. You see, in my own personal experience, I was a practising obstetrician for over 40 years, and during that time I looked after over 9,000 women where I jealously wouldn't let anybody else look after them; I wouldn't share their care with anybody. I'd say, 'No, that's mine, you've given me that responsibility and I'm going to look after it.' I can say it now, not one of those 9,000 women died and I had never any reason to think that I could have done better if I had abortion.

Deputy McManus: Just very quickly, Dr Daly did indicate his concern about this idea of intention being the yardstick. He made the point that there are dangers in that because, for example, if a doctor tends to do good, let's say a hypothetical situation, but by good intentions happens to damage or hurt his patient, or indeed a foetus, that the intention to do good is not sufficient because he may have done something that is actually destructive to the woman's health or the person's health. So that to depend solely on the intention of the doctor is flawed as well surely, or are doctors omnipotent?

Professor O'Dwyer: I can see that the legal people would tell you that if you foresee something happening and you do something which might cause it to happen, that's intention. But that's not the intention that Peter Charlton is talking about in his offence against the person. That's not the intention that's in the 1861 Act, where it says that to do something with intent … and me now, for example, were I to bring some patient into the hospital with intent to procure a miscarriage, she didn't have to be pregnant at all, it was my intent to do it that was the crime. So intent is very important.

Chairman: Can I just turn to page 176 of the brief book, which is the last page of your own submission? I just wanted to put one matter to you there because I thought it might shorten the questioning a bit. I see in the first clear paragraph on the page, if you like, you've said:

> From an analysis of the various options, option (i) alone would satisfy the common good, [and that's your view as a citizen] so long as it was clearly understood

> that insertion of an appropriate clause into the Constitution could not, and would not, deprive any pregnant woman of necessary medical or surgical treatment during her pregnancy.

So in a way ....

Professor O'Dwyer: That's what I would hope would ....

Chairman: That's your preferred option?

Professor O'Dwyer: To me that would be perfection if that could happen. I know that there are three options – that the Government in the end of the day would have three options. They'll have the option of a constitutional amendment. They'll have the option of a constitutional amendment plus the heads of legislation, and they'll have a third one of just legislation itself. I hope that they'll take perhaps another one – to amend the Constitution, provided it could be absolutely explicitly stated that no one would be put at risk. I think you see … I've very strong views about women being denied treatment in pregnancy. I think not only the Medical Council says it's unethical. I think not only is it unethical, I think it's reprehensible to withhold treatment from a pregnant woman because you might damage her baby, unless she demands herself that no treatment be given, which is a different thing. But for me in a sort of paternal father figure to say to her, 'I don't think you should be treated for your breast because young Murphy here might be damaged' – I think that's terrible. That's what I would like to avoid, that there would be something put in that would ensure that every woman was entitled to proper treatment.

Deputy Enright: I'd like to join with the Chairman and Deputy McManus in thanking you for coming in. We appreciate your coming to us this afternoon. During your career of 40 years you mentioned that you looked after the welfare of 9,000 women. I think you mentioned that all of them lived, which is a wonderful achievement.

In regard to Dr Keane, the one thing Dr Keane was concerned over is exactly as you have stated, that you will provide medical care and treatment for a mother who is expecting a baby; that you will ensure her health and that it may happen, because of looking after her health, that the treatment may, in fact, affect the foetus and it may lead to the foetus being lost. Isn't that more or less along the lines ....

Professor O'Dwyer: Yes.

Deputy Enright: Dr Keane is concerned as to the legal position of the current situation. He feels that he is not protected by law and I think it would be correct to state that he feels that maybe on occasions he would be on the wrong side of the law. Again, like you, his approach is to look after the mother and child or foetus. He has worries about it, and I think Dr Clinch also has worries about the legal position as well.

Society changes and you have had situations in the past where, because of social changes and changes in attitude and everything else, down the road some people, in providing such care for the protection of the mother, they may be worried regarding their legal status. You go along with the views expressed in the book by Mr Peter Charleton, SC. It is a book that has no other standing but his considered view, and he is a very eminent senior counsel. But Peter Charleton's view has no legal status.

Professor O'Dwyer: There is no contrary decision ever in the Irish courts contrary to his view.

Deputy Enright: I am aware of that, but while I would have the height of respect for his views, they can be tested. There has been a constitutional amendment and there has been a Supreme Court decision on it following the X case. That will not necessarily guarantee there will not be future challenges to any further amendment to the Constitution.

Professor O'Dwyer: I read the transcript of the X case a number of times. In fact, I read two of them because there were two. There was one that was withdrawn and then we got the final one. It is pathetic reading in parts, that mature people, at the peak of their profession, would give us something like what is in that transcript on the X case. It could happen again, of course it could happen. If you amend the Constitution again it can be subject to scrutiny by the Supreme Court and can be amended. That can happen to anything that you do, but I have no fear. To answer your question, maybe I disagree with Dr Keane because I am longer in the tooth than he is and a more hardy warrior perhaps, but I would have no fear whatever of doing something, such as he mentioned, and finding myself on the wrong side of the law. I think I would defend that and I would get someone like Peter Charleton to defend me.

Chairman: Peter Charleton normally prosecutes people nowadays. Are there any further questions? I want to put a question or two before 5 o'clock. I call Deputy McGennis.

Deputy McGennis: I thank Professor O'Dwyer for attending the committee and I recognise he has travelled, presumably from Galway today, to be here. We are very grateful for that.

When discussing intent *versus* effect in relation to a question by Deputy McManus – we also had a discussion in relation to that with Professor Bonnar and Dr Clinch, which covered definitions, etc., – in your submission you mention the document addressed to the committee from the newly elected chairman of the Institute of Obstetricians and Gynaecologists, Professor Bonnar. In the second page Professor Bonnar mentions four areas in which pregnancy or termination would be necessary and you say on page two: 'I can only conclude that it is in such condition [that is, pulmonary hypertension] that Professor Bonnar feels that to protect the mother's life the pregnancy has to be terminated.' That is part of your submission. Do I understand what you are saying here because your following sentence states: 'Surely such a termination is a deliberate intentional act and constitutes abortion as defined by the Medical Council or under any other definition'. Do I understand then that you actually disagree with the submission we received from Professor Bonnar, as chairman of the Institute of Obstetricians and Gynaecologists?

Given your view – I understand it has been expressed by a number of people – of the Supreme Court judgment in the X case in relation to the constitutional amendment,

would you not agree that, in fact, amending the Constitution is probably not a healthy thing to do in the context of achieving the objective which was sought by the people in 1983 and voted for by the people in 1983, that it is not the best way to go about achieving the objective in 1983, maybe your objective, the objective of a number of people who have made submissions, people who have been before us this evening and people who will come before us further down the road, that it is not, in fact, the way to go and is not the safest way to go about achieving that objective?

Professor O'Dwyer: Let me take quickly the two questions. Professor Bonnar's submission from the institute had a rather tortuous gestation – let us put it that way – and there was more than one draft. I disagreed with him on the use of the word 'termination', which appeared in it at first. He amended that to 'therapeutic termination' – I think that is what the word is.

Chairman: The words are 'therapeutic intervention'.

Professor O'Dwyer: Yes, 'intervention'. I objected to the use of the word 'intervention' because I said: 'Intervention to me will lend itself to all sorts of constructions, legal constructions and I would be much happier if you would use the word "treatment"'. Then this thing, 'intervention' appeared in the last paragraph too, I think, and he took it out there and he put in the word 'treatment' and I said: 'Now hold it, John. You should put a comma after that word "treatment" and put in "other than abortion"'. Because, you remember that a judge of the High Court said that abortion was medical treatment by any definition and I said we leave ourselves open to being caught there and we have been caught with the other one.

Now, interestingly, therapeutic intervention has been interpreted by at least one University College Dublin graduate in the US writing recently, who said that the institute is allowing for termination of pregnancy in certain cases and he said what is therapeutic intervention if it is not termination of pregnancy? So, that is the first question.

The second one is, I do not think there is anything wrong with having another referendum. After all, you know, in Switzerland they have constitutional plebiscites or referendums almost every six months and they do not seem to get into any trouble.

Deputy McGennis: I was not concerned with frequency, or holding them, but the objective, the intent – to use that word – in the 1983 referendum was to absolutely prohibit abortion.

Professor O'Dwyer: That is right, but you see ....

Deputy McGennis: The effect was that it actually allowed abortion.

Professor O'Dwyer: Well it did not actually, it should not have allowed it.

Deputy McGennis: No, no, but it did. It may not have been intended, but it did.

Professor O'Dwyer: If I may come back to that. I believe that the 1983 referendum was fundamentally right. You see, there was a clause in it 'as far as practicable'. Now, in the X case, to my view as an ordinary layman, it was not practicable to bring somebody out of the jurisdiction back into the jurisdiction to charge her with something. That is not practicable. But they did that and they got themselves all tied up in this knot in the X case.

I want us to roll back the X case and the only way I can do that is with a constitutional amendment. I cannot do it any other way. It cannot be done by legislation because this is the Supreme Court decision on legislation and all legislation will follow from that, but not if the people roll it back. That is what I think and that is why I have suggested a wording and if a wording can be given which will protect the woman's right to everything she is entitled to then I think we would, to my mind, and I will not be around perhaps to see it all through, we could have done something worthwhile.

I wish you luck in your deliberations. I know you have a dreadful job to do, to try and satisfy everybody. It is an impossible job, but you have to do it, you are there to do it and I wish you well and I hope that you will be successful and that you will come up with something that we can all subscribe to.

Chairman: Thank you very much, Professor. I have been stopped by the clock but I thank you for your assistance. I would like to thank you for giving us the benefit of your experience, which is clearly very extensive in this area. I do not have to remind you of that. You pointed it out to us yourself very graciously. I would like to extend our appreciation to you and to all the contributors here today.

THE JOINT COMMITTEE ADJOURNED AT 5 PM UNTIL 10.30 AM ON TUESDAY, 9 MAY 2000.

TUESDAY, 9 MAY 2000, 10.40 AM
MEMBERS PRESENT:
DEPUTY T. ENRIGHT, S. KIRK, M. McGENNIS, L. McMANUS, J. O'KEEFFE, SENATOR J. DARDIS, D. O'DONOVAN, F. O'DOWD, K. O'MEARA

DEPUTY B. LENIHAN IN THE CHAIR

Professor Walter Prendiville

Chairman: We are now in public session. I would like to welcome Professor Walter Prendiville of the Coombe Women's Hospital to this meeting of the Joint Committee on the Constitution. Professor Prendiville, we've asked you to speak to us today. The format of this meeting is that you may make a very brief opening statement if you wish, which will be followed by a question and answer session with the members. I want to draw your attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you. A transcript will, however, be prepared of what you say and when published, that transcript will have absolute privilege. So I'd now ask you to make an opening statement.

Professor Walter Prendiville: Okay, thank you very much.

Chairman: Sorry, perhaps you had better start by stating your qualifications and experience and then the points you wish to make to us.

Professor Prendiville: My name is Walter Prendiville and I'm a consultant gynaecologist in the Coombe Women's Hospital and in the Adelaide and Meath Hospital in Tallaght. I am a Fellow of the Royal College of Obstetricians and Gynaecologists and a Fellow of the Royal Australian College of Obstetricians and Gynaecologists. I wrote my thesis on the prevention of unwanted pregnancy, in other words, trying to develop a test that would identify the fertile period, whilst a research fellow in the Middlesex Hospital and my major research interests are in the prevention of disease, particularly in the three areas of cervical cancer, post-partum haemorrhage and unwanted pregnancy.

I think that the committee has an exceptionally difficult task and I genuinely laud their efforts and don't pretend that the issue isn't difficult. I wanted to discuss three points in the few minutes I have before questions. The first one is the question of abortion being a yes-no, right-wrong, black and white issue. The second one was whether or not there are – and what are – the medical indications for termination of pregnancy and the third one is trying to put abortion amongst Irishwomen in context from my point of view as a practising clinician interested in women's health.

Every year I ask the medical students in their fourth year what they think about abortion. I ask them as a group and I ask the entire class, giving them three options – abortion should always be available on demand, it should never be available on demand or it should be available in certain circumstances. Over the last ten years the division of responses has roughly been 1 to 2% saying never, 1% saying on demand – or less than 1% – and 97 plus % saying in certain defined circumstances. These circumstances vary according to the individual medical student and I believe that that's the same for the general medical population.

Whether a particular woman or doctor or the public at large would agree with a woman choosing to have a termination of pregnancy depends on a number of factors quite apart from the religious or moral stance of that person or community. I think there are a few people in our community who feel that abortion is always wrong, but I believe that they are actually very much a small minority. The factors that come into play for a doctor faced with a woman who has an unwanted pregnancy that really do, I believe, influence the decision-making process are the gestational age, the specific circumstances of the conception and the condition of the mother and the condition of the foetus. Who in this country cannot tell the difference fundamentally between a newborn baby and a conception of just a few hours which has not yet implanted in the womb? In my view, most doctors and most men and women of reproductive age do not have a profound difficulty with preventing this pregnancy from implanting – witness the very widespread prescription and the use of the post-coital pill and the common use of the intra-uterine contraceptive device.

In terms of the specific circumstances, the committee has already heard from a previous expert witness declaring the profound distress of a woman who has been raped. I believe that most members of the medical profession and the public are supportive of early termination of pregnancy in this circumstance. In relation to medical indications of termination of pregnancy, for reasons that are not entirely clear to me, the public debate and legislative and political discussion concerning abortion seems to have concentrated largely on the individual issue of medical indication of termination of pregnancy. There are both maternal and foetal circumstances where termination of pregnancy would be indicated on medical grounds.

Again, I think we have tended to see medical indications as a yes-no, black and white, right or wrong perspective, whereas in truth the risks are relative. Whilst it is absolutely true that there are medical circumstances where termination of pregnancy will profoundly reduce the risk of a woman dying, it is not true to say that a woman will definitely die if she continues with her pregnancy no matter what the condition. It is a question of relative risk. You have already heard of Eisenmenger's and serious aortic stenosis. A woman with Eisenmenger's will not have a 100% risk of dying if she continues with pregnancy, but her chance of so doing will be about 40% if she does and you have already had reference to source material for that. An early termination of pregnancy in these circumstances will profoundly reduce this risk. Indeed, there are very few, if any, circumstances where pregnancy is not more risky than early termination of pregnancy, but the chance of the mother dying is so small in most circumstances that both doctor and mother would not wish for anything else than continuation of the pregnancy.

In terms of foetal indications of termination of pregnancy, it is perhaps hard for people to understand that a termination of pregnancy should be considered for foetal reasons in certain circumstances. If a foetus has a condition that is not compatible with life and where the mother and doctor consider that continuing with the pregnancy will serve no purpose and that it will be associated with unnecessary physical and psychological suffering, then a termination of pregnancy is indicated, I believe, reasonably. Anencephaly is such a situation. Women with anencephaly in Ireland are unusual in the European and North American and Australian circumstances in that they usually

do not have the choice of terminating a non-viable pregnancy until that foetus has become viable, such that it can be born alive, then suffer and then die. I believe that benefits nobody. It doesn't benefit the mother, it doesn't benefit the foetus – all it can do is add to the suffering of the mother. I don't mean that every anencephalic pregnancy should be terminated. Several mothers will choose to continue with their pregnancy, to deliver their baby, to hold their baby and to grieve, but other mothers will not choose to do that and in other countries they have that choice.

Also, you have already heard from an expert witness last week about the difficult problem of parents with children who have cystic fibrosis and those same parents who wish to have further children without this condition and I don't wish to repeat that.

The third issue I wanted to mention very briefly is the question of putting abortion in context. The problem with abortion for specific medical conditions or for rape is very rare. You know this, I know it, everybody knows it. Six thousand women or so chose to have a termination of pregnancy annually and they do so, in a great majority of cases, because of social, economic or other reasons. I believe this is the real issue which should occupy most of our time both in this committee and in the wider public forum. I appreciate that it is not within the strict terms of reference for this committee but in the same way that the major management approach to cervical cancer is the recognition and treatment of pre-cancer, so we should very seriously consider preventing the huge number of unwanted pregnancies that occur.

If we are considering what to do about abortion in Irish women, I am presuming that the primary concern pivots around two central actuarial issues of, first, how to reduce the unnecessary high rate and, second, how to improve the care of women who have unwanted pregnancies. There is very good evidence from abroad that in the absence of access to legalised abortion, women will resort to illegal abortion. Illegal abortion is not good for anyone. Illegal abortion is associated with high rates of very genuine morbidity and significant maternal mortality. I appreciate this situation does not prevail in Ireland because Irish women have ready access to abortion services in the UK, albeit without the necessary counselling and post-termination of pregnancy care that they so desperately need and that all their English counterparts receive. So long as the UK continues to provide access to abortion services for Irish women, the likelihood of Irish women resorting to illegal termination of pregnancy is remote and negligible.

Finally, there is good evidence that there is an interdependent relationship between abortion rates and contraception in terms of availability, accessibility, education and perhaps a collective cultural responsibility towards sexuality in teenagers. It is the combination of these factors which will dictate how many women will end up with an unwanted pregnancy. Each country appears to have a different approach to this problem. Many have arrived at their circumstance by deliberating seriously and implementing specific programmes; I am thinking of the Netherlands. In Ireland, we seem, until now, to have dealt with this by crisis management. We haven't planned how to deal with the fact that a lot of our communities' young men and women are having sex and that unless we equip them with the necessary information and means to deal with this situation, we will have a massive burden of unwanted pregnancies and of human suffering and our rate of unwanted pregnancy and abortion will continue to rise. It seems to me that, until now, we have seemed unconcerned about this. One of the reasons, and I think it is a very important reason, is that women with an unwanted pregnancy do not publicise their plight. Rather, quite reasonably, they wish to hide it, forget it and get on with their lives, and who can blame them? However, it is a very real and substantial amount of human suffering and we, the health care providers and the politicians, should rightly be judged in terms of how we deal with this problem.

If we are really serious about the problem of abortion and how to reduce its volume, we should begin to look at the evidence available elsewhere and which strategies are associated with the lowest rates of unwanted pregnancy and abortion. Simply legislating for or against abortion in different circumstances will not alter the abortion rate amongst Irish women. We need to look at the Netherlands and other countries with low rates of abortion and ask ourselves how they arrived at their low rates, and we need to look at Romania and Russia and other countries with high abortion rates and ask how they got it so spectacularly wrong. Otherwise, we will be condemned to continue with similar rates to the UK, at the very least. I thank you for your time.

Chairman: Thank you very much, Professor. I would ask the members to indicate if they want to ask any questions. Deputy O'Keeffe.

Deputy J. O'Keeffe: Thank you, Professor. We had some discussion last week among those who were making submissions as to how exactly we define abortion because it is not defined in the Green Paper which we are considering. How would you define abortion?

Professor Prendiville: I am actually amazed that the committee have not yet defined the term 'abortion'. Abortion is synonymous with miscarriage when the pregnancy terminates spontaneously without interference, though in the traditional text books the termination of a pregnancy by either spontaneous natural occurrence or by interference is called abortion, and they have traditionally been called the same thing. In other words, the ending of a pregnancy before viability is what an abortion is, and viability has changed over the years. Classically it is divided into first trimester termination of pregnancy, the first third; mid-trimester termination of pregnancy; and thereafter you are talking about viability. Now that viability gestational age has come down from 28 weeks to either 500 grams or 24 weeks in many countries but, by and large, for the very great majority of circumstances, termination of pregnancy, where the pregnancy terminates as a result of interference, is considered in the first trimester. There are very few normal pregnancies that are terminated anywhere after the first trimester, though that does happen.

Deputy J. O'Keeffe: I gather from your evidence that you feel uncomfortable with the present constitutional and legal framework within which we are operating in Ireland. Is my impression correct, and do you have any

specific proposals that you would like to leave with us as to how either the constitutional or statutory aspect should be changed?

Professor Prendiville: If I can step back just for a moment and say that I am not at all an expert in legal or political progress. I believe that the way we have managed it so far is quite wrong and I think that if we continue in the way we have that we will be likely to continue to get it wrong. I would leave the methodology and logistics of how to change the *status quo* to those more expert than I, but I would say that if we continue with our current policy in terms of reproduction for women, it is likely that we will continue to have similar rates of abortion to the UK and to Australia and the US. I think we are unlikely to reach the excessive numbers of eastern Europe and the developing world as more and more of our women become educated, but I believe if we really do wish to reduce the abortion rate in Ireland, we have to look at those countries that have legislated such that not just the availability of contraception but the accessibility of contraception and the education of our young women and men is profoundly increased, and the classic country is the Netherlands, but many northern European countries would adopt a similar philosophy.

I have to say that whether or not abortion is available in Ireland for social reasons is a relatively unimportant issue so long as Irish women can continue to access abortion abroad. What is more important is how we go about reducing the number of women who have an unwanted pregnancy. I think that is the most crucial point that we as a society and this committee need to consider. There is fairly clear evidence that accessibility as well as availability … everyone knows that the pill is available and that various contraceptive methods are available in Ireland but we have a genuine problem in that many of our young men and women do not use contraception for their first or early sexual experience, and the Netherlands and other northern European countries have managed to educate their very young teenagers such that before they have their first sexual experience, they are prepared and much less likely to have an unwanted pregnancy. As it happens, the Netherlands has a very low rate of abortion. As it happens, they have a very low threshold for doing abortion at a very very early stage, and they have access to early abortion, very wide, very generous access to early abortion. Now that's, if you like, a separate issue and I think the real message from the Netherlands is that they educate their young men and women very early and that they make contraception both available and highly accessible, and I think that is what we should consider.

Deputy J. O'Keeffe: Your comparison of Ireland with the Netherlands is that the Dutch have education – a lot of it at a young age. They have availability and accessibility to contraception, particularly the young people. They have what would be termed a liberal abortion regime and yet they have a lower rate of abortion ....

Professor Prendiville: Than anywhere else in Europe or in England, considerably lower. There is a very good paper by – I can't pronounce the names terribly well – Kulczychi, Potts and Rosenfield in *The Lancet* in '96 that compares abortion rates throughout the world and the use of contraception. I commend it to you. It is called 'Abortion and fertility regulation' and I can let you have it. It was in *The Lancet* in 1996, volume 347, pages 60 and 63 to 68. It reviews that question and the relationship between contraception and abortion availability very carefully. I really think it puts it into perspective. Essentially, I am saying that I believe – and I certainly think it is worth exploring – that education of very young people, accessibility of contraception and a responsibility to sexuality that prevails in northern Europe – and it does not prevail even in England nor in Ireland amongst our teenagers – is the only way we are going to change our society. I think that what we legislate for will actually not make any difference to 99% of the women who have an abortion.

Deputy J. O'Keeffe: We have your evidence on the comparison between Ireland and the Netherlands. Can you paint a picture of the comparison between Ireland and the UK in relation to education and abortion rates generally?

Professor Prendiville: I think that we have very similar abortion rates. I think, like here, the UK has very widespread availability of contraception, but has very very patchy accessibility and sex education and that there are a huge number of poorly educated people in the UK who are not well educated at the appropriate age because most terminated pregnancies happen to teenagers and to young women. Mostly young men and young women in England are relatively uneducated in this regard, whereas their counterparts in northern Europe or in the Netherlands are very much more educated. We are like the British in this regard.

Deputy J. O'Keeffe: Could I just ask one other question, Professor? You are aware of the constitutional complexities here and indeed the legal framework. If there was – and I will not ask you for a one sentence solution – if you were to make one major recommendation, if you had it within your power to implement one recommendation to effect a reduction in the abortion rate in Ireland, what would that recommendation be?

Professor Prendiville: That recommendation would be to adopt a strategy whereby our young women and men were educated and provided with the means to prevent unwanted pregnancy at a very early age.

Deputy J. O'Keeffe: Thank you, Professor.

Chairman: Just one matter arising from Deputy O'Keeffe's questioning, I don't know whether you studied the position in Germany and in the Federal Republic before and since unification.

Professor Prendiville: No, not in that regard.

Chairman: I would be interested to hear and I wonder if you could assist us at all from the literature in that regard.

Professor Prendiville: No, but it would not be hard to access the resources and to provide those to you, but the specific circumstances in East and West Germany I am not familiar with.

Chairman: It is just that West Germany had our position of a constitutional ban, though not as rigid a constitutional ban as is here, but had a very definite constitutional limit and appears to have had a much lower abortion rate, but it may be that it was a combination of that constitutional limit and similar type approaches to the approaches you talked about in the Netherlands.

Professor Prendiville: I am sure that is true.

Chairman: That is why I thought it would be interesting to explore because culturally it is that bit closer to us in its tradition ....

Professor Prendiville: Yes.

Chairman: .... though I gather since unification matters have changed in Germany because a more liberal legal arrangement had been introduced as a condition of unification, but it was an experience that I thought might be of assistance to us and I wondered could you help us on it in any way?

Professor Prendiville: Not at this time. I'd have to read up on Germany.

Chairman: I will take Deputy McManus.

Deputy McManus: Thank you very much indeed. First of all, thank you very much Professor Prendiville for coming here this morning. We appreciate very much your attendance here. I have a couple of questions. The first one, maybe if you could just clarify for me this issue of risk to the woman's life and possible risk to a woman's health. Are there circumstances where you feel that terminating a pregnancy would be significant in terms of protecting a woman's health?

Professor Prendiville: Yes, I do because I think that the risk of dying is the extreme result of a particular medical condition and morbidity is the lesser outcome, so there is absolutely no doubt that in the very rare circumstances where a termination of pregnancy is recommended for a maternal indication, that if the mother doesn't die, she is likely to suffer significant morbidity. I am talking now about all of the medical conditions whether they require an indirect or a direct termination of pregnancy. So, yes I do, I think that serious morbidity or health risk is a lesser outcome than mortality. Mortality is easier to measure, but for every mortality there is a lot of serious morbidity. So, yes, I think so.

Deputy McManus: Thank your very much. You have separated out in a sense the sort of medical conditions or issues where, for example, a women with encephalitis, that kind of situation, where you feel there is an argument for abortion. Some of the people who came before us in the last few days have made the point that it really does not matter whether it happens here or in England, but the point that was made by some of the doctors was that they felt that there was a difference in the sense that the standards in Britain weren't necessarily always proper and that there were difficulties, for example, in that particular situation with post-mortems or lack of information where maybe an autopsy isn't even held or the information isn't coming back. Is there not an argument that in those circumstances, leaving aside all the others, although I hate the word 'social', but you know separating it out on those medical grounds, is there or is there not an argument for providing that kind of service here?

Professor Prendiville: I would have to agree with you. I think that there is a very strong argument for having a termination of pregnancy available in a country for medical indications, maternal or foetal. When I said that I didn't think it mattered quite so much, what I was really trying to say was that for women who are healthy, we are unlikely to see serious morbidity and mortality if they have their termination of pregnancy in the UK. In other words, they won't have to resort to illegal abortion. For women who have genuine medical conditions, and there have been several in the last few years, they have by and large been referred abroad, I think that they are disadvantaged by going to the UK. Of course, the more serious the medical condition, the more likely that the referring doctor will pick an institution in the UK with very excellent health care, but there is no doubt that it would be better, I believe, for that woman to be able to have her termination of pregnancy in Ireland.

Deputy McManus: Could I ask another question? One of the assumptions that has been coming up has been that if you do legislate to provide abortion here, even circumscribed very tightly, that the floodgates open inevitably. I have difficulties with that assumption, particularly when I look to see what has happened in Northern Ireland, where it does appear to me that there is circumscribed in law conditions whereby women can have abortions and it would appear that the floodgates haven't opened, possibly because again people go to Britain. Do you see it as the inevitable outcome if one does provide abortion in certain circumstances, which aren't allowed for at the moment, like encephalitis?

Professor Prendiville: I would say two things. First of all, the floodgates are already open – 6,000 women go and have a termination of pregnancy every year, so the floodgates are already open. Our charge is to shut the floodgates, not to prevent women with unwanted pregnancy having a termination of pregnancy, but to reduce the number who get pregnant. That's our challenge.

Secondly, the great majority of Irish obstetricians and gynaecologists do not wish to perform termination of pregnancy in a so-called social bracket. They just do not wish to do that. With the greatest of respect for colleagues outside the major general hospitals, or indeed maternity hospitals, the number of institutions that would be likely to be equipped to carry out termination of pregnancy for sick mothers is fairly limited. Therefore, the floodgates, I think, are unlikely to open if this committee legislates or advocates legislating for specific medical conditions. You cannot fake an anencephalic, you don't fake an Eisenmenger's. So I think it's very, very unlikely and I do not see my specialty taking on social abortion at this time or in the foreseeable future.

Deputy McManus: I have two final questions which I will ask together. First, I am supportive of the view you

hold in relation to preventing crisis pregnancies and I think we have failed totally to face up to that. Education is the key. I wonder if you feel that, for example, a simple measure like contraceptives being available on the GMS, the medical card, is the kind of practical approach we should adopt. Second, you have written about possible developments in relation to abortion where, for example, in the future it may be – it seems to be happening already – that a woman would take a pill and that that may change the doctor's approach to the issue in the sense that it is – in your own words and I hope I am not misquoting you – as much about aesthetics as it is about ethics.

Professor Prendiville: They're somebody else's words which I quoted but they do reflect a particular dilemma – not dilemma, they reflect a very genuine entity. You are asking two questions. The first one in relation to early termination, the second one related to early termination versus late. I referred to it earlier and I really do feel that the great majority of people, not just of reproductive age but specifically of reproductive age, do not have a huge ethical problem with preventing the implantation of a very early conception, when it is a few cells and not formed into a foetus, obviously incapable of independent life and not recognised, not homonised, not ensouled, not human.

I think that the very great majority of people do not have a particular problem with preventing that pregnancy becoming a viable human being. That is witnessed by the widespread, one of the highest rates of post-coital contraception in Europe we have. The widespread use of post-coital contraception and the lesser but definite use of the IUCD suggest to me that doctors and the general public don't have a profound ethical problem with that situation. But the great majority of people have a serious ethical problem with termination of pregnancy at later gestational age. So I think that really does reflect the fact that the ethics of this situation are not black and white. They are very grey.

To answer your second question, I'm quite sure that in the future we may be able to avoid the experience of the UK and the horrendous, awful circumstance of having to evacuate a uterus in a healthy woman with a healthy pregnancy where the pregnancy is identifiable as a foetus and recognisable, etc. I think that in the very near future it is likely, already it's likely, that it will be possible to terminate pregnancy before it is a serious ethical problem for the majority of people. That demands widespread education about the recognition of ovulation, of pregnancy and the accessibility to a facility that would allow people to prevent them becoming pregnant, so to speak, when they have already had intercourse in an unprotected way. I personally believe that that's the way forward and we may be able to completely miss the awful circumstance of termination of pregnancy that's happened throughout the world. I think we should put some money into researching and understanding very, very, very early recognition of conception at this time.

Senator O'Donovan: I welcome the Professor. I have a couple of queries. Some of the points I wished to make have already been raised. You mention lack of education, maybe in our schools or parenting, as being possibly a major factor in the large number of unwanted pregnancies. Having regard to the fact that our young population is seen, not alone in Europe but throughout the world, as being one of the most educated, how can you align this ignorance on one aspect of our lifestyle? Is it a taboo, is there a stigma attached because we are primarily a Catholic country or have you any views to offer on that? In other words, it does not make sense when somebody says that. I have teenage children and in a village not too far from where I live in a very remote part of rural Ireland there are contraceptives available in both the ladies and gents toilets of local pubs. I believe that in rural Ireland the morning after pill is quite freely available. Having regard to all that, it puzzles me that there are nearly 6,000 women at a later stage in pregnancy going abroad to have terminations. It doesn't add up to me, as a lay person.

Professor Prendiville: I can understand the difficulty in saying that we need education. We are perceived and we perceive ourselves to be a very educated population. I think in many ways we are. But I don't think education in terms of ability to earn money or education in terms of appreciation of literature or music or politics translates into or confers upon us sexual education.

I believe that we don't have the same level of education in relation to sexuality at the particularly crucial time when men and women are at risk of having unprotected intercourse. There are very few people who are over 30 who do not understand how to avoid getting pregnant and, indeed, how to access the means to prevent unwanted pregnancy. But there is a huge population of women in Dublin and in Kerry, Galway and Donegal who (a) don't understand how to access contraception and (b) actually don't have a clear understanding of the risk of pregnancy. So I think we are educated in many areas of life but I don't think we are particularly educated as a population at that time in our development sexually.

Senator O'Donovan: I wish to follow up a question Deputy O'Keeffe raised on the definition of abortion. I'm a little confused on this. You are probably the tenth medical expert to come before the committee. At least two and possibly three were slow to align the terminology of abortion with termination. I got the impression from at least two, if not three, of the expert witnesses, without naming them, that they felt in crisis situations where there was maybe a serious heart condition with the mother, where the ectopic pregnancy occurred and a couple of other conditions such as cancer of the cervix or a severe medical condition had developed, that the spontaneous abortion you mentioned ....

Professor Prendiville: Induced.

Senator O'Donovan: Whatever. Doctors differ and patients die, so to speak. I have a difficulty in trying to ascertain if the other experts are on a wrong vein if they say: 'Such instances are not abortion *per se*'. It's involuntary termination or whatever and it's acceptable. I think it's acceptable to Catholic Church teaching in certain instances.

It would be helpful to me, as a member of this committee, if there was a definitive, clear decision on what is or isn't abortion. Some of the experts said that abortion in any circumstances whatsoever, either induced or spontaneous, is a type of abortion. Others were inclined to say that's not really abortion. Abortion is a sort of dirty word.

Where would you stand on that? I'm not trying to trap you into criticising what others said.

Professor Prendiville: I'll try to avoid being trapped. I understand the difficulty. I think its a reasonable difficulty. If you look in the textbooks of medicine and obstetrics and gynaecology, abortion is defined as the … when a pregnancy ends before viability. Now, abortion can be spontaneous or it can be induced. It is very reasonable for colleagues to wish not to use the term 'abortion' if they perceive that that may result in them not being able to look after women at risk of dying in specific circumstances. I can understand too the genuine ambition of colleagues from a particular philosophical point of view who wish to facilitate the treatment of women with cancer by calling that circumstance an indirect abortion, whereby you're treating the condition as opposed to terminating the pregnancy.

If you look at the classical textbooks, an abortion is an abortion and the reason it's done is very … that an abortion is an abortion. In other words, it is the ending of a pregnancy whether that ending occurs because of nature, because of the doctor or because they are treating a condition or not. Now, there is a move in nomenclature circles to change the word 'abortion' to 'miscarriage' when the pregnancy aborts spontaneously and to reserve the term 'abortion' for the circumstance when the pregnancy is terminated. That's a reasonable distinction because a lot of people do not like to be told they've just had an abortion when they've spontaneously miscarried. But, in the classical traditional textbooks an abortion is when a pregnancy is terminated before viability.

Senator O'Donovan: Now, this is a view that I have gathered from listening to political people of different persuasions over the last two years since this committee was formed. There seem to be three different views coming forward. Some of my colleagues may or may not agree. One is that there seems to be a demand, echoed by some political people, for an absolute constitutional ban – absolute, full-stop. The other would be a constitutional change incorporating certain clear parameters where this may be allowed or not, as opposed to sort of open-ended abortion on demand. The third would be mere legislation.

I personally feel that, having regard to the 1937 Constitution, to the amendment and to the X and C cases, it would be difficult to ignore the Constitution whichever road we take. I am just wondering have you a particular view or do you feel – you may have answered this already and I don't want to go over it – that legislation in itself will be adequate. If so, is it possible that the Medical Council or the association of gynaecologists and obstetricians can set out clear parameters of exceptional cases where this would be allowed?

Professor Prendiville: I find that a very difficult question to answer because I'm not an expert on the Constitution or on the law. But I believe, to answer one aspect of your question, that the Institute of Obstetrics and Gynaecology would be likely to be able to circumscribe specific medical indications, be they maternal or foetal, where termination of pregnancy is justified on medical grounds. I believe that the great majority of the population wish to see that available. I don't believe that … I'm sorry, I don't know whether the great majority, or whether any majority of the population, wish to see termination of pregnancy here for other reasons. I think that is unlikely, personally, at this point in time for a number of reasons, but I think that the majority of both gynaecologists, general practitioners and the general public would like to see women with genuine medical indications provided for in this country. I think that the Institute of Obstetricians and Gynaecologists, which would be the appropriate body, would be able to frame such a circumstance.

I mean, the other thing is that a paediatrician faced with a very difficult decision about when to turn off resuscitative equipment with a very sick or non-viable child doesn't have the decision decided at a referendum, quite rightly because circumstances change so profoundly and it is not fair to ask a doctor to have to accommodate that. I think it's very similar with abortion for medical indications … that if you allow the profession, once it declares itself, to work in the best and most caring way for its patients, it's likely to run a sensible course in changing times. Cardiac conditions were not a major problem 30 years ago, very few of them survived to adulthood. Now, cardiac conditions patients do. Some of these problems are new and the times will change, conditions will change. To proscribe it I think will cause difficulties, certainly in terms of a referendum. I think a referendum is a wrong way to go, but I have a very innocent view of constitutional and legal matters. I'm not an expert in that regard and don't wish to be or pretend to be.

Chairman: We are nearly at full-time. I call Senator Dardis.

Senator Dardis: You've made the point very forcibly to Senator O'Donovan and also, I think, to Deputy O'Keeffe regarding you're lack of expertise in the legal area and I accept that.

Professor Prendiville: Thank you.

Senator Dardis: I don't wish to ask you to express a legal opinion. Nevertheless, do you think it is possible to define circumstances within a constitutional framework? I mean, surely we are asking for something that's too complicated in that situation.

Professor Prendiville: I think you are correct in that assumption. My belief is that it is too difficult to prescribe constitutionally the various factors – gestational age, degree of sickness, relative risk of dying, degree of normality of the foetus, likelihood of termination to cause problems. It is very, very difficult to include that in a succinct and understandable framework that the general public can understand.

Senator Dardis: Well then that leads to the next question and the next question is … you spoke about the 97% of the students who would favour termination or abortion in defined circumstances. If the circumstances are very clearly defined, do you think that that would preclude the possibility of social abortion, so to speak? In other words, is it possible to achieve that objective?

Professor Prendiville: Yes, I do believe it is possible to achieve that and I think Northern Ireland has done that. I

think that, unless the nature of the profession of obstetrics and gynaecology changes radically, it is very unlikely that social termination of pregnancy would be accommodated within the specialty of obstetrics and gynaecology. So, I personally feel that it is possible to do that and that the Institute of Obstetrics and Gynaecology would be unlikely to betray that trust were it endowed upon them. That's my own belief.

Senator Dardis: There was a view expressed to us last week as to where abortion should be available in circumstances where it would be allowed or where it would be required. The view was very definitely that it should be restricted, let's say, to the teaching hospitals or to major centres. Do you have a view with regard to that?

Professor Prendiville: I personally would not like to see it restricted to particular hospitals because I think individual hospitals have different ethical frameworks and some of our hospitals are controlled by boards of lay people rather than medical people. I think it is fair to say that termination of pregnancy in the rare circumstance where medical indications prevail would need to be carried out in a hospital of sufficient size to have the expertise and resource to look after that woman and there are not many of those. For a woman who is very sick, there are not many.

Senator Dardis: I have a final question which is unrelated. You spoke earlier on about the first experience … the younger people .. that that tended to be the unprotected sex where you had the possibility of the unwanted pregnancy. But, I noticed that in the Adelaide Society's submission they talk about many Irish women have termination of pregnancy at a later gestational age than their British counterparts. Perhaps you could reconcile that for me.

Professor Prendiville: Yes, indeed. I think that they do so because they recognise pregnancy later and because they get to counselling services, if they go to them, and get to termination facilities later than their counterparts do in the UK so I don't think they are irreconcilable. Just to add to your previous point, I think you'll find it as difficult to find a tertiary level referral hospital who wishes to take on the responsibility as you will to have one to curtail it.

Senator Dardis: One final short question. There is a lot of talk about the advances in medical science, advances in technology. To what extent can we anticipate that diagnostic technology is advancing at a rate that will allow us to identify some of these extreme situations at a very early stage so that the intervention can be at an early stage?

Professor Prendiville: I really don't feel I'm sufficiently expert to give you a concise answer to that. I think that would need a prepared response and I think the person to answer that best would probably be Sean Daly who has done a fellowship in mid-maternal foetal medicine. I am sorry to pass the buck and Sean, I'm sorry, but that's what I believe.

Chairman: We've heard from him already in fact.

Deputy J. O'Keeffe: Missed the boat.

Senator O'Meara: Thank you also, Professor Prendiville, for coming to speak to us today. In particular I'm interested in your remarks about the Netherlands experience and the challenge to us which I think as legislators we must take up to effectively, as you put it yourself, shut the floodgates which are already open from this country in the direction of Britain, but not in a legal sense necessarily, rather in terms of how we deal with the issues of sexuality, unwanted pregnancy and so on. Before I do that, I just want to ask you something specific in relation to what you said earlier about very early termination of pregnancies. I wasn't clear whether you were referring to the availability of the morning-after pill or whether there were other scientific and medical advances which we might not necessarily be familiar with as lay people.

Professor Prendiville: No, I am referring to post-coital contraception, the use of the intra-uterine contraceptive device but I am also referring to the rapidly changing area of understanding in relation to very early pregnancy, such that in the UK many women will choose to have termination of pregnancy by taking a tablet. That's by and large not available to Irish women. At this point in time, it's not quite as successful in very, very early pregnancy but I believe that the time is coming and I believe it is worth investing in research in this area, to develop technologies and pharmacologies that will be able to prevent an established pregnancy. I do believe that even at this point in time, if there were widespread availability and accessibility to the recognition of pre-implantation pregnancy that that would be ethically much more acceptable to many people than termination of pregnancy at eight, ten and 12 weeks is.

Senator O'Meara: You are effectively talking about the morning-after pill – are you? I just want to be clear. Are you talking about what I would understand to be the morning-after pill?

Professor Prendiville: I am talking about the morning-after pill but I'm also talking about other things. There is a window of time between post-coital contraception – people wanted not to use the morning-after pill terminology because it suggests that – and this is widely held – that it only works the morning after whereas it works for about 72 hours and the IUCD as a pre-implantation device for up to about five to seven days. There is a window thereafter until pregnancy is eight, nine weeks and it's only after that that termination of pregnancy is actually successful in a reasonable proportion of cases and I believe that window of time, certainly until the expected menstruation and in the few days and perhaps week after, that that is the area that we should concentrate on, that may allow us to prevent implanted pregnancies in the future.

At this point in time, I think that ethically many people believe that post-coital contraception, be it the 72-hour pill or be it the five, six day IUCD is very ethically acceptable in a crisis pregnancy and that a lot of people would not find termination of pregnancy later acceptable

with the same person in the same circumstances. So I think that to mount a campaign of recognising pregnancy the minute it's happened and facilitating prevention of implantation would be far more ethically acceptable to our population at this time than what we do at the moment. Infinitely more acceptable to both sides of this argument, the pro-life movement and the pro-choice movement, is the idea of preventing pregnancies and whilst there may be different strategies which both sides advocate, they have a common ambition and perhaps that is what we need to ....

Senator O'Meara: Yes, which brings me to the second question which is the common area, I think, among all of us which is that we need to look more carefully at why we have such a high rate of unwanted pregnancy and why we have such a high rate of abortion and in the Mahon, Conlon and Dillon study, I don't know if you are familiar with it ....

Professor Prendiville: Yes I am.

Senator O'Meara: I have referred to it before. There are issues there which you have referred to yourself, for instance, the fact that so many women travel to England without any counselling, that so many go for reasons of secrecy which you've referred to. I certainly find it worrying, to say the least, that women who choose to have an abortion for reasons of secrecy only and to block out or deny, shall we say, the other issues that come into play and what that says about our culture here in this country, particularly about our attitude to sexuality. We still have a long way to go, I think, in relation to dealing with issues of sexuality. The fact that the relationships and sexuality programme is only now starting in schools leads to – it will be a time before we can study whether there is a positive effect in relation to reducing the number of pregnancies, particularly teenage pregnancies, but it also raises the question as to whether it would be possible for say the legislator or a Minister for Health, for instance, to effectively launch what it appears to me to be what you're suggesting is a proactive campaign of sexuality education, of contraception education, of much broader accessibility to contraception, particularly to young people, probably you're looking at 16 to 18 year olds and younger ....

Professor Prendiville: And younger.

Senator O'Meara: .... considering that some of our very high profile legal cases have involved teenage girls, you know, and we know of course as members of the public and as legislators and public representatives, that there is a major issue around teenage sexuality. To actually move towards that kind of campaign would suggest that we need to be looking at a proactive campaign of sexuality education in schools, in the community, advertisements and television and all that and that you actually would need to move into that space if you are genuinely looking at reducing the number of pregnancies and reducing the number of abortions in particular.

Professor Prendiville: I agree. I think somebody needs to be funded to do some research on how exactly the Netherlands have achieved it and to develop some pilot programmes here and to determine if they work and, indeed, any other strategies that any other lobby group wish to put forward should also be evaluated in the Irish context and evaluated urgently.

Senator O'Meara: Thank you for that.

Deputy M. McGennis: To follow on actually directly from the last question and the last point that was made, I would immediately embark upon the kind of campaign that you're talking about of relationships and sexuality or sex education and more freely available contraception if I felt that that would in fact reduce the numbers of unwanted pregnancies or crisis pregnancies, but I think maybe what we are missing out on is, and maybe that your suggestion that funding be made available for research on the Netherlands experience might actually reveal something else which we haven't discussed so far and which we haven't discussed an awful lot during the hearings – that is the relationship between parents and their sons and daughters. I have no doubt that that is an influencing factor.

I think maybe the degree of openness between a son and daughter and mother and father has a lot to do with whether you see that daughter ending up in a situation of a crisis pregnancy. In tandem with what you're talking about, because if you were to presume, as I would have, that the UK must have reasonably easily accessible contraceptives, has had some sort of sex education programme in place for many years, then they have achieved little or nothing. I think our own studies might indicate that you are finding the instances … I mean you would see them at your clinic and we would see them at our clinics … you're finding the instances of crisis pregnancies or, if you like, what would be termed unmarried mothers are cropping up almost always in particular in socio-economic groupings as well. I think that it's not just simple availability of contraceptives and good sex education in schools, it's also to do with the need to, in certain circumstances, educate parents. It appears that where young people have ambitions for themselves you find much less instances of crisis pregnancies or at least maybe those pregnancies being carried through to term. If the young people themselves, particularly young women, haven't a sense of their own worth or ambitions for the future then you're seeing, I think, greater instances of unplanned or crisis pregnancies. I think maybe what you're suggesting is spot on, but I think maybe we're missing a vital component to getting, reducing the numbers of crisis pregnancies.

Professor Prendiville: I'll be brief in my response. I think that it's true that there may be a difference between those women with an unwanted pregnancy who choose or are able or are organised whereby they have a termination of pregnancy, but I don't think that there's a social economic protection from unwanted pregnancy and it may be that certain categories of women with an unwanted pregnancy in difficult circumstances do not or cannot or are unable to either culturally, economically or for whatever other reason choose to have a termination of pregnancy. There are other groups who decide and are organised and do have a termination of pregnancy but I think unwanted pregnancy happens across the board

socially and economically, though the outcome may be different.

I think you're absolutely right and I agree with you, and I never pretended otherwise, that I believe the answer to unwanted pregnancy is a combination of interventions. My understanding from the Netherlands experience is that it is an interdependent, multi-factorial approach whereby it's availability of contraception, it's accessibility of contraception, it's comprehensive sex education and life education and it is also a supportive society whether that's within or without the family in terms of educating young people and preparing them for their first sexual experience. I agree that it's a multi-factorial phenomenon and I don't feel that it is necessarily that copying the Netherlands experience is the answer because we live in a different world and we have different … it may not be possible to provide the kind of education that is truly protective in our circumstances. I believe that what we should do is define a number of strategies and research them by randomised control trials or by intervening in different areas in different ways so that we can rapidly discover which is the best answer for our country at this time but we need to quickly.

Senator O'Dowd: There's just one point I want to clarify. It's just the options which in the future will be open to mothers or expectant mothers. You were saying you have the morning after pill. I'm just trying to get what is the next timeframe that you're talking about, an absolute timeframe, theoretically, that they do have the option of taking a pill as opposed to having a physical abortion?

Professor Prendiville: At this time it's the post-coital contraception, which is 72 hours, and the inter-uterine device, which prevents implantation up to five/seven days. Thereafter, there is not as yet a well researched available pharmacological or other intervention that is successful in the first few weeks of gestation post-implantation.

Senator O'Dowd: In terms of the timespan where you think that in theory one could theoretically work?

Professor Prendiville: I don't wish to speculate but I believe ....

Senator O'Dowd: When then does the actual implantation finally take place in medical terms?

Professor Prendiville: A week to ten days after conception. I think that that is the time that it is ethically acceptable to an awful lot of people to intervene. Whether that will change in the future or not I'm afraid is entirely speculative.

Senator O'Dowd: Fair enough. Thank you.

Chairman: Professor Prendiville, I'd like to thank you for coming to us this morning and assisting us as much as you have and for making what is no doubt your very valuable time available and your experience in these matters. I certainly derived great benefit from what you told us. Thank you very much.

Professor Prendiville: Thank you very much.

Chairman: I'm not going to suspend the sitting, I'm going to take the next witness. We have two further witnesses to take this morning. I wonder if we could make the questions as brief as possible. The next witness is Mr Fred Lowe.

Mr Fred Lowe

Chairman: We continue to be in public session and I would like to welcome Mr Fred Lowe, who is a senior clinical psychologist at Baggot Street Hospital, to this meeting of the Joint Committee on the Constitution. Mr Lowe, we received your presentation which has been circulated to the members. The presentation is at page 129 of the brief book and that brief book in fact has been laid before the Houses so you're statement enjoys absolute privilege.

Mr Fred Lowe: Okay.

Chairman: The format of this meeting is that you may make a very brief opening statement elaborating on your submission, if you wish, which will be followed by question and answer session with the members. I have to draw your attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you in your utterances here today, though a transcript is prepared of what you say and that, when published, has absolute privilege. I would ask Fred Lowe to make an opening statement to the committee.

Mr Fred Lowe: For your own comfort while reading my submission I'd like to point out two minor typographical errors. The third paragraph down, 'only pregnant women must endure', there's no 'who' there, and the last four lines of my submission were pasted when they should have been cut and so please omit them altogether.

I'm not a medical person, I'm a principal clinical psychologist but I do deal extensively with rape victims. What I wanted to point out in my submission was that there is a very special case where rape is concerned because rape is where consent has been removed from the woman and the woman is confronted with a situation where she may find herself pregnant totally against her wishes and perhaps as the result of the coercive wish of the rapist. I think for the State to take over that man's wish to impregnate a woman and then say that the woman must submit to that wish is a breach with the rest of our law, which gives very strong emphasis to the integrity of our body and our right to control our own bodies.

We cannot allow, for example, people to remove organs from our bodies after death unless that is our wish so that we respect the integrity of a dead body if that is the wish of the person. There was a recent concern about parts being removed from foetuses and unborn babies because we felt the parents had a right to say that their children should not be used and their body parts should not be used. That wish is very much there in Irish law and yet

when it comes to a woman who has been forced into a pregnancy we somehow say 'you cannot now choose what happens to your body, you must submit to what that man has chosen to do to your body.'

I have dealt with women who have felt that coercion, that situation where they have been given no choice, and I do feel our Constitution should help them rather than remove that choice from them.

Chairman: I'm glad you mentioned the Constitution … sorry, you've finished ....

Mr Lowe: I have.

Chairman: .... because the present constitutional framework does not appear to recognise that option. That's part of the coercive power of the State. Isn't that right?

Mr Lowe: That is true.

Chairman: Because rape of itself under the current constitutional arrangement is not an indication. You'd accept that? I mean it's a matter of law I know, it's not ....

Mr Lowe: Yes.

Chairman: The view has been expressed … first of all in relation to the morning after pill, as it's commonly called, and post-coital contraceptive devices, the joint committee for family planning attached to the Institute of Obstetricians and Gynaecologists has written to us. It's at page 128 of the brief book, just in fact before your submission, expressing a very strong view in that respect. How many rape victims does the availability of post-coital contraception assist?

Mr Lowe: If the rape victim comes forward quickly, then the morning after pill is offered automatically. There are some exceptions to that. Some rape victims do not come forward within the first two or three days. Secondly, there has been a spate of rapes in England, for example, where sleeping tablets have been given to young women and they have been unaware that they have been raped until they find themselves pregnant. Now, you can see under those circumstances the opportunity to give the morning after pill has been removed from the woman.

Chairman: The view has been expressed to us on the ethical side that it is wrong to compound the wrong done to the woman by inflicting a wrong on an unborn person, or again terminology, on the quickened life without birth, as it's called in the Irish text. Have you any comment to make on that?

Mr Lowe: I can only look at the situation which occurred in Kosovo recently where hundreds of women who were made pregnant by Serbs had babies and the fates of those babies were horrifying. Many were left out to die, many were dumped in institutions and we can see from that the extremely disturbing effects of an unwanted pregnancy where it is the result of coercion and rape.

Chairman: The view has also been expressed to us that categoric … to introduce this category … it is a difficult category to introduce because of the uncertainty of application. I think one of the masters of the hospitals indicated that it is very difficult to assess whether in fact a rape has taken place. That's one of the great difficulties in introducing this category into the legal system.

Mr Lowe: I have pointed out in my written submission that the British legal system has introduced a greater uncertainty because, in effect, a woman cannot look at the circumstances of her pregnancy. It is up to two doctors to decide whether her mental or physical health required that her foetus be removed. I'm saying that we must look at the circumstances of the pregnancy and recognise that the *sequelae* of that rape is just as important to the woman's welfare and health as dealing with the event itself.

Chairman: They were just questions that arose from the submission, from the evidence to date that I felt should be put initially. Are there any questions? Senator Dardis?

Senator Dardis: Thank you very much for your presentation and for your submission. At the conclusion of your submission you state that every form of words will be inadequate for some case at some time. That's a very succinct summary of things that have been said to us in much greater … with far more words. You talk about removing the matter from the Constitution altogether. On the basis that it would be removed from the Constitution, what then would you proceed to do?

Mr Lowe: I think legislation is the best means because legislation is more easily changed for circumstances and legislation, I think, can take better account of the special social circumstances of rape victims. I would go down the road of having good, strong legislation so that all of the social dimensions can be looked at.

Senator Dardis: Do you think that it is possible to define psychological conditions sufficiently accurately to preclude a general opening up of abortion?

Mr Lowe: In my written submission I have quite clearly not said psychological outcome alone is the important thing. I think if we are going to have a situation where abortion is used as a means of contraception then it is wrong. When a woman has unprotected sex she is taking a chance and, even if a mistake occurs because of, say, contraception going wrong, there is an outside chance which she may have to consider in a different way than if that choice about having sex is taken away from her. My whole piece was about coercion and about the removal of choice from a woman. It was not about whether the woman should have the choice to have an abortion.

Chairman: Well, I think that's very clear from the submission. In fact, you gave the example, of course, of deception as well as rape. Deputy O'Keeffe?

Deputy J. O'Keeffe: Your views, obviously, on rape are very clear and very strong but do you appreciate the difficulty of framing a legislative or a constitutional proviso on that score? I mean, there are rape trials that go on for months. Who would decide as to whether it was a rape? If one were to try to frame a special provision for the

victim of a rape, would it be the victim who … we are talking about, at your suggestion, allowing action to be taken within a relatively short time after. How would one deal with the question of proof of rape in that narrow, short time frame?

Mr Lowe: There are relatively few rapes which lead to extreme controversy as to whether the rape had occurred. Most of those, legally, occur around whether consent had taken place or not. I am talking here about very clear cut cases of coercion and I don't think doctors who have dealt with rape victims have any doubt in their own mind about which people have been raped or not.

I do feel the morning after pill, which technically, remember, is an abortifacient, and .... I do recall one earlier interview when we were interviewing for doctors at the sexual assault unit, one of the doctors interviewed was asked if he would give the morning after pill to a rape victim and he said that the ruling of his hospital was that they would give it providing she wasn't ovulating at the time. Now, that is technically correct in terms of what the Church's teaching is about but it is rather beside the point in terms of the needs of the rape victim.

Deputy J. O'Keeffe: Just following that up a little further, and leaving aside that particular hospital, is it in fact normal practice, if there is a rape, that the morning after pill is made available to the victim?

Mr Lowe: I believe it is.

Deputy J. O'Keeffe: Is that just in urban Ireland or right throughout Ireland?

Mr Lowe: I'm sorry?

Deputy J. O'Keeffe: Is that right throughout Ireland or is it just confined to urban Ireland?

Mr Lowe: I cannot speak about right throughout Ireland, I can only talk about what I believe to be the normal practice here in Dublin.

Deputy J. O'Keeffe: I see. Could I just touch on one other issue, Mr Lowe? It is not touched on in your submission. Am I correct in thinking that you gave evidence in the X case, is that correct, on the question of suicide?

Mr Lowe: I believe that was not.

Deputy J. O'Keeffe: I see. The problem was that I'm just interested because the issue of suicide came up and ....

Chairman: I'm not clear about this at all, actually. It's not in your submission. Were you a witness in the X case?

Mr Lowe: I was but I believed that was not something that was going to be dug out later.

Deputy J. O'Keeffe: If it causes you a problem, I'm sorry. It's just that we did have evidence last week from a number of medical witnesses on the question of suicide generally and … which obviously has an impact on the present constitutional provision and the interpretation of that provision as a consequence of the X case. If it causes any problem, I am ....

Mr Lowe: I see it as irrelevance because my submission was nothing to do with suicide, it was about the woman's right to choose not to have an enforced pregnancy.

Deputy J. O'Keeffe: Yes.

Mr Lowe: Suicide does not enter into it.

Deputy J. O'Keeffe: If you prefer to confine your submission to that particular aspect, that's fine.

Mr Lowe: My submission was confined to that.

Deputy J. O'Keeffe: Yes, and you prefer to confine your evidence to your submission?

Mr Lowe: I do.

Chairman: Deputy McManus?

Deputy McManus: First of all, thank you very much for your submission and coming here today, Mr Lowe. I appreciate you are confining it to you submission, but I just wonder about the issue of incest, whether you are including that or whether it is a totally separate issue.

The second question I'd like to ask, just to save time, is whether or not there is an institute or an association of clinical psychologists that has the position or policy in relation to this issue. I can only think … I am just, I suppose, thinking of a specific case where there was a case of incest and where, indeed, a psychologist was, in effect, very encouraging to the idea of delivery of the baby rather than having the other option. I just wonder if it is something that has been discussed among yourselves or whether you are coming as an individual with particular experience?

Mr Lowe: I am speaking as an individual, not for my profession or for my employers. I am here as an individual with experience of dealing with rape victims. I do not see incest as being essentially different when we are talking about terminations. If a couple have chosen to have incestuous relationships I think that is not a matter which I wish to discuss in this … but if the incest involved coercion or rape then I would say it would come under the conditions which I am talking about. My whole concern is about the choice of a woman as to whether she has become pregnant or not. If that choice has been removed I do not believe we should enforce anything on her.

Deputy McManus: Just one last question, do you know is rape a reason for being able to access an abortion in Northern Ireland?

Mr Lowe: Northern Ireland has the same rules as in England. It doesn't include rapes specifically.

Deputy McManus: Thank you.

Chairman: Any further questions? The general ruling to guide us on this is that decisions or judgments of a duly constituted court cannot be subject to review or discussion in the House as the House is not a judicial body. Of course, that ruling really relates to a case, say, that's decided last week and the Members want to attack the judge for giving

too lenient a sentence or whatever. I suppose in the case of the X case – it is just for the benefit of the members generally – the view I have taken in these hearings is that clearly it's a case of immense public interest and the decision itself as reported … full and fair criticism and comment on the decision itself is permitted but we don't want to delve into the facts of the case itself, but have you a view on the decision in itself as a decision? I appreciate again you are making a personal view, you are not here on behalf of any body. There has been an amount of evidence before us from the medical witnesses that they wouldn't view the type of circumstances – I appreciate you don't want to talk about the facts of that particular case – the type of circumstances disclosed in that case in their view wouldn't be a medical indication for a termination. That view has been expressed quite strongly I think by a number of the doctors who have appeared before us.

Mr Lowe: I would simply reiterate again that to turn it into a medical debate is lessening the options open to the woman who has had her choice removed under the circumstances of rape. I would include statutory rape under the same heading as rape because in law we deem those girls not to be able to have the choice. To broaden it out into a discussion about suicide is irrelevant. This is about the right to choose and if someone takes away that right I think our Constitution should not uphold the rights of that person.

Chairman: That in fact is at the core of your submission.

Mr Lowe: Yes, and I don't wish to discuss suicide or anything else. This is very much about whether the debate should centre around a basic human right about our owning our own bodies and not allowing other people to do things to our bodies against our wish.

Chairman: That's your philosophical point of departure ....

Mr Lowe: It is.

Chairman: .... in your submission and very clearly put. Thank you very much for making your time available to assist us today. I do appreciate your assistance.

Mr Lowe: Thank you.

Chairman: I'll suspend the session for five minutes.

SITTING SUSPENDED AT 12.05 PM AND RESUMED AT 12.15 PM

Professor Gerard Bury

Chairman: We are now in public session and I would like to welcome the following representatives of the Irish Medical Council, Professor Gerard Bury, who is the president, Dr John Hillery, who is the vice-president, Dr Helena Stokes, who is the chairman of the Ethics Committee, and Mr Brendan Healy, who is the chairman of the Fitness to Practise Committee. I welcome you all to this meeting of the Joint Committee on the Constitution.

We have received a submission from the Medical Council. This submission was not in the original book of submissions, which has been tabled before the Houses. This submission is, therefore, not in the brief book, but it has been circulated to the Members. I propose to read this submission into the record and then we will proceed to the questioning. The document is headed 'Medical Council submission to the All-Party Oireachtas Committee on the Constitution, Tuesday, 9th May 2000'.

Introduction

The Medical Council's mission is to protect the interests of the public when dealing with members of the medical profession. It does this by:

- supervising undergraduate education and post-graduate training
- maintaining registers of practitioners
- disciplinary procedures
- publishing guidelines on professional standards

The Council was established under the Medical Practitioners Act, 1978. The 25 members of Council are elected (by the profession) or appointed (by academic bodies and the Minister for Health and Children) every five years.

The Guide to Ethical Conduct and Behaviour

Each Council since 1978 has published a set of professional standards or ethical guidelines for the profession. The principles underpinning each publication have included:

- The guidelines do not have statutory force; they represent advice on generally accepted standards of practice.
- The guidelines do not constitute a rulebook or code of practice. Rather, they identify key ethical and professional principles.
- The clinical independence of doctors practising in Ireland must not be undermined by these guidelines. Each doctor must examine the ethical principles relevant to individual cases and make a personal decision about their application.
- The guidelines may form the basis for judging the practice of a doctor who is the subject of a complaint.
- Breaches of the Guide to Ethical Conduct may constitute professional misconduct.

On a five-yearly basis, successive Councils have requested general submissions from the profession and public and have re-examined previous publications (and those from other countries) in detail. An updated guideline is then published. When new ethical or professional principles are identified or when novel applications of existing principles are promoted, the revised guidelines address these issues.

The disciplinary process

The Medical Council receives approximately 200 complaints each year in relation to the 12,500 practitioners registered with it. Complaints are received from members of the public, doctors, other colleagues

and from employers such as Health Boards. Each complaint is investigated by the Fitness to Practise Committee and if a *prima facie* case exists, an enquiry is established; approximately 30 enquires are carried out each year.

All enquiries are held with legal representation and serious allegations must be dealt with under the criminal standards of evidence and proof. If an allegation of professional misconduct is upheld, the Medical Council decides on an appropriate penalty, which must then be confirmed by application to the High Court.

The Fitness to Practise Committee and Medical Council are conscious that the principles outlined in the Ethical Guidelines may become the basis for disciplinary actions. It has always been the policy of the Council to avoid hypothetical cases or speculation about the possible outcome of an enquiry.

A Guide to Ethical Conduct and Behaviour (1998): Reproductive Medicine

Following calls for submissions and an extended internal review, the Fifth Edition of the guidelines was published in 1998. Almost 500 submissions were received, many in relation to issues of reproductive medicine; a single submission requested the Council to consider facilitating termination of pregnancy.

The Ethics Committee and Medical Council carefully considered both the existing legal uncertainty and the real needs of women dealing with crisis pregnancies. The Council guideline offers doctors a clear statement of professional responsibilities. Section 26.5 states:

The deliberate and intentional destruction of the unborn child is professional misconduct. 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. Refusal by the doctor to treat a woman with a serious illness because she is pregnant would be grounds for a complaint and could be considered to be professional misconduct.

The Green Paper on Abortion

The Medical Council welcomes the publication of the Green Paper, the establishment of the All-Party Oireachtas Committee and the debate on the needs of women with crisis pregnancies. The Green Paper sets out the current situation in Ireland and identifies options for change.

The Council also welcomes an opportunity to comment on how standards of medical practice in Ireland are ultimately decided in Ireland.

At present, any finding of professional misconduct where a penalty of suspension, erasure or attachment of conditions is imposed must be confirmed by the High Court before the penalty is implemented. The Courts have ruled that such hearings should deal with the facts of the allegations as well as issues of law and natural justice. Ultimately, then, a decision on the acceptability of medical practice is made, not by medical peers, but by the Courts on the basis of evidence presented.

In Conclusion

The Medical Council's role in protecting the public interest encompasses a range of responsibilities. An informed debate on issues of reproductive medicine, and particularly on termination of pregnancy, is to be welcomed.

In developing future professional guidance to doctors, the Council will pay careful attention to the outcome of this debate. The Council wishes the members of the All Party Committee every success with their work.

I have to draw your attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you in your utterances before the committee. And I think the submission is clear in its terms. I don't know do you wish to elaborate on it in any way.

Professor Gerard Bury: Not at all. We're happy to take any questions or issues that arise from it.

Chairman: So in that case I'll proceed to questions and I call Senator O'Dowd.

Senator O'Dowd: Thank you, Chairman. I'd like to welcome the Medical Council and Professor Bury here this morning. I will just try to tease out a couple of points. The biggest problem we face here is listening to different consultants telling us that some of them certainly have worries over the present legal situation and that procedures which they carry out, which are to protect the life of the mother rather than to kill a child as such, that they worry that if we change the law, if we have a referendum, you know, that situation may get worse rather than better. Your views would be terribly important to us and to the whole country on this whole issue. Could you elaborate on any views you may have basically on this issue as to, you know, how should we change the law or should we change the law so that consultants can take out basically what your guideline there is, your ethical committee guideline, when '*a child in utero suffer or lose its life as a side-effect of standard medical treatment … then this is not unethical*'? I think everybody would agree with that. That's the problem.

Professor Bury: Well, I think it's not the place of the Medical Council to advise you on what legislation or other routes to follow in terms of resolving what we recognise to be a difficult issue not just for the committee but obviously for the population. The Medical Council's role is a very specific one and that is to protect the public in terms of dealing with individual medical practitioners.

What our submission has tried to address is the fact that we have a complex set of mandates imposed on us by the Medical Practitioners Act. That requires us to both offer professional standards to our colleagues and also to implement discipline or disciplinary functions within the profession. The ethical guidelines form the basis for the professional principles that we ask colleagues to abide by. As we have tried to stress, this is not a code book. This isn't a set of equations in which you look up the answer to your current problem and simply follow what the text says. These are core principles which we require doctors to implement carefully and conscientiously in the context of the clinical situation facing them and their patient.

At the end of the day, the very simple paragraph which this edition of the ethical guide contains in relation to termination of pregnancy is clearly stated and is the policy of council. I don't wish to seem to be evasive or to avoid your question but at the end of the day that paragraph, like all the other parts of the ethical guide, may at some stage form the basis for a disciplinary action within council. What we cannot be seen to do is prejudge the outcome of such an action by saying in this hypothetical situation

or in that speculative one the council would do X or would do Y. This is not to be evasive about this particular issue. It is a core response which the council has, a core attitude which the council has maintained in relation to all these ethical principles over the 20 years of its existence.

If a disciplinary function or problem comes along it would be decided under the rules, under the criminal rules, of evidence and proof on submission with legal representation. The fitness to practise committee are a team which hears that inquiry, will take all of that evidence into account and will decide in those circumstances whether serious professional misconduct has occurred.

At the end of the day, the council's responsibility is to give ethical guidance to members of the profession. It takes all points of view and all submissions that are offered to it into account when it publishes and revises its ethical guidelines every five years, as it has done to date.

We have indicated that this debate and the one that your committee is currently engaged on and the Green Paper are welcome. We will, like any debate which is going on on issues of relevance to professional standards, pay attention to that and we will listen carefully to the outcome of this debate and hopefully that debate will be a fruitful one from your point of view. But, at the end of the day, it is not the council's prerogative or purpose to offer you guidance about how that debate should be structured or, indeed, to even offer you an assurance about how we will respond to the outcome of this debate.

Senator O'Dowd: Could I just make one further point? I accept what you're saying but the difficulty is that there is a problem. There is a serious worry on a lot of people who are members of your association about the whole issue. We, as legislators, have to try and resolve that issue. And, to me, it would be clearly helpful if, looking again at what you call the side-effect of standard medical treatment, in other words, could there be a list of treatments, you know, which would be part of your ethical guidelines, ones that don't breach that? One of the issues that come up here is that there are rare and unusual complications and yet we haven't been able to get clarity on the totality, if that's possible, of that list or a method by which we could maybe even refer to people like yourselves about those issues.

Professor Bury: I suppose sadly this comes back to the core issue I've been putting to you. The code is not a prescriptive document. Whether in this area or in others where dilemmas in medical practice arise, it does not take a prescriptive view for good sound reasons. One, the scientific basis for medicine changes on a regular basis. We both add and delete to our core of acceptable practice. Secondly, we've emphasised the clinical independence of practitioners in this country. It's one of those aspects of medicine which has stood the country and the population very well over many years. We do not want to impinge and cannot be seen to impinge on that aspect of clinical independence. It is still the responsibility, and will remain the responsibility, of individual practitioners to take the core principles which are enunciated in these guidelines, in whichever current edition is in publication or in force, and to apply them to the clinical situation in which they find themselves.

Senator Dardis: Thank you, Chairman, and thank you for your attendance here this afternoon and for clarifying the situation. Could I ask you, you state in your submission that there are approximately 200 complaints each year and that's very small in relation to the number of practitioners. But in the recent past, have any of those complaints in any year related to section 26.5?

Professor Bury: I have to say to you, and again I don't wish to be evasive, but the subject of fitness to practise is one that we have not discussed in the public arena for very good sound reasons. It is not to be secretive or conceal the process but we are required by the courts to only publish or make known cases which have been approved by the High Court. Maybe I could ask the Chairman just in relation to the privilege that you mentioned at the start. I can certainly answer the question but it hasn't been the normal practice of council to do so or to give any information in relation to fitness to practise cases in the past.

Senator Dardis: We are not asking you to particularise a case; we are just asking you for a statement if any of the cases did relate to this particular section.

Professor Bury: What I can say to you is that any convictions under professional misconduct, which have been made by the council, are published in the public media. To date, none of those publications and none of the public notices which have been provided in relation to fitness to practise cases at any stage to my knowledge in the 22 years of the council's existence have dealt with section 26.5 or its equivalent in previous publications.

Chairman: It does point up here … what you are saying is that the High Court has not confirmed, it has not proceeded to that level in relation to this particular guideline.

Professor Bury: Again, I don't want to be evasive but I'm being very careful that we have a precedent in council of not disclosing or discussing the content of complaints at any stage until the courts have ruled on them. Now, I'm not being evasive on this issue but I do not want to prejudice our ability to use that principle as we have used it for more than 20 years in the past. We have not discussed the content of fitness to practise or disciplinary matters until they've been dealt with in the courts. What I'm saying at this stage is there is absolutely no public material in publication that the council has ever made available that deals with a case under this heading.

Senator Dardis: Well, I was not asking about the content. It is best to be fair, Chairman. I was asking a different question, but, however, we will ....

Chairman: You were asking a question about the complaints.

Senator Dardis: Were there any complaints?

Chairman: Were there any complaints.

Senator Dardis: Not the nature of the complaints.

Chairman: You are established under a statute. Is that correct?

Professor Bury: Yes.

Chairman: And in relation to complaints, what I think you are saying to the committee is that you attach great importance to the confidentiality of the complaint, which is a common feature of any prosecuting or enforcing body, and there is certainly no question of our trying to infringe on that. Do you publish statistics in relation to complaints?

Professor Bury: Our five yearly report details both the statistics in relation to all complaints that are dealt with and identifies yet again in the public arena all those doctors who have been found guilty of serious professional misconduct. Can I say to you that our statute, the Medical Practitioners Act, 1978, lays out specifically those very few instances where the council is empowered to make public the content of complaints or of inquiries, and those circumstances all relate to confirmation by the High Court of a preceding hearing. This is one of our difficulties in relation to a wide range of issues. It is not at all related to this specific one. Our dealings with the public obviously are intended to inform them of doctors who are inappropriately in practice or have been, but we are highly restricted in terms of what information we can make public and what we cannot.

Senator Dardis: Moving on from that, Chairman ....

Chairman: Do you want to move on from it?

Senator Dardis: Yes.

Chairman: I mean, I am prepared to reserve your rights and look into it but I am not anxious to simply have the matter put now if there are objections being made.

Professor Bury: And I'd be very happy to accept your guidance on that, Chairman.

Chairman: I am prepared to reserve the issue if you want to return to it. I think that is the best way to approach it.

Senator Dardis: Thank you, Chairman. Well, moving on from that ....

Chairman: Are you happy with that, Senator?

Senator Dardis: Yes. Has the council ever taken a view, as a council, as to whether or not legislation and/or the Constitution should be used to circumscribe what is in the medical ethics? In other words, your ethics would be subordinate to the law, obviously, or would they?

Professor Bury: Well, you've two questions. If I can answer the first, the council has never made a decision and, in fact, has never discussed the issue of legislative or constitutional change in relation to any issue of medical ethics or professional standards. Secondly, I think there is a well accepted and acknowledged difference between law and ethics. I think we are in the throes of a clear-cut distinction between the current law in this country and the current professional standards as they relate to termination of pregnancy. I think the council has made very clear that it reserves the right to distinguish between the two and to publish what it believes to be its own responsibilities in relation to the practice of medicine.

Deputy McGennis: One of the issues which we have had a lot of difficulty with, and I suppose it is highlighted by virtue of the fact that it is not defined even in the Green Paper, and that is, if you like, what constitutes an abortion. Many of the witnesses who have come before us are quite clear in their minds as to what they would believe constitutes an abortion, and then other witnesses who have followed on would have had diametrically opposed views on the issue.

In section 26.5, it states: 'The deliberate and intentional destruction of the unborn child is professional misconduct'. Could I ask you, is that just simply how you state it or is that how the general Medical Council would define abortion? Is this a definition of abortion or is this something else?

The other point, I suppose, may be based on the answer and it is that it was felt, certainly by some of the witnesses, I think particularly the masters of the three main maternity hospitals, that, in certain instances, this guideline, they felt or feared, might put them outside of the law … sorry, that the treatments which they were carrying on in their hospitals … that they felt that they may be working outside the law as it exists by virtue of this guideline. So, I suppose the first question is probably the more important one.

Professor Bury: Well, perhaps I can answer the second because it leads to the answer to the first. First of all, this is not the law.

Deputy McGennis: I am aware of that. That's not what I asked.

Professor Bury: Well, it is because you said that the masters feared they would put themselves outside the law.

Deputy McGennis: Sorry, there were two separate questions.

Professor Bury: I understand. This is not the law. Let me come back to the principles that underpin the ethical guidelines. This is advice from colleagues to colleagues. The final point of those underpinning principles is that these guidelines … breaches of these guidelines may constitute professional misconduct.

Now, my answer to your first question about the first line of our guideline here in 26.5 is that, essentially, whether this guideline has been breached is a matter for an inquiry to take evidence on and hear application on. Should such a case arise and when evidence is presented to that inquiry, as in any other alleged breach of a professional principle, if the evidence warrants a conclusion that that principle has been breached, the inquiry team must then ask itself if that breach constitutes serious professional misconduct. If all of those 'ifs' hold, there may be a finding of professional misconduct against that doctor, which, as we've outlined, must then go to the High Court for confirmation. The facts and the natural

justice of those proceedings will then be re-heard by the High Court at the discretion of the doctor. The doctor may choose to simply accept the finding of the council and not challenge its rulings. But, at the end of the day, the doctor has the option to bring all of that material for re-hearing to the High Court – a long-winded answer.

The first line of this phrase is not intended to be a definition of anything. It is intended to stand on its own rights as clear, unequivocal guidance to the profession. Whether or not a doctor's action constitutes a breach of that statement will only be established after a full inquiry is held with all of the protections and representations that are implicit in the law.

Deputy McGennis: Sorry, Chairman, then, just a brief follow-on question. The definition is an area we have huge problems with because doctors who presumably are guided by your guidelines and have some affiliation to your organisation have stated categorically on the record of the House that they believe that the deliberate and intentional destruction of the unborn child is professional misconduct and that, therefore, is what they would understand abortion to be. Now, you're saying that would be for somebody much further down the road to decide upon, and yet doctors who have given evidence have stated this is their definition, their understanding of what abortion is.

Professor Bury: Well, that's entirely the prerogative of those doctors. My point is that this is a clear statement. Abortion is not mentioned in this document. Abortion is a lay term. If it's going to be used technically, in my understanding as a general practitioner, it relates to any termination of pregnancy, for natural or other reasons, prior to about 14 weeks of the pregnancy. That's the only technical sense in which it's used. The broader use of abortion seems to be as a lay term meaning a whole host of different things to different people. Your comment I'd agree about. The definition, then, of that lay term is entirely equivocal and open to debate. We've tried to avoid adding to that equivocation by using terminology that's relatively clear-cut.

Deputy McGennis: Yes, and I think that's the huge problem we have had all along because, what's been defined as medical treatment by one doctor would on the next day be described by another doctor as an abortion. There is a total misunderstanding or non-understanding or a belief by people who have come here that something in one instance is a particular thing and, in another is not. Doctors would then cite the guidelines as their definition of what constitutes abortion. You are stating quite clearly that is not what this first line is intended to do.

Professor Bury: The first line speaks for itself, I think.

Deputy McGennis: Well then maybe you'd help me, because I'm trying to get a very simple handle on the first line of the definition and in your view it does not describe what constitutes abortion.

Professor Bury: I, I'm sorry, I'm not sure if I understand your question. I'm not sure if I can answer it ....

Deputy McGennis: Well then you can understand the difficulty we're having in understanding the answers, not just from you, but from others.

Professor Bury: I appreciate your difficulty, which I suspect is one of the reasons we've had both an extended public debate, a Green Paper, an all-party committee and an outcome yet to be decided and, in some ways perhaps, that's an appropriate issue for society to make a decision on rather than technicians in the very, most fundamental sense of the word. Doctors can offer expert advice, expert intervention, support to women with crisis pregnancies at all sorts of stages. At the end of the day I suspect that society, perhaps represented by its public representatives, has to take its own view on what all of this difficult evidence adds up to.

Deputy McGennis: Well, it's made all the more difficult if you can't get a straight answer.

Chairman: Senator O'Meara.

Senator O'Meara: Thank you Chairman and I thank you all for coming to speak to us today. You have said to us, Professor Bury, that there is the law and there are medical guidelines and you said they are purely guidelines … they are only guidelines there, the advice in general of, you know, one set of practitioners to other practitioners or to the wider professional body. Can I put it to you that they are a bit more than that from the point of view … certainly my impression is from all we have heard during our hearings is that Medical Council guidelines do provide a framework and a very important ethical framework within which medical practitioners in this country operate? So, from our point of view it is extremely important that we examine their application ....

Professor Bury: Yes.

Senator O'Meara: .... and particularly their application when we are drawing up a legislative framework which, as the Chairman has pointed out on more than one occasion, is what we are attempting to do, so we have to explore that.

In the first instance, would you agree that the Medical Council guidelines are more than just a set of guidelines, I mean, they are the ethical framework, and in that context, from the point of view of the day to day operation of medicine in this country, particularly in relation to reproductive medicine, they're extremely important?

Professor Bury: There is no question of it.

Senator O'Meara: Yes.

Professor Bury: That is their purpose.

Senator O'Meara: And they do more than guide. They do, in effect, dictate – perhaps there is somewhere in between guide and dictate – they do, in effect, dictate practice – decisions made in hospitals.

Professor Bury: They are intended for all doctors in all disciplines and they have that effect. I have no issue ....

Senator O'Meara: Yes.

Professor Bury: .... with that.

Senator O'Meara: Doctors use them to make decisions.

Professor Bury: Yes.

Senator O'Meara: Or when they are making decisions.

Professor Bury: Yes.

Senator O'Meara: To narrow that down a bit, in relation to decisions about the termination of pregnancy, and we explored this at great length last week and I am attempting to be as brief as possible, I want to make a distinction between the cases where there is either a medical emergency, a threat to the mother's life and a situation where there is no chance of the pregnancy being viable. I want to make a distinction between that, on the one hand, and situations where the mother's health may be at risk and where the foetus may be viable but there is a foetal abnormality which is not life-threatening, necessarily. We were told – and I want to be specific in relation to the issue of cystic fibrosis – that first of all, parents are already making decisions to travel to England to have a termination where an amniocentesis shows that cystic fibrosis is present and we were also given the opinion that the possibility of termination should be available here. What is your view of that in relation to the Medical Council guidelines?

Professor Bury: What is my opinion about cystic fibrosis?

Senator O'Meara: What is your opinion on the availability of termination here in the case of cystic fibrosis being identified in a pregnancy?

Professor Bury: Again .... I come back to your original point. These guidelines are more than that and they have weight – the weight of the profession and the weight of public submission and the weight of quite a lot of thinking and thought behind them before they're produced. They do reflect the thinking of the profession, the elected membership of the council and all that comes with that and they are revised carefully every year. They are intended to offer some structure or framework to day to day practice and, as you've said, that's an important function and by and large they fulfill that function.

Their second role is as a guide to what'll get you into trouble. Our response has always been that we will not speculate on the nature of what may constitute getting you into trouble or not. That is an issue for the clinical independence of the doctor involved to make a conscience-driven decision about, I suppose, in association or in collaboration with his or her patient. It would be quite inappropriate, given the history of the council, to offer you a hypothetical response to the situation or a response to the hypothetical situation you have offered me. It is, I think, not something the council has ever done in relation to any issue in the ethical guidelines and it is probably not being fair to the profession or the public to offer them potted wisdom about what this actually means. It is up to individual doctors to make that decision in the circumstances they find themselves.

Senator O'Meara: Well, I put it – thank you for that – I put it to the doctor who was expanding on this particular view last week that in actual fact the termination of a pregnancy of a foetus which had cystic fibrosis does constitute the deliberate and intentional destruction of the unborn child. There is no issue of the health of the mother and there is no issue of the non-viability of the foetus. In that context it is quite clear to me that to terminate in those circumstances is directly in line with what the Medical Council guidelines calls the deliberate and intentional destruction of the unborn and, therefore, is professional misconduct. The words are very clear.

Professor Bury: And then, in the circumstances you have outlined, the doctor involved must ask himself or herself whether that seems a reasonable interpretation. It is inappropriate to speculate because it would be then, with an allegation of such an action, it would be for an inquiry to hear evidence for and against that argument and to make its mind up based on all of the evidence and not simply guided by a single line in a text which was produced some years before, but obviously that has some weight.

Senator O'Meara: If we as legislators were to frame an Act of Parliament, an Act of this Oireachtas, to allow for that situation, in other words, the termination of pregnancy in the event of cystic fibrosis, it would be in direct conflict with these guidelines.

Professor Bury: Again, it would seem that that's the case if you were to legislate in that way, yes.

Senator O'Meara: Thank you, Chairman.

Chairman: It would also be in contravention of the Constitution so it would be an Act to amend the Constitution in the first instance.

Senator O'Meara: Obviously, yes. Thank you, Chairman.

Chairman: Just one or two questions might clear matters up a little bit. You have a legislative role through the operation of the ethics system. You are setting norms when you draw up the ethics. Is that a fair point?

Professor Bury: Yes. I'm not sure if that has the force of legislation. They constitute professional advice rather than law.

Chairman: You do not like giving advance rulings or answering hypothetical queries because it is the clinical judgment of the individual practitioner that matters and in any event, it is all subject to confirmation by the High Court.

Professor Bury: You put it very well.

Chairman: Right. That is that. Ethics is subordinate to law.

Professor Bury: I would not accept that. I think the council has felt that ethical issues … professional standards have their own merits and will, of course, be taken into account – the council will examine all the issues, whether

they be legal, whether they be contractual, whether they be personal in terms of drawing up these sorts of guidelines, but ultimately the council's responsibility is to publish what it sees as ethical standards for the profession and not simply to repeat law.

Chairman: Oh yes. I accept that. When I said ethics is subordinate to law perhaps I did not formulate the question well. What I meant was that your ethical standards have to reflect the legal provisions that obtain in the jurisdiction. You are a statutory body.

Professor Bury: Well, the same answer applies.

Chairman: But if there is a direct criminal prohibition on abortion, as there is in the State subject to certain exceptions which are unclear, that is a factor in relation to the formulation of your ethical standards.

Professor Bury: It's a factor, but what I'm not accepting is a simple statement that because the law says X, we will establish that as a principle of ethics. It doesn't necessarily follow.

Chairman: Yes, but if the law prohibits a particular procedure and you are a statutory body, you would have to, at least, provide for that much in the ethics, while of course ethics generally provides for a higher standard.

Professor Bury: I am not necessarily claiming a higher standard but if the law introduced euthanasia tomorrow, as in certain parts of Australia or other EU states, that would not necessarily make that an ethical procedure.

Chairman: Yes. You say someone else has to do it rather than the medical profession, essentially?

Professor Bury: Well, I am giving you a hypothetical situation now and I don't want to necessarily get drawn too far into it but ....

Deputy McGennis: Chairman, on a point of order, your question is where the law does not permit. The answer seems to be where the law permits we will not necessarily do that, so I think that is not the answer to your question, if I am understanding what you asked.

Chairman: Yes, that is true as well so ....

Deputy McGennis: Where the law prohibits, then surely you cannot ....

Chairman: You're taking just the case of a prohibition, where the law prohibits a particular procedure ....

Deputy McGennis: Yes, that is not provided for.

Chairman: .... it does not provide for it, as is the case with the great bulk of terminations in the jurisdiction.

Professor Bury: I think in general that is of course the case. I mean, we will respect the law. There is no question of simply ignoring or taking a cavalier attitude to it but I think in very general terms there may be occasions when a distinction may have to be drawn between the law and ethical principles of practice.

Chairman: I suppose, if I was more concrete, were the Oireachtas to pass a different Act from the Act proposed by Senator O'Meara or were the Oireachtas to categorise the real and substantial risks to the life of the mother in legislation, either in general or in specific terms, that I take it is an Act around which the Medical Council could draw up very clear guidelines?

Professor Bury: It is an Act that the council would very carefully explore and examine in terms of reviewing its guidelines, I can assure you of that.

Chairman: Yes.

Professor Bury: I cannot give you a commitment as to how the council will act at any stage in the future.

Chairman: Naturally, because these guidelines are drawn up after a process of consultation every five years.

Professor Bury: Yes.

Chairman: You're the facilitator of that consultation.

Professor Bury: Yes.

Chairman: Sorry for interrupting the line of questioning. Deputy Kirk was next. We have but seven minutes. You must be very brief in your questions.

Deputy Kirk: Yes, Chairman. Very briefly, abortion is freely available in the UK. Abortion is not available in Ireland. The Medical Council has ethical guidelines in Ireland. Different professional attitudes exist in the UK. What is the comparative ethical guidelines in Ireland *vis-à-vis* the UK? Are there different standards in different jurisdictions?

Professor Bury: Again, I can't quote you the General Medical Council's current guidelines. They come in several volumes and deal extensively with a range of reproductive issues but they clearly have a quite different set of standards which they believe apply to professionals working in the UK.

Deputy Kirk: Do you find any contradiction in that?

Professor Bury: Do I find a contradiction between that? Not necessarily. I mean, there are very many ways in which the health care system in the UK and Ireland differs, not just in terms of its legislative funding, structural or ultimate aims. You know, there are many differences and the principles of ethical conduct are drawn up in both legislations following a process of consultation, as we've outlined. The process of consultation here is informed by … I think the last time the Medical Council published its guidelines we placed three public notices over a period of a year appealing for submissions. We directed, I think, about 100 individual notices to organisations and individuals asking them for their views. We have a Medical Council which differs quite significantly in this country to

the GMC in that predominantly the make-up of our council is elected and professional. The GMC currently is lay and has a very significant number of appointed representatives. I'm not suggesting cause and effect; I'm simply describing a different process. The process here has produced the very clear guidance and stand on ethical principles which you have in front of you. I really can't speak for or defend the UK approach.

Deputy J. O'Keeffe: Professor, if a doctor prescribes the morning after pill, could that be unethical?

Professor Bury: If he prescribed it in circumstances where it was inappropriate or harmful to the woman who is receiving it, it's certainly a possibility.

Deputy J. O'Keeffe: But only in that situation?

Professor Bury: As opposed to?

Deputy J. O'Keeffe: The normal … I understand it is normal practice to have it prescribed.

Professor Bury: It currently is a part of normal practice that hasn't been challenged or in fact even addressed within the ethical guidelines. It's seen as normal practice.

Deputy J. O'Keeffe: Also, the question of the IUCD – don't ask me to describe the detail – I understand that's also normal medical practice?

Professor Bury: It's dealt with as normal practice.

Deputy J. O'Keeffe: And it would not then, in normal circumstances, be considered to be unethical?

Professor Bury: Again, the ethical guidelines don't in any way suggest that its use be subject to anything other than the normal provisions of care.

Deputy J. O'Keeffe: And yet many would claim that both are abortifacient. Does that factor have any … would that factor have been considered by the Medical Council?

Professor Bury: I think you can assume – not assume. I am sorry. That sounds very cheeky and I don't mean to say that but the ethical guidelines have been very carefully weighed and the content has been included on the basis of exclusion of a very large amount of material. I think the issues that we felt needed to be dealt with as principles of practice are dealt with. Neither the morning after pill … neither emergency contraception, which is probably a more appropriate term, nor the IUCD are referred to or dealt with other than as normal practice.

Deputy J. O'Keeffe: Could I explore the issue a little further? What is or what should be normal medical practice in relation to a doctor treating a girl who has been raped? Has that figured in your discussions and can you give any indication as to what the attitude of the Medical Council is to such a situation?

Professor Bury: Again, the issue is not addressed specifically other than in general guidance to doctors about the issues of dealing with victims of violence, with perpetrators of violence, in fact, with those who are underage, with those with special needs. That issue is dealt with as a part of normal practice. It does not refer to any special circumstances. We have some copies, by the way, of the ethical guidelines for you. You are welcome to read those or leaf through them at your own pace.

Deputy J. O'Keeffe: Do I take it then that the issue specifically of rape and indeed incest, there isn't a specific guideline ....

Professor Bury: There's no reference to either one.

Deputy J. O'Keeffe: .... or can you even give some assistance? Has there been complaints on that score coming before the council?

Professor Bury: Well, if I can take complaints or your mention of complaints as being has the absence of such a reference been drawn to our attention, no, it has not. All of the issues you've mentioned are not omissions from the current guidelines; they are simply dealt with as parts of normal practice.

Deputy J. O'Keeffe: If I might just touch on a couple of other issues that arise or have arisen in an earlier submission. The question of counselling to a pregnant mother who is talking about having an abortion … the question of having an infection screen … the question of post-abortion counselling. Has that issue been discussed by the Medical Council, or those issues? Have they come before your council and without specific guidelines? Have you any views to offer to us as to how you would view those areas and how they should be dealt with by your members?

Professor Bury: I think council deals with all of those as normal parts of practice?

Deputy J. O'Keeffe: They would be known?

Professor Bury: Absolutely.

Deputy J. O'Keeffe: Thank you.

Professor Bury: Can I just be clear about one point, and apologies for sounding like I'm correct if I'm not. Every doctor practising in this country is required to be a registered medical practitioner. It is not a matter of desire or wish to be affiliated with a certain branch or part of medicine. There is a simple requirement that doctors be registered. Representing yourself as a registered medical practitioner when you're not potentially is a criminal offence so in terms of membership of the council, can I put it to you that it actually is a requirement of practice, essentially, and it is not a matter of affiliation or otherwise that doctors are linked to the council.

Chairman: Yes. You're a statutory body set up to safeguard the public interest in relation to the practice of medicine.

Professor Bury: Precisely.

Chairman: And that, I presume, is why you're reluctant to express views on matters of, if you like, public contention because you're there, like the DPP in relation to the criminal law, in general terms to protect the public interest, not to actually say what the public interest is. Isn't that right?

Professor Bury: You've put it very well. Further, I don't wish in any sense to seem evasive but I will not prejudice a member of the public bringing a case to our door of a very serious problem with a doctor which we've messed up by debating, discussing or undermining at a prior occasion.

Chairman: I appreciate your reluctance to discuss hypothetical cases, and I raise as a matter of law in this respect, that if there was a complaint about a breach of the ethical guideline in relation to the deliberate and intentional destruction of an unborn child, and there was a case to answer and it went to the fitness to practice committee, the decision on the matter, if it involved a certain severe penalty or even a censure, I think in your submission, would have to be confirmed by the High Court.

Professor Bury: Correct, the fitness to practice committee sitting as an inquiry team actually has an independent life. Its finding is not subject to confirmation by The Medical Council. That finding simply stands. The council then hears the outcome of that inquiry and decides on penalty. The whole matter must then go to the High Court for implementation.

Chairman: I want to go straight to the High Court for a moment. Would the High Court have regard to general constitutional and statutory provisions as well as the ethical guidelines in arriving at a decision on whether to confirm?

Professor Bury: Always.

Chairman: So the High Court would have jurisdiction in this context to consider the constitutional framework, the legislative framework and your own guidelines?

Professor Bury: What may seem like an obscure reference at the bottom of page 2 and the top of page 3 is actually to that point. Unlike other jurisdictions, in this country the High Court or the courts are the ultimate arbiters of medical practice. In many other countries the courts confine themselves to deciding on the natural justice of proceedings. Here the facts of the case and all the issues and factors which you've outlined are taken into consideration by the courts.

Chairman: Of course, from a practical point of view, the facts of the case are on your mind because that is the system you are administering, but for the purposes of our inquiries here, it is the law that I want to focus on rather than the facts. I just want to be absolutely clear on this, that the High Court has full jurisdiction to apply the Constitution and the statute law as well as the ethical guidelines in its assessment of whether to uphold the complaint.

Professor Bury: That is my understanding.

Chairman: It is not just a limited statutory appeal to the High Court on The Medical Council's ethical guidelines?

Professor Bury: My understanding is that the High Court and, in some cases, the Supreme Court has been involved and have taken all of those issues and all of the law and all of the constitutional matters into account.

Chairman: Well, of course, the Supreme Court wouldn't have any jurisdiction here that is not of the High Court. Just taking the position of the High Court, therefore, in this context, were a case to proceed and the facts were established and since the facts are agreed they are not an issue, the High Court judge would then have to assess whether the doctor was in breach or whether the charge was substantiated in the context not alone of your ethical guideline but of the constitutional and statutory provisions?

Professor Bury: Yes.

Chairman: So I take it from all of that, that you would take it that a degree of legislative certainty – I am using the word 'legislative' to include constitutional and statutory – here is a desirable thing?

Professor Bury: At present, inasmuch as we have scoped that out, we might arrive at the situation you've outlined and find a clear conflict between our ethical guideline and either a constitutional or legislative provision, which the High Court has to take into account. Obviously, it would be more appropriate if both were in tune with each other or if there were not a clear contrast or conflict between the two. Inasmuch as from a lay perspective the council has considered the steps you have outlined, we have considered that we may end at some point where there is a clear conflict between our ethical guidelines and some legislative or case based precedent which we believe will have to be settled in the High Court or Supreme Court subsequently.

Chairman: That can happen in other contexts.

Professor Bury: In a range of issues, but I am not aware of any other direct area where the law, as it currently is stated, and the ethical guidelines appear to be at odds.

Chairman: Deputy McManus and then Deputy Enright.

Deputy McManus: Would you define 'unborn child'? Would you comment on the concern that has been expressed where in very rare circumstances the treatment is the deliberate destruction of the foetus and the concern that some masters have expressed. I am thinking of Dr Keane in particular. He felt unsupported by the medical guidelines in those circumstances. The last point is another issue that has been raised, concern about anencephaly where a woman is, in effect, not forced, but certainly the option is not given to her to do anything other than carry on to full term even though there is no chance of the foetus being viable at the birth. Is this not a matter of professional concern?

Professor Bury: You have a number of questions there.

Deputy McManus: Yes, three.

Professor Bury: The first one, a definition of unborn child – I think that is an issue of contention in itself. All I can say is the council will take submissions on such a definition, but I am not in a position to offer you one.

Deputy M. McGennis: We do not want you to add to our problems; we were hoping you would try to reduce them.

Professor Bury: I am sorry. That is unlikely. Your second point ....

Deputy McManus: The treatment is the destruction, is the termination of pregnancy.

Professor Bury: I think that the substance of that paragraph deals with assurances to the doctor involved that a woman must be offered and made available to her whatever treatments are appropriate. Again, this comes back to direct and indirect effects, such as the arguments being teased out. There is no doubt that the council wishes to see women not denied appropriate care. Again, I would have to say to you that I don't want to get into speculating over the extent to which a treatment may be defined as intended to treat the woman rather than to bring about another effect. The council will take a very careful view should such a case arise in listening to submissions about that. We recognise that certain types of treatment may bring about the death of the child. It depends on intent, it depends on purpose. Encephalitis is a very difficult situation. I think in some ways it comes back to your first question – is a dead foetus an unborn child. To be quite honest, I will come back to my first point, we will take submissions in those circumstances, but I am not in a position to offer you a list of cases, which we will deal with one way and a list of cases which we will deal with in some other.

Deputy Enright: I thank you for attending here. I will finish off on exactly the last point you made, that you will take submissions as to whether or not somebody was technically correct or not. Dr Keane on page 50 of the report on Wednesday, 3 May, said that technically any form of termination of pregnancy or abortion is against the law of this country. Further down along the line he said that despite the serious considerations that are given to these individual cases, in the technical termination of pregnancy that we occasionally and very rarely thankfully have to perform, we are technically on the wrong side of the law in doing so and we will feel exposed in that area. Dr Declan Keane is unhappy with the law. I gather Dr Peter McKenna again expressed reservations that he was technically on the wrong side of the law in what they were doing. Both of them were quite clear that their whole ethos was the preservation of the life of the woman and the unborn child. That was their ethos, they would look after both and try and make sure that both survive.

Basically, what I am asking is that rather than waiting for you having to take submissions, all I can say is that if I am a GP down the country or if I happen to be here in Dublin in a senior position in a hospital, you are the body that protects the interests of the public. Your own members, I am sure, might like some affirmative statements from you as to how they can ensure that what they are doing … that their professional work has the backing of the law of this country. I would like your views on that?

Professor Bury: I suppose I would repeat the same statement to you. We would like the guidance in law of what the legislators think about this issue. I repeat, the law is your business, not ours. Our business is to produce professional standards. The law does not, at the moment have clarity that I can simply disentangle, to be quite honest with you. I think when that clarity is there, it will be easier for us all to deal more effectively with the application of the law.

Deputy Enright: Very briefly, the bottom line is that we are not experts in this field.

Professor Bury: Nor are we.

Deputy Enright: We can go to the Department of Justice, Equality and Law Reform who will be able to give us good advice as well, and perhaps to the Department of Health and Children and so on, and get a lot of expert opinions. But in regard to matters of this nature, you are the people with the professional skills, dedication and work. You have given your lives to this profession. We need some guidance from you in instances of this nature. I am personally not competent to make decisions on the way the law might be able to work in co-operation with the medical profession.

Chairman: I think, Deputy, that the problem is that we have had assistance, very good assistance, from a number of medical practitioners but, in a sense, we are talking to a statutory body here rather than a medical practitioner. Therefore, the body doesn't wish to act *ultra vires* in expressing too many opinions. Is that fair?

Professor Bury: I think you should be here.

Deputy Enright: The thing is that they are the body who decides, after taking submissions, that perhaps somebody has acted unethically. They are the statutory body. One of the unpleasant parts of your job is that you have to take a colleague to court. It is not something you do with any pleasure. It is something you would be reluctant to do. But there is the problem; it is people in the field that I'm wondering about.

Professor Bury: The council, in effect, functions as a lay body and the council, at least in my role as president … one of my roles is to remind the council that we are here to represent the public. We include public membership, we come from a disparate group of disciplines and represent a diversity of opinions. That's a very healthy process. We are here, we are not appointed a council purely to bring ultimate technical expertise to its functioning.

If and when any allegation of professional misconduct is made against a doctor, the evidence that is brought to us is the technical evidence from those who are expert in the field. The council will deal with it under the rules of evidence as any other lay body will do. We may have some experience in the field but, in fact, that can sometimes be a hindrance rather than a help. Our business is not to bring our prejudices, our anecdotal views, our personal limited experience, it is to listen to the evidence

that's brought before us and make an objective decision on the basis of that material.

Senator O'Donovan: I am obliged to be brief because time is running out. Under the ethics committee or your guide to ethical conduct and behaviour, section 26.5, do I take it that due regard was had in this section to the existing constitutional provisions that prevailed? The reason I ask is that it is not too distant from the proposed amendment in 1992.

Professor Bury: All I can say is that there were 500 submissions eventually made to the council about the review of the ethical guideline. Many of them dealt with issues of reproductive medicine. Council members then brought their own views. A specific sub-group of the council met 18 times to look at the drafting of these guidelines. Every possible factor and every possible piece of evidence was brought to bear. As I said in answer to an earlier question, we had a tome three times larger that ultimately got whittled down to the slim volume you have with you now. Every factor was taken into account but I come back to a previous statement, we believe the ethical principles stand in their own right.

Senator O'Donovan: You say there that the ethics committee and medical council carefully considered both existing legal uncertainty and the real needs of women, etc. Can I take it from that – I am looking for guidance rather than being accusatorial – that at the time of compiling this review of the code of conduct in 1998 you were unhappy with the legal position appertaining to the constitutional provision or the law, that there's a lot of uncertainty and you or your council as it currently stands were unhappy with it?

Professor Bury: The council, I think, at the time was unhappy that there was a lack of clarity about the law. There seems to be some confusion, a lot of confusion, about exactly what the law currently is and how it should be interpreted. What we felt an obligation to do was to issue or offer as clear an ethical statement as possible, whatever the law said.

Senator O'Donovan: Having regard to the fact that the law or the constitutional provisions have not changed since 1998, that uncertainty still prevails.

Professor Bury: Yes, it does.

Chairman: I thank Professor Bury and the representatives of the Medical Council for their attendance and assistance.

SITTING SUSPENDED AT 1.15 PM AND RESUMED AT 2.30 PM.

Dr Alastair McFarlane

Chairman: We are now in public session. I welcome Dr Alistair McFarlane who is a consultant obstetrician gynaecologist to this meeting of the Joint Committee on the Constitution. You wrote to us on 23 February … in fact, you wrote to us on 25 November last and you also enclosed an earlier submission which you made to the interdepartmental committee.

Dr McFarlane: Yes, that's correct.

Chairman: We have received those submissions and circulated them to Members. They are at page 137 of the brief book.

The format of this meeting is that you make a brief opening statement elaborating on your submission, if you wish, and that will be followed by a question and answer session with Members. I have to draw your attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you. Perhaps you would like to speak to your submission, Dr McFarlane.

Dr McFarlane: I will make a brief point first. I am very glad to be able to come down, I only heard about this last Thursday evening and I only got the document yesterday at 3 pm. I have read it once on the bus coming down. Therefore, I've read through it but, obviously, have not had time to fully digest it or remember everything.

Chairman: Yes, we had problems contacting you. Were you away on holidays for a while?

Dr McFarlane: I was, for two weeks, unfortunately, yes. I'll need to refer to it now and again during the session for that reason.

Chairman: Are you a member of the institute?

Dr McFarlane: I am.

Chairman: And are you familiar with the letter which Professor Bonnar has written on behalf of the institute?

Dr McFarlane: I am.

Chairman: That's at page 127. Are you happy with that letter?

Dr McFarlane: Yes, he states that the Green Paper is comprehensive and adds that this document itself is comprehensive, putting all points of view forward one would imagine. It's not saying anywhere, of course, that everything stated in this document or the Green Paper is true or accurate. It simply states that it is comprehensive and objective.

Chairman: Well then, in the second paragraph he refers to these 'rare complications which arise where therapeutic

intervention is required at a stage in pregnancy when there will be little or no prospect for the survival of the baby due to extreme immaturity.' Do you accept that?

Dr McFarlane: Yes. This is true now, unfortunately. In the future, and maybe with super-incubators retaining fluid, we may be able to put the baby into that and keep it alive. That is really for the future. At present, no, they would not survive.

Chairman: 'In these exceptional situations failure to intervene may result in the death of both mother and baby. We consider that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example for social reasons, and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother.' So that is the crucial sentence of course.

Dr McFarlane: Yes, I don't, of course, like that use of the word 'abortion'. In my document I make it clear that I would not use 'abortion' in that manner. That word, therefore, is used in a way that I would not have used it.

Chairman: Well, in clinical practice .... We received a definition this morning – there was none in the Green Paper – but we did receive a definition which suggested that there was a difference between a spontaneous … that abortion was where pregnancy ends before viability. Would you accept that definition?

Dr McFarlane: I'm sorry, could you repeat that?

Chairman: An abortion arises where pregnancy ends before viability.

Dr McFarlane: Before viability?

Chairman: Yes.

Dr McFarlane: Well, I don't use the word that way and I believe it's essential not to use it just like that to cover all possibilities. For the purpose of the legislation, you'd have to restrict the use to the way we use it in ordinary speech about the matter.

Chairman: You mean there are two categories then, spontaneous and induced. You don't accept a spontaneous abortion, you wouldn't be comfortable with that?

Dr McFarlane: That is a miscarriage.

Chairman: That is a miscarriage.

Dr McFarlane: Yes.

Chairman: And an induced abortion is an abortion in the true sense in your vocabulary?

Dr McFarlane: No, I don't use the word abortion that way. Not in my vocabulary no.

Chairman: Well, how do you use the term or how would you use the term?

Dr McFarlane: I would use it as, I think, I give a sort of definition somewhere in my document. I am not saying it's perfect but it's the ....

Senator O'Meara: Page 138.

Chairman: 138.

Dr McFarlane: Which page is that?

Senator O'Meara: Page 138.

Chairman: Page 138. You say words are powerful.

Dr McFarlane: That is right, yes.

Chairman: I am sure that you already have noticed that the pro-life movement, anti-abortion uses different words from the pro-choice movement, pro-abortion.

Dr McFarlane: Yes. I've got in emphasised letters though that the deliberate ending of the life of a little human being by whatever means … the action having been taken before birth and where he or she could have survived with recognised ante natal care.

Chairman: That is your development of the word but in the classical medical textbooks, an abortion included a miscarriage, is that not correct?

Dr McFarlane: It's true but it's not helpful for the purposes of this committee meeting.

Chairman: That is why I say in veterinary practice, for example, this linguistic difficulty never arises, is that not right?

Dr McFarlane: I don't know, it is an interesting question, I must talk to a vet on that point.

Chairman: Well, people in the countryside in Ireland would commonly refer to beasts having abortions.

Dr McFarlane: But logically you could talk of miscarriages too. I do feel the word miscarriage should be restricted to something happening spontaneously and naturally. It is used by doctors now. If you look up a textbook they talk about a woman say … by mental distress following an abortion or after a miscarriage. They are using the word like that now in the textbooks that we are recommending they should use.

Chairman: Yes. Professor Prendiville, who was with us this morning, suggested there was some development in the use of language here all right. In relation to your submission, I do not know whether you read the transcript of the evidence we had from the masters of the three main maternity hospitals in Dublin?

Dr McFarlane: I would have read it, yes but I am not that familiar with it.

Chairman: You are not that familiar with it.

Dr McFarlane: I have read through it, yes.

Chairman: I think it is a fair summary of what they are saying, that they're more comfortable with the expression 'termination' in relation to the very rare cases where they say there is a serious risk to the life of the mother in the continuation of the pregnancy. They were more comfortable with that expression.

Dr McFarlane: The word 'termination', if you like, is the same as ending the pregnancy. The fact that termination is used in England is a euphemism for what I call abortion, so I prefer to avoid the word termination just for that reason only.

Chairman: I think in fairness to the masters, they were not using it as a euphemism for a generalised availability of abortion in any sense.

Dr McFarlane: Oh I know, but it is used that way and I think, therefore, it is a carryover to this country too, so just ending the pregnancy is, I think, very neutral compared to say, termination, which has these English overtones coming over. It literally means the same, of course, I accept that.

Chairman: Yes, summarising their evidence, they are suggesting that ending the pregnancy is necessary in certain cases such as the Eisenmenger and related heart conditions and also the liver condition. Have you any comment to make on that?

Dr McFarlane: I give a list of examples in fact where it was necessary to, in my opinion, look at my document. In fact in the document in 1998 I give a whole list of, on the second page, starting at the bottom ....

Chairman: You accept that in severe Eisenmenger's it may be necessary to end the pregnancy?

Dr McFarlane: It may be, yes.

Chairman: Yes.

Dr McFarlane: Because the baby is doomed, of course, the mother is also doomed in the severe cases … yes, where that is your judgment, yes.

Chairman: We have also heard evidence from the masters about foetal abnormality, where the foetus will die immediately after birth in the anencephaly example.

Dr McFarlane: Did I use the word 'immediately'? Anyway, within a reasonable time.

Chairman: Within a reasonable time.

Dr McFarlane: I don't think 'immediately' is relevant, a few days or hours or weeks can be probably all right by me.

Chairman: Have you any view on that? I think you expressed your view on that.

Dr McFarlane: It is dealt with in the Green Paper at that point. On page 119, it says it's not practical to have a category of 'incompatibility with life' with normal babies as they might survive hours or days or weeks or even months. Some of them can live longer than just a few hours, yes. I don't see that is a problem or why that was even said. Some die within the first few days or weeks. Is that different from dying straight away? Not really.

Chairman: Well, the masters felt that anencephaly was the one case if where they felt there should be a specific provision, giving them the option of ending the pregnancy.

Dr McFarlane: Well if the baby is so abnormal it cannot live, no problem there either. I don't think in fact it's illegal now, why provide for it? I am sure it's okay to do it now.

Deputy J. O'Keeffe: Could I just come in on that one, Dr McFarlane. I noticed that in your submission, not in your letter to us but in your submission to the working group in the Department of Health, that you referred to spina bifida and that you said it was routine practice.

Dr McFarlane: No, no, I referred to gross hydrocephaly, you know, with gallons of fluid in the baby's head with spina bifida. They often go together of course. Not if it had spina bifida alone, nor did I mean that.

Chairman: So it would be spina bifida with hydrocephaly?

Dr McFarlane: They usually go together, yes.

Chairman: In that instance you said it was routine practice to tap the presenting head in labour or the aftercoming head if a breach presents so that the vaginal delivery can occur and that you have often done this.

Dr McFarlane: It always has been done, that's the point I was trying to make, even people who say you have to have to allow for an abortion or don't do abortions. We've already been doing that for a whole generation, this has been normal practice.

Chairman: What you are talking about then is … obviously, it is a baby after the birth. Do you refer to the baby in the womb as an unborn baby or a foetus?

Dr McFarlane: I would always avoid the word foetus except among colleagues. In talking to the people such as yourself or family I would use the word baby and to the patients above all I would use the word baby.

Chairman: Well you say that in relation to this baby, which has, you would say, a lethal foetal deformity?

Dr McFarlane: This one is lethal, yes.

Chairman: And effectively you would, as you say yourself, tap the head of the baby?

Dr McFarlane: Yes. The problem is the mother will die unless you do that.

Chairman: Would you, rather than waiting for that to happen, would you perform an abortion or termination at an earlier stage?

Dr McFarlane: Not abortion, please.

Chairman: Would you end – I am careful with the words I am using, I am really not using the words to present any particular view, I am merely curious – would you take steps to end the pregnancy earlier rather than waiting to tap the head of the baby?

Dr McFarlane: If you could be sure you'd end up like that, which might be difficult then, yes, that might not be a problem, allowing for the fact of course, that what you have to say … to provisions there inducing labour that early, it might not just be dangerous to the mother, it could run into problems, it could be tricky. It is safer than it used to be. That is one point.

Secondly, the mother might well be distressed by that sort of approach and much prefer to keep the baby to the last minute and would be much happier delivering in the labour room like everybody else and hold the baby like everybody else. That might be much more beneficial emotionally. You can't ignore that sort of thing but if all that could be … if you allow for all that and if you don't include those two points, I would not object to … if you were sure you would end up in that situation, having seen the baby early on in the scan, you should end up like that and I would have no objection. Furthermore, I don't think it would be illegal either about the Constitution.

Deputy J. O'Keeffe: I am trying to explore this issue on the basis that you go through this procedure at first because doing something that to a layman, let's be frank, Dr McFarlane, sounds to me somewhat horrific but ....

Dr McFarlane: It is, I assure you, most unpleasant, a horrible thing to have to do. The gowns … they pour out into a bucket on the floor, head shrinks down. It is most unpleasant, yes.

Deputy J. O'Keeffe: But ....

Dr McFarlane: The alternative is to do a section, cut the head through the uterine wall, through a small incision and slew it out that way, but I don't think that's to me a rational thing to do.

Deputy J. O'Keeffe: But if you … could I bring you back a stage further then?

Dr McFarlane: Yes.

Deputy O'Keeffe: If, say, at three months ....

Dr McFarlane: Yes.

Deputy J. O'Keeffe: .... you had not just evidence but proof of a lethal foetal deformity – I presume modern medical science is such that long before birth it is now possible to know that – what would you do in that situation? Would you wait until the full nine months ....

Dr McFarlane: Again if you think that emotionally it would be harmful to the woman to do an ending of her pregnancy you would be wise to wait, wouldn't you? I would think it would be … reasonably difficult but if the baby cannot survive, we are not required to keep it alive if it cannot survive or if you try to keep it alive rather. We are not required to do the impossible, therefore, it could be done, certainly in theory.

Deputy J. O'Keeffe: So in certain circumstances you would terminate the pregnancy at that stage?

Dr McFarlane: I think I'd have to take into account the emotional effect on the woman of agreeing to that sort of procedure, whether it would be better for her to wait. I'd have to take that into account, but if I did take it into account I was sure it was still okay to go ahead, then I wouldn't regard anything wrong in it because you can't save the baby, so why try?

Deputy J. O'Keeffe: Could I just go over one other area with you, the question of a young girl being referred to you who has been raped? What would be your attitude in that situation?

Dr McFarlane: Raped, great sympathy. It's a horrible, unforgivable crime and we have to do our best to look after the girl through the pregnancy, but I also feel there's another much younger being in existence and I would not regard it as correct to go ahead and do an abortion. That would be an abortion, yes.

Deputy J. O'Keeffe: If it came to you at an early stage would you prescribe the morning after pill, which I understand has an efficacy ....

Dr McFarlane: Yes, I ....

Deputy J. O'Keeffe: .... over 72 hours?

Dr McFarlane: But to be consistent remember the morning after pill in fact is a contraceptive pill in a big dose and that pill works by preventing ovulation. So in a big dose to prevent ovulation that would be quite correct, depending on the day in the cycle where you feel she is. If you feel she is bang in the middle of the month where perhaps she is pregnant, that's a different matter. The same of course would apply to the use of the coil put in after the rape where you think she's pregnant.

Deputy J. O'Keeffe: And I understood from some evidence we had earlier that in a situation of rape it is fairly standard medical practice to prescribe the morning after pill ....

Dr McFarlane: I ....

Deputy J. O'Keeffe: .... and indeed in many other instances as well.

Dr McFarlane: I strongly suspect ....

Deputy J. O'Keeffe: Is that correct?

Dr McFarlane: Sorry, I strongly suspect that GPs are in fact giving the morning pill in those sort of situations as well of course as unplanned intercourse where she thinks she might be pregnant. They use it I think fairly liberally, I suspect.

Deputy J. O'Keeffe: But you wouldn't prescribe except you had investigated the state of ....

Dr McFarlane: No.

Deputy J. O'Keeffe: .... the menstrual cycle ....

Dr McFarlane: No, where I believe she hadn't got pregnant yet, conception has not occurred. Then obviously I would use it then ....

Deputy J. O'Keeffe: I see. There's another procedure known as the IUCD.

Dr McFarlane: Yes.

Deputy J. O'Keeffe: Would you avail of that procedure in such a situation?

Dr McFarlane: In a rape case?

Deputy J. O'Keeffe: Yes.

Dr McFarlane: No. If I thought she had conceived, no. If I thought she hadn't conceived then probably yes, because it would protect her against a further … if she has a lifestyle where rape is going to occur, I might fit it then, otherwise not, no. I don't … as I say I am more in favour of the coil for certain people in certain situations, certain women.

Deputy J. O'Keeffe: So for you the crucial issue is – I'm not really an expert on this – implantation? Is that the crucial issue?

Dr McFarlane: No, conception, conception.

Deputy J. O'Keeffe: And when do you regard conception as having taken place?

Dr McFarlane: When the nucleus of the spermatozoa fuses with the nucleus of the egg, usually in the fallopian tube. When they fuse, you then have a new individual, not just the sperm touching the cell or … of the cell when in fact they fuse in the centre of the cell.

Deputy J. O'Keeffe: And how long normally does that take after intercourse?

Dr McFarlane: Probably about an hour or two. I don't know.

Deputy J. O'Keeffe: I see.

Dr McFarlane: From actual contact to actual fusion.

Deputy J. O'Keeffe: Right.

Dr McFarlane: Good question.

Deputy J. O'Keeffe: Thank you.

Senator O'Donovan: Just briefly, you mentioned about the word 'abortion' being defined but could I put it to you as an experienced ....

Dr McFarlane: Could I just interrupt there? Do I say 'defined'? I thought I said 'used'.

Senator O'Donovan: You said, 'To conclude I urge that the word 'abortion' be defined …'

Dr McFarlane: I'm sorry, yes.

Senator O'Donovan: I'm interested in that point – I don't want to labour it. That's in the concluding remarks of your actually penultimate paragraph. Would that be more appropriate for somebody with your knowledge and experience and training or from the medical profession to provide us with an absolute unequivocal definition? The reason why I ask this is that from some of the witnesses we've heard here some people say it's technically abortion but we can't use that word. That word is taboo. But it was explained to us here today by one and maybe on another day by another witness that any termination of pregnancy, whether it's accidental as in a miscarriage or induced in a case where there is a serious risk to the health of the mother, whatever way you want to skin a cat, that is in fact abortion.

Dr McFarlane: That's the point I have been arguing against all the time. Words have uses, not meanings and a lot of people make use of the word … the ones that use the word that way, to put it bluntly, in a very broad sense are those who are in favour of abortion. Those who restrict it like myself are against abortion. It has to be in a very broad sense because obviously there can't be an outright ban, can there? That wouldn't be sensible.

Senator O'Donovan: Sorry could you ....

Dr McFarlane: There can't be an outright ban on abortion if you use the word 'abortion' in a very broad sense to include everything like ectopic pregnancy or whatever you like to put into a list. You can't have an outright ban then. In my sense I think you could.

Senator O'Donovan: But in your sense would you not follow up on this either by maybe a constitutional amendment or by legislative change? Would you not have to clearly categorise and specify those unusual areas? You mentioned a couple, including things like ectopic pregnancies and cancer of the cervix. Would it not be appropriate for your organisation to specify clearly the exceptions to the rule, so to speak, and bring more clarity to the ....

Dr McFarlane: I accept you're making a good point. Could the list ever be fully comprehensive? I feel if you give a list of typical examples as I've tried to do you can deduce from them the ones that you forgot to mention, that weren't mentioned. I think a list of examples, to keep this thing on the ground about real situations as you suggest, is necessary, yes. I'm not sure if the organisation

are willing to do that but as a counsellor I don't think I would be willing to do it.

Senator O'Donovan: The reason I want to tease this out a little bit more if we move on and you are aware of the X case and the C case and the implications thereafter. Is it not more likely that we would have a High Court or a Supreme Court ruling on the, I use the word again, 'definition' of abortion, because somewhere along the line either a husband or next of kin or a partner is going to say … well you described it as essential medical or clinical treatment. Somebody else will swear in the Supreme Court or High Court, 'This is, according to medical practice and medical laws, is in fact abortion'. In other words, I would like to avoid a continuity of Supreme Court decisions on constitutional issues if we could have more clarity on that issue.

Dr McFarlane: I agree with you. I'm sure the word was not … if it had been better defined … I think you were hoping we'd … this discussion would bring out the way the word should be used. I made my contribution with that in mind. I agree that if we wait for the courts to decide, it would not be a good thing at all.

Senator O'Donovan: I understand that your preferred option is – correct me if I'm wrong – an absolute constitutional prohibition on abortion.

Dr McFarlane: With it very carefully defined in the way I've done it. If the baby can go on living with normal sort of care, that's got to be attached to any definition of abortion. Most people didn't do that in the document, actually. You know what they meant, they never said that, so I agree with much of what they said, but I feel their definitions were not as they should've been.

Senator O'Donovan: And would you see a possibility in an option of either a constitutional change in this area or is there a possibility that we will need legislation as well? Have you a view on that? You referred to the people's choice and obviously you mean, I presume, another referendum.

Dr McFarlane: Like '83? The question there which we are discussing is should we have a list of choices in an abortion referendum, a referendum on the matter, not … and I wasn't too keen on that idea at all, although it'd probably cause the least controversy, to have a list of things people could vote for. I, myself, would favour a ban, as was the intention in 1983, but it must be carefully phrased what you mean by … how you use the word abortion. If you use it, I think, in the way which is apparent from my documents, I don't think it'd be a problem.

Senator O'Donovan: But is it not likely that that type of referendum would create more confusion, as happened, I think, in 1992, than it would solve?

Dr McFarlane: There would certainly be confusion. The pro-abortion crowd would try to create confusion and the pro-life crowd might try to simplify things a bit. There would be confusion, yes, but I hope that if the committee spells out what … how they want the word 'abortion' to be used, it should not be so difficult.

Senator O'Donovan: If I was a Supreme Court judge sitting on a decision on abortion … we've listened to nine or ten medical experts here and I have come to the conclusion that there are three different views. Those who say, 'Look, in certain instances, it's not abortion at all.'. Others are saying, 'Whatever road you go down, it's technically abortion. That's it.'. You can imagine the difficulty that I would foresee down the road in a challenge to that situation. Would you not agree that, whatever route we take, whatever route this committee or this Government might take, clarity, by way of either referendum or by way of legislation, is essential to ensure that there is no misinterpretation or lack of definition in the future?

Dr McFarlane: I agree, clarity is essential. If you read all the documents, as I did yesterday coming down on the bus, you could end up quite confused by all the different views put forward. Mine was intended to try to clarify things really.

Senator O'Donovan: I appreciate. Thank you.

Chairman: Are there any other questions? Just one point. Professor Bonnar made the point that, while different words might be used, there was no disagreement between the doctors on the consequences of their actions. In other words, they could agree what they were doing even if they could not agree in the descriptions of what they were doing.

Dr McFarlane: That's correct.

Chairman: You'd agree with that, I take it?

Dr McFarlane: I do, yes.

Chairman: Just as the argument has been, as we know, a very divisive argument in the United States and other jurisdictions, that division as to language enters the medical profession itself.

Dr McFarlane: Yes.

Chairman: Thank you very much for your assistance, Dr McFarlane.

Dr McFarlane: Would you like the good medical practice circular from the Royal College of Obstetricians about how to do abortions in England? It's only two columns. For your reference library.

Chairman: Yes, certainly. You can just leave it there and we'll take it in a moment. We thank you for writing to us and coming here to assist us today at such very short notice. We do appreciate your help in this matter.

SITTING SUSPENDED AT 3.05 PM AND RESUMED AT 3.15 PM

Dr John D. Sheehan

Chairman: We are now in public session. I would like to welcome Dr John D. Sheehan, who is a consultant in perinatal psychiatry at the Rotunda Hospital, to this meeting of the joint committee. Dr Sheehan, you wrote to us a letter – it's at page 159 of the committee's brief book – dated 25 January this year and you said:

> Dear Mr Lenihan,
> I am writing to you as a Consultant Psychiatrist, regarding the issue of abortion and risk of suicide. I am the Consultant Psychiatrist attached to the Rotunda Hospital, Dublin. I would like to make an oral submission if possible to the Joint Committee.

We received your letter. Your existence has been mentioned to us by at least one previous witness before us last week.

The procedure at this meeting is that you may make an opening statement outlining the matters about this issue which you wish to outline to us. That will be followed by a question and answer session with the members. I have to draw your attention to the fact that while members of this committee have absolute privilege this same privilege does not apply to you in your utterances. I invite Dr Sheehan to make a short statement, elaborating on your request to speak to us.

Dr John D. Sheehan: Thank you very much indeed. I'd like to thank the committee very much indeed, too, for the opportunity of speaking here today. As you outlined in the introduction ....

Chairman: Perhaps you would state your qualifications ....

Dr Sheehan: Right.

Chairman: .... before your enter into the substance of the matter.

Dr Sheehan: I am a consultant psychiatrist in the Rotunda Hospital and in the Mater Hospital. I qualified in 1980 with my basic medical degree. I did a membership at the Royal College of Physicians following that, and also a membership of the Royal College of Psychiatry, so I have got dual qualifications in terms of being a physician and a psychiatrist. I also have a master's in psychoanalytical psychotherapy which was a two-year master's course in St Vincent's Hospital, Elm Park, associated with UCD. My interest in perinatal issues is that there are very few psychiatrists working specifically in the area of perinatal psychiatry which, in a sense, would be psychiatry in relation to motherhood and mothers and babies. I have a particular interest in that. I have also ongoing research in the area. I have published a little bit as well on suicide with Dr Dermot Walsh who, as everyone knows, is the inspector of mental hospitals. I have an interest in suicide and a specific interest in perinatal psychiatry. That is my background. I qualified in 1980 and I have been a consultant in Ireland for the last five years. Previously I was a consultant at Guy's Hospital in London. That is my background.

My reason for writing to the committee is that I felt I could contribute some information regarding the area of suicide and pregnancy and suicide in the postnatal period, particularly in view of the Supreme Court decision in relation to the X case. Essentially there are several things I wanted to try and look at with the committee. The first was the concept of risk and risk assessment. As you all know, the Supreme Court decided, essentially, that if there was a real and substantial risk that the mother might commit suicide, then the termination of pregnancy should be permissible.

I'd like to briefly look at the concept of risk and risk assessment and then I'd like to look at the actual data in relation to suicide in pregnancy and suicide in the postnatal period. If you'd like me to proceed at this stage I can talk a little bit about ....

Chairman: Yes, just one point arising from what you have said so far. Very few psychiatrists practise in this area. Do you mean internationally or specifically here in Ireland?

Dr Sheehan: Well, in Ireland in terms of people with specific attachments to maternity hospitals there is myself and Dr Anthony McCarthy attached to Holles Street, I am attached to the Rotunda, Dr Siobhán Barry would be attached to the Coombe. I think we are the only three consultants with specific sessions, in other words with specific sessions committed to perinatal psychiatry. I have four sessions which is almost half a job. Dr McCarthy would have five sessions which, again, is approximately half a job and Dr Barry has again roughly the same number of sessions. It is the area where we have special interests and links with the maternity hospitals. There are several other psychiatrists around the country who would do some work in perinatal psychiatry but the level of involvement would obviously be much less.

Chairman: This would be in provincial locations.

Dr Sheehan Yes.

Chairman: You want to elaborate then on the subject itself.

Dr Sheehan: In terms of the Supreme Court judgment, again the basis of the judgment was that essentially the Supreme Court decided that 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. The risk 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. That is what the actual Supreme Court was talking about. The concept then of a real and substantial risk … if we focus on risk, in psychiatry and in psychology risk assessment – first of all it has to be said it is notoriously difficult.

The late Dr Michael Kelleher who was involved in Irish suicide research and who wrote extensively about suicide published an editorial in *The Irish Journal of Psychological Medicine* in 1994. In this he actually addresses this specific question about risk assessment. The study he quotes was a study by an American author called Pokorny who looked at 4,800 patients and followed them up over four to six years. This was in a veterans administration centre in the US. His conclusion was that Pokorny, using the best available prediction techniques, could only predict suicide correctly in 2.8% of cases. When he turned it around and said, in other words, out of 100 people that you predict will commit suicide, using the best predictive methods, you are going to be wrong 97 times out of a 100. That gives an indication of how bad we are at assessing risk. Again, that sort of figure is very much generally accepted. It's not quoting one study that's biased in a certain way. Risk assessment is notoriously difficult and Pokorny's efforts would be very typical. So to actually determine risk is a real problem.

So, if determining risk is such a problem, I felt the other way of looking at the concept of a real and substantial risk was to ask the actual basic question, which is how many women who are pregnant commit suicide? Forget about trying to predict and trying to look at probabilities, but if you actually say how many women who are pregnant commit suicide, there are several interesting studies on this. In the UK, the report on confidential inquiries into maternal deaths in the United Kingdom – the latest one is the 1994 to 1996 publication – looking at that three year period, 1994 to 1996, in the UK, with a population of roughly 60 million people, the estimated number of pregnancies among that group was three million in the actual three years. The total number of deaths due to suicide in women who were pregnant in the three year period was five. So the actual number of women who commit suicide who are pregnant is extremely small. Most authors will describe the risk and describe suicide in pregnancy as a rare event. So this, of course, raises questions about the Supreme Court decision which stated that there was a probability that the woman, that the mother would commit suicide.

To move on from the confidential inquiry, if you look at the nine months following delivery of a baby, the suicide rate – again, we are dealing with very small numbers and that's problematic, of course – but the suicide rate is four times greater in the nine months following the pregnancy than during the pregnancy. So a woman is more likely to end her life by suicide following delivery. In essence, what I have said so far is that suicide in pregnancy is obviously rare. The actual authors of the confidential inquiry quoted Louis Appleby, who is a professor of psychiatry in Manchester.

Appleby has a very widely quoted paper on suicide rates in pregnancy and after delivery. The statement that's attributed to Appleby is that, in a sense, pregnancy is a protective factor against suicide. So if you look at Appleby's work, and Appleby looked at the period 1973 to 1984 – he looked at an 11 year period – and his work was published in the *British Medical Journal* in 1991. Appleby found that, in fact, the suicide rate in pregnancy was one twentieth of what one would expect among matched non-pregnant population. The suicide rate in pregnancy was only one twentieth of what one would have expected. Also, following up on that, when he looked at the suicide rate in women who delivered a baby, he found that the suicide rate was only one sixth of what one would expect compared to the population average for women of the same age, but a non-pregnant population.

The slight hitch in that was that the actual rate for teenagers was again much lower – it was one third of what one would expect. Clearly, it wasn't as low as the one sixth rate which occurred in the overall number of women. So Appleby's work showed that pregnancy essentially is protective against suicide and also what he described as motherhood again is protective. To quote him exactly from the study, he said 'Motherhood seems to protect against suicide'. So that's the work of Appleby in an English context relating to suicide.

The other paper that is widely quoted is a Finnish study, again published in the *British Medical Journal*, published in 1996. The Finnish study was a very interesting study because it looked at essentially the Finnish national register. Appleby again had looked at the British or the English national register but this was the Finnish national register. The aim of the study was to look at suicide rates in pregnancy and afterwards. In the Finnish study – again, with the Finnish population – again the rate of suicide in pregnancy was much reduced. The rate – in fact, there was approximately – I haven't the figure just in front of me – but following delivery, they found too that, similar to Appleby's work, again the rate of suicide was only half that of what the general suicide rate was. Again, they had the same finding with teenage mothers because the teenage mothers had again after delivery an increased rate, but less than the overall rate.

Also, in terms of the Finnish study, the interesting finding they had was that they actually looked at suicide rates in three different groups. They looked at the general population rate and compared that with women who delivered babies, women who miscarried and women who had terminations. The interesting finding there was that after miscarriage or termination, the suicide rate was actually increased relative to the general rate and again relative to the rate after delivery.

What has to be said in all of these findings is that you're dealing with terribly small numbers. So although I could project overheads for graphs and things – they look very impressive – the other side of the coin is that the numbers are terribly small so it's not that you're looking at very large numbers. You're comparing very small numbers and, therefore, looking specifically at statistical associations, you have to be very careful about that side of it. So that's really a summary of the areas I'd like to go over. Maybe I could stop there for questions.

Chairman: There are one or two short questions I have to put first. You're not discussing the condition of pregnancy of itself as a contributory factor to suicide. You're generalising from statistics about the incidence of suicide among pregnant women. Isn't that correct?

Dr Sheehan: That's right. I don't think it would be possible to look specifically at a single factor because suicide is a very complex issue. Essentially, suicide, the factors involved in suicide, are what we call multifactorial. So it's not a single factor that relates to suicide, it's a combination of, in a sense, multiple factors, including, for example, the presence of psychiatric illness, so the presence of depression or a psychosis or perhaps alcohol problems coupled with the absence, for example, of social supports. It's related to socio-economic class. It's related to marital status. There are multiple factors involved.

Chairman: General outlook and prospects in life of the subject I assume is very important.

Dr Sheehan: That would be part of it, but it's an interaction of many different factors. That's the point. It's not like simply a cause and effect, it's a multifactorial complex issue.

Chairman: Yes, but the assumed connection in the controversial court decision you referred to was the connection between a risk of suicide and the fact of a rape or a violation of sexual integrity. Now, can you help us on that subject?

Dr Sheehan: Again, I think nearly every psychiatrist would give you the same answer, which is every case is dealt with on its individual merits. Therefore, you are into – I obviously don't know the details of these cases in a sense, so one would only speculate. Therefore, I think what one has to do is actually look at the facts which are how many actual deaths are there? That's, I think, the only real way you can do it because when you start talking about probabilities, as I said at the very outset, the best predictors are going to be wrong 97 times out of 100. That, of course, is a hopeless situation. On the other hand, if you look at the actual number of deaths, then you will get an idea of the numbers. The number of deaths, as you can see, are extremely small. So when you go back to the probability of a person who is, for example, raped or is a victim of incest, again to actually say what is the probability or likelihood of that person committing suicide I think you have to go back then to say how many women commit suicide. That gives you a much better idea than trying to use formulae and different ways of saying this is likely or not likely because that is only slightly better than guesswork. That's the reality.

Chairman: In the case of a medical condition, such as Eisenmenger's syndrome, the doctors have been able to – this condition is very rare but predictive figures have been given to us by the doctors who treat this condition. Are you saying to me it's impossible to even construct that type of investigative apparatus in the case of the suicide threat?

Dr Sheehan: Absolutely. If you take Eisenmenger's, it's a pathological condition that's describable. The abnormalities in the heart are well recognised and described. If you look at suicide – suicide, you know, is not a mental illness. Suicide refers to a behaviour. People commit suicide, for example, who accidentally take too many tablets. People commit suicide because they are psychotically ill and they've delusions that they're the Devil incarnate. In other words, suicide is not a diagnosis. Eisenmenger's is a medical condition, it's a diagnosis, and therefore you can talk about, you know, frequency of occurrence, prognosis, etc. But suicide is simply a behaviour which covers a multitude of different problems and different psychiatric disorders.

Chairman: So, I take it from that then that clinical psychiatry has no acceptable procedure. There's no procedure in the literature which would establish or demonstrate the risk of suicide in the case of a pregnant woman.

Dr Sheehan: No. There is no test or in a sense there is no fail safe way of saying the person will or will not commit suicide. It actually doesn't exist. What one usually does is that if you take a person who presents, whether pregnant or not pregnant, if we just take the concept of how does the doctor manage someone who's suicidal, the usual way is clearly you have to assess that person very carefully and you have to assess the multitude of factors that can be involved in suicide. Then if a person has what we call suicidal intent which often – in other words, they may have a plan made, they may have stored tablets, they may have arranged times that they'll actually commit suicide – well the usual intervention at that point then would be mobilising supports for the person, perhaps admission to hospital, involving the family, if the person has had a major depression you treat the depression, if a person is drinking excessively you'd obviously help them to stop drinking excessively. In other words, the interventions are directed at helping and supporting the individual and treating whatever condition is there.

The other point that has to be made is that, you see, it's actually quite extraordinary but if you look at the general population, and there are several studies that have done this, and if you look at the concept of thoughts of suicide and how frequently they occur in the general population, Eugene Paykez, who is a professor in Cambridge, did a study in the US several years ago but he found that, for example, 9% of the population had thoughts of suicide in a particular year. If you think of the actual suicide rate, the number of people who end their lives is nothing like 9% but, in other words, thoughts of suicide are not infrequent at all.

If I could even digress for a minute, when preparing for this I was watching Sky television the other evening and I noticed that the manager of Aston Villa, John Gregory, had just been given a new three year contract worth £1 million a year. He was asked in the interview what did he think of this and he said, 'Well, I know one thing, if we're relegated I'll commit suicide'. So, you see, the context I want to put this in is that many people will say things like this and this is entirely different to someone who says, you know, for example, 'I am going to end my life, I am going to do it this way, I've stored up the tablets.' So you see the difference between what we talk about ideation or ideas and, for example, plans or intent.

Also, then, if you look at the aspect of many people saying, 'I wish I were dead' – you know, they find something bad has happened and they say 'I wish I were dead'. Now they will never actually do anything about that but the thought, what we call a passive death wish, is

there. So I am just really trying to give a flavour of the complexity of what we're talking about and how prediction is so difficult and how to be certain is clearly, you know, impossible in terms of prediction.

Deputy McGennis: I lost the train of my question when I was listening to the follow-up answer there. Accepting the results of the research, and I do totally, and I think actually it has been reinforcing comments that have been made by the masters of the three hospitals that there is a protection there in pregnancy for expectant mothers, and you're drawing the distinction between Eisenmenger's, where it's a pathological condition and it's easy to say this is wrong so therefore X needs to be done. Can you explain to me then, am I right in thinking that it's either psychologists or psychiatrists regularly, you know, when a patient is referred to them, will draw up personality profiles? I think I have seen two at least where they would have indicated that this person would have suicidal tendencies or might be likely to commit suicide. I'm not sure exactly how it would have been identified in the paper.

The reverse side of the result of the research, those who actually do commit suicide, and again this is only anecdotal from my perspective, not obviously among the expectant mother population, but the other side of the population which seems to be very prominent, that is, young men. Any of the cases I would know of personally, either friends, relations or, indeed, in the political sphere, as far as I know are cases where nobody picked up on the fact that this young person was likely to commit suicide. So is it that the entire science is, you know, so unreliable and then it would seem to suggest that, as you're saying, there's a very much reduced risk of suicide among pregnant women, that you really can't be sure anyway?

Dr Sheehan: Absolutely. I mean at the moment we have in western Europe and the US an epidemic of suicide in young men. So, in fact, if we look at the men who are say roughly the same age as the women we're talking about here, in fact, the suicide rate in those men is seven times greater than the suicide rate in the women. Now in the women that we are talking about who are pregnant, their suicide rate is one twentieth of the women's rate which is one sixth of that of the men's rate. So suicide in young men is, as you know, an epidemic at the moment and has equalled or nearly surpassed deaths compared to road traffic accidents.

But, going back maybe 20 years, there was a famous paper by Barraclough, which essentially said that the majority of people who committed suicide had contacted their doctor or a health care professional in the number of months before committing suicide. The recent research in young men shows that's no longer the case. So, in fact, at least 50% of those young men who commit suicide have no contact whatsoever with health services. So again, if you look at the concept of prediction, obviously we only start to try and predict in people we're seeing. Looking at the young men situation, when you're not even seeing maybe 50% of those, there isn't a scientific way of predicting who will or will not. I am sure everyone in the room here is familiar with stories, because it is such a problem, of people in local communities who say, 'That young fellow – bright, seems to be getting on fine, and his father came home and he was hung in the farm, in the shed' – unexplained and completely out of the blue. This is why I've tried to move it away from the concept of prediction because, Michael Kelleher's final paragraph, in summary he said that it indicates that medicine and psychology do not have the ability to predict suicide. That's Michael Kelleher, Lord have mercy on him, his conclusion from his editorial, and that's correct. To accurately predict suicide, we don't have that ability.

Deputy McGennis: Just a quick follow-up question, Chairman, if it's okay. I think when Dr Anthony Clare was with us and he was discussing that issue, he felt that the – I'm paraphrasing so it's not exactly his words – that the decision in the X case in relation to suicide may have been the wrong decision, that if the decision had been related to the offence, that is, the rape and the trauma which that caused to the young person, and if the decision to say that, yes, you know, abortion would be permissible in relation to the crime as distinct from the possibility of suicide, that it might have been a more appropriate judgment. How would you feel about that?

Dr Sheehan: Well, again, if you look at, in a sense, suicide post rape or abortion, it comes back to the ....

Deputy McGennis: Sorry, I'm not asking about the suicide element at all. I'm separating it as, I think, Dr Clare did. He felt that the judgment in the X case, in fact, did not reflect what had happened to the girl. What had happened to the girl was that she had been raped, sexually assaulted and had found herself pregnant as a result of that, and that the case, if you like, was being made on the basis that she might commit suicide, that if the judgment had been made on the basis of what she had suffered, if you like, that it might be more honest. I know your area of expertise is suicide but how would you feel about that as a ....

Chairman: Do you mind if I interrupt one second? I have the actual extract if you want me to read it out.

Deputy McGennis: Yes, please, Chairman.

Chairman: What Dr Clare said was:

> The reason the X case went the way it did was that that was the only way, it seemed to me, the compassion of the Supreme Court could be expressed was through this interpretation. I think the psychologist at the time was exposed to very understandable scientific criticism but we all knew what was going on. What was going on, I felt, was a compassionate response to an appalling situation and I felt the Irish people felt the same. It wasn't her suicidal statement, it was really the way she became pregnant.

That's really what Dr Clare said about that.

Deputy McGennis: Thank you, Chairman.

Chairman: I thought that might help you.

Dr Sheehan: What you're asking there, in a sense, is should abortion be allowed in case of rape. I think the answer to that is that, I mean, certainly there isn't any substantial research or literature which would indicate that that is the treatment or solution to rape.

Deputy McGennis: No, I'm only just asking for your own opinion.

Dr Sheehan: Well, in a sense, I would stick very firmly to, in a sense, the published literature because that would be my role, I think, here. The vast majority of people who I would see who've been raped or who've been victims of incest have not been pregnant, and I would see the actual major psychological consequences of that trauma. That can be a very long-lasting and profound effect. But in terms of determining from a literature point of view and a research point of view is there, in a sense, evidence to say that abortion or termination would be the correct thing to do in the case of rape. There isn't such literature there.

Deputy McGennis: I suppose I'm not really looking for what the textbooks might say. I'm really looking for your own view in relation to the matter where a woman who has suffered that, who feels that she wants a termination of pregnancy, that she wants to have an abortion, just what your own view would be, not that it would be the clinical or medical way of treating the condition, if you like, or the crime, but just, if that was her wish, if that was the way she felt she wanted to deal with it, what would your view be? Would you be supportive or would you feel that this is something that you wouldn't want to get involved in?

Dr Sheehan: I wouldn't influence a person one way or the other because I think that's an individual choice, but I think that, in terms of … One of the things that I see at work every week, for example, is I see many women who are pregnant, and they would be referred to me in the course of pregnancy because we screen everyone for past histories of depression, and a past history of depression is the major risk factor, for example, for post-natal depression. Many of the women I would see on a weekly basis will say the same thing to me, which is the pregnancy was unplanned, it was unwanted, they'd a lot of distress, usually for most of the first trimester, like the first 12 or 14 weeks, and now they're very happy to be pregnant.

Deputy McGennis: But there is a difference between an unplanned pregnancy, now, and a rape.

Dr Sheehan: What I'm saying is this … in other words that, if you look at, in a sense, psychological responses, you're not actually dealing with something that's cast in stone. You're dealing with something that's what we call 'dynamic', and it changes. Therefore, I think it's very, very difficult, you know, to make general statements, because essentially what it comes back to often is that a case has to be dealt with on its individual merits. For example, one thing that is clear is that most people will strongly advocate that, when people are extremely distressed, it's not the time to make very important decisions. So, that adds a further complication to the unfortunate circumstances of a person who is, say, pregnant after incest or pregnant after rape. It is very difficult to generalise.

Deputy McGennis: Dr Clare seemed to have a very clear view of what his response would be in that particular situation, but I think I'm not getting that sense from you.

Dr Sheehan: No, because I don't think it's a black and white issue and I don't think it's an easy issue. Again, I think the very fact that I would see so many women at work every week who have changed their views and have, in a sense, moved on … Again, if you look at the number of women, for example, I think the complexity of the answer I'm giving you is reflected, you know, in the Trinity study looking at the number of women who, having been a victim of a rape, for example, continued the pregnancy. I think almost half continued the pregnancy.

Deputy McGennis: I'm not suggesting that there would be compulsory abortion for anybody who's been raped. I'm saying, well, you know, if that half feel that they can proceed, and they have as you statistically have shown, and quite a number have kept their babies, some have given them up for adoption and that, that is not what I am talking about. What I am talking about is the individual case, if you like, the reality that was referred to in the X case. The reality was, you know, that this abortion was being permitted on the basis of the risk of suicide and maybe that was not why it was actually being permitted at all.

Dr Sheehan: I think the decision there, the basis for suicide, as I'm pointing out, is clearly flawed in the X case, that the probability was that this young mother would commit suicide. If you go back, though, to the Finnish paper I quoted earlier, again I think this is interesting because, although suicide is clearly rare in pregnant women and rare in the post-natal year, when you look at suicide in women who have had abortions, the suicide rate in women who have had abortions is six times higher than those who have actually delivered their babies. Again, that's not specifying rape or incest. It's a general figure. The actual morbidity and mortality with suicide is actually six times greater in the Finnish study. So, it does imply that the psychological consequences are actually much greater after termination.

That's borne out too when you look at the work done on women who have terminations because of, say, foetal abnormality. Again the psychological consequences in that group of women are far greater than those in a general sense. Linking to, for example, a baby that's a wanted baby, the mother has to grieve for losing the baby but also has to deal with her own action which is bringing the pregnancy to an end. The guilt often there is profound. So, I'm sorry I'm seeming sort of evasive, but I don't think it's as simple – unfortunately I think it's such a complex question that that's what I'm trying to capture in the answer.

Chairman: I think in fairness to Doctor Clare, his answer was in response to a question about possible legislative and constitutional approaches. I don't think he was giving a psychiatric opinion.

Deputy M. McGennis No. It was to do with the legal position, yes.

Chairman: The legal position. Senator O'Meara.

Senator O'Meara: Thank you chairman. Just picking up on the point you've just made, Dr Sheehan, and just to thank you for coming today. Clearly it is a very difficult

issue and one that is virtually impossible to construct a framework around, it would appear. We as legislators were looking for clarity, clear lines and a clear framework on it. I think it simply isn't possible to construct one. Because in effect, if you can't predict a situation, say, unlike a medical condition – Eisenberger's Syndrome or whatever, of the number of medical conditions that we've heard – if you can't actually predict with any degree of certainty, then the question arises: can you then legislate? But can I ask you in relation to the studies that you quoted, which were extremely – and you did it in a very clear fashion and I'd like to thank you for that – those studies would have been carried out, I take it, in countries where abortion was legally available?

Dr Sheehan: That's correct because the Appleby study is a UK study and the Finnish study is a national Finnish study.

Senator O'Meara: Would there be an issue there from the point of view that, given that abortion is legally available just say in the case of a severely traumatic pregnancy arising either from rape or incest, the fact that abortion is legally available in those countries would, in effect, by giving individuals in those circumstances a choice, would potentially deal with the problem or partially with the problem of the trauma ....

Dr Sheehan: You see, yes ....

Senator O'Meara: .... separate from the trauma of the rape or the incest?

Dr Sheehan: Again, logically that seems very reasonable, I think, and yet the trouble with the Finnish findings is that one would expect … if one regarded the opportunity for an abortion, legally available in Finland, one would then expect that women choosing that option would have less psychological distress and certainly would have a lower suicide rate, whereas the findings are quite the opposite, so it doesn't tie in. To understand it … again this is purely an opinion because the data isn't there … one has to look at, in a sense, the women who become pregnant with an unwanted pregnancy. One has to look at, for example, the fact that it's much more likely they'll be in relationships or won't be in relationships; they'll be in relationships that are abusive. In other words, there's a lot more difficulties and problems going on and I think one of the difficulties with looking at, in a sense, global suicide rates and figures is that you miss that complexity. So someone who is socially unsupported, maybe in a violent relationship, maybe has a drug problem, an alcohol problem – that doesn't come across in the statistics and they're all factors, of course, that are involved in suicide apart from pregnancy.

Senator O'Meara: And of course, I think, nor is the Constitution capable of dealing with those complexities either.

Dr Sheehan: The task you have is extremely difficult, there is no doubt. If one looks at the papers written, for example, on psychological effects post-termination, you can look at people saying well, things are better for a woman post-termination and you can find papers saying, well there are these terrible consequences as well. They're all there, you see, but to actually try to decipher them and understand them – it's very difficult.

Senator O'Meara: Thank you Dr Sheehan. Thank you chairman.

Chairman: Deputy O'Keeffe.

Deputy J. O'Keeffe: Dr Sheehan, I think it's fairly clear from your evidence that you don't really see the risk of self-destruction as being a real live risk in virtually all cases. It's not something that in your experience is a real risk, that one can factor in as far as the mother is concerned?

Dr Sheehan: That's right. To look at the quote I used from both the studies is that suicide in pregnancy is extremely rare and that's the factual situation.

Deputy J. O'Keeffe: That accords with the other evidence we had here, it's very much at one with Dr ....

Dr Sheehan: Absolutely.

Deputy J. O'Keeffe: We had in 1992, an amendment to the Constitution which essentially covered that point and which was rejected substantially by the people and that was it shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life as distinct from the health of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life, not being a risk of self-destruction.

Now that route was followed before and was rejected.

Dr Sheehan: Yes.

Deputy J. O'Keeffe: So, as you are aware we've been looking at the entire issue, and looking at the seven options in the Green Paper and very much taking on board your own evidence in relation to suicide. Can you assist us in any way by suggesting how in a constitutional or legislative framework we might progress this matter in any way? Have you any views you feel might be helpful from that point of view?

Dr Sheehan: Well again, I take on board what you are saying, that it is extremely complicated and difficult. What I think is reasonable is the guidelines of the Medical Council because although the Medical Council had great difficulty finding wording, but the guidelines written by the Medical Council which, I think, by and large, doctors are happy with – I'm not sure about the general population – I mean the concept of direct and indirect abortion and that – I think if the actual Medical Council guidelines, which are ....

Chairman: We have them.

Dr Sheehan: You have them.

Deputy J. O'Keeffe: We had them this morning.

Chairman: We've examined them throughout the hearings.

Dr Sheehan: In my view, it may be reasonable to legislate on those lines, but perhaps putting that – I'm not now an expert in law or whatever, or constitutional matters – but if that then was put to a referendum, so, in a sense, to legislate for, in a sense, what would be regarded at the moment as ethical medical practice, that might be a way forward, but I'm not an expert by any means in this area. I'd have to say that, but from a medical point of view, most doctors understand the guidelines and are happy with the guidelines. They seem to work very well.

Chairman: You don't have to apply them expressly in any event. I'm sorry, Deputy O'Keeffe, you have possession.

Deputy J. O'Keeffe: Well, on that issue, we discussed the relevant paragraph earlier today. Are you suggesting that paragraph be written into the Constitution?

Dr Sheehan: Maybe not in exactly the same words, but I think the concept that's there, in the sense of what is ethical practice, because – now again, this is going beyond my own area – but just following the proceedings here during last week, the masters of the three maternity hospitals in Dublin would have outlined what current clinical practice is, and I don't think anyone would for one second say that what happens in any of the three main maternity hospitals was unethical. The actual practices and workings are completely consistent with the guidelines of the Medical Council and if ....

Deputy J. O'Keeffe: Accepting that point, and they did make it quite clear that in the event of the life of the mother being at risk that in certain rare cases abortions were carried out, whether you call it an abortion or not – a termination was carried out ....

Dr Sheehan: You see, I think one of the difficulties that – my own understanding of it is that probably people are saying exactly the same thing but using different words.

Deputy J. O'Keeffe: Yes, that's one of the problems. One of the problems is the definition ....

Dr Sheehan: Absolutely.

Deputy O'Keeffe: .... but would you not also accept that the Medical Council reviews their guidelines every five years and they refer to standard medical treatment. Would you not agree that standard medical treatment itself evolves and changes, if not every year, probably each every five years and is always changing and evolving?

Dr Sheehan: I think that's correct and yet the purpose of the Medical Council is to ensure – one of its functions is to ensure ethical behaviour and ethical practice. That is the safeguard there.

Deputy J. O'Keeffe: Would you not see the difficulty that, if we are going to put something into the Constitution, that you cannot review the Constitution every five years to … do you see the problem ....

Dr Sheehan: I do.

Deputy J. O'Keeffe: .... about the need for certainty in the Constitution?

Dr Sheehan: Absolutely, and it's .... You know, it's ....

Deputy J. O'Keeffe: Would you agree with those who say that because of the difficulties about definition and because of current medical practice, in fact that there would be considerable danger in putting an absolute blanket prohibition on abortion in the Constitution?

Dr Sheehan: Again it depends on the interpretation ....

Deputy J. O'Keeffe: Well, on termination.

Dr Sheehan: .... of the word because in essence any doctor will say here .... For example, the case that was talked about last week with severe high blood pressure, pre-eclampsia, that a woman will be induced and if the little baby does not survive, that's not the purpose of the induction; it is to treat the woman's high blood pressure and to prevent the mother's death. So, it's trying to encapsulate that which is so difficult because I don't think ....

Deputy J. O'Keeffe: But an absolute ban or prohibition on abortion would of course cover that situation, would it not?

Dr Sheehan: Well, you see, it depends what you're calling abortion there. That's the difficulty because, you know, I think there are people who would argue that in a sense inducing a woman early, in other words, delivering the little … delivering the baby or delivering a foetus, some people would I think describe that as abortion whereas most people, you know, doctors would say well that's in a sense good medical practice.

Deputy J. O'Keeffe: Could it be both?

Dr Sheehan: Well, you see the action is the same. It just depends on the wording used but I don't think any doctor would argue about, you know, saving a life of a mother. If, unfortunately, a little baby doesn't survive as a consequence, that's seen as the consequence.

Deputy J. O'Keeffe: Would you accept in that situation, that whether one is looking at it as a doctor treating the mother or as legislators who are trying to advise on a legal and constitutional framework, it would be quite unacceptable to have an approach which would not protect the life of the mother?

Dr Sheehan: Yes, these are the dilemmas that are there, clearly, aren't they?

Deputy J. O'Keeffe: Well, is there not .... Where is the dilemma? Are we not all in the situation where one would have to ensure that the life of the mother was not at risk?

Dr Sheehan: Well again, I'm only quoting from what I read in the newspapers last week but I believe that the Master of Holles Street said that there was a question of getting lawyers into the bedside and finding out was there, you know, were they correct to proceed, etc. That's really what I mean by a dilemma. I think good medical practice is you go ahead and you treat. There's no question about that.

Deputy J. O'Keeffe: And you save the life of the mother if ....

Dr Sheehan: Yes, or if the mother has cancer you treat her for cancer ....

Deputy J. O'Keeffe: Yes.

Dr Sheehan: .... but, again, I have to prefix this by saying this is not my particular area of expertise.

Deputy J. O'Keeffe: Sure, but you will understand why we are trying to probe the issue to try and ....

Dr Sheehan: Yes, absolutely.

Chairman: Just to go back to the issue where you have put yourself .... Sorry, Deputy.

Deputy J. O'Keeffe: Go ahead.

Chairman: In the X case the Supreme Court, if we can leave aside the question of probability, which is really a procedural issue in a court relating to the nature of proof, but the question of the X case, the legal test laid down by the Supreme Court was a real and substantial risk to the life of the mother. It is not the legal test you are objecting to. It is the application of that test to the facts disclosed in the X case and, in particular, the threat of self-destruction. Is that a fair summary of your position?

Dr Sheehan: Sorry, if you say that again to me, please.

Chairman: In the X case the statement of law or principle of law established was that a real and substantial threat to the life of the mother was a ground for intervention ....

Dr Sheehan: Yes.

Chairman: .... call it abortion or whatever wording, but what you are disputing is that there was a real and substantial risk on the facts disclosed in the case, in other words, that the risk of self-destruction is not such a case. Is that what you are saying?

Dr Sheehan: If I follow what you're saying – again I don't know the details of the case, you know, specific details – but clearly there wasn't a real and substantial risk, you know, and there wasn't a probability that that 14 year old girl would have gone on to commit suicide, and that's borne out by both international figures and the Finnish study and the British study.

Chairman: The review group which preceded the Green Paper and this committee suggested that you could require written certification by appropriate medical specialists of real and substantial risk to the life of the mother. Now there is not much doubt that specialists such as the masters of the maternity hospitals could provide us with that kind of certification but I take it from what you are saying that psychiatrists would not be in a position to provide that kind of certification in relation to the specific ground of self-destruction disclosed in the X case?

Dr Sheehan: Absolutely. They would not be in that position, and going back even, as I said, to Pokorny's paper and quoting .... You know, you're going to be wrong 97 times out of 100. It's not in any way possible to predict accurately. That's the overall finding.

Chairman: Would you go so far as to say that no reputable psychiatrist could lend himself to such an operation, or herself?

Dr Sheehan: Yes. I think any psychiatrist who is experienced in the area and who knows the research would, you know, be wise to say 'I cannot predict this accurately'. Certainly, if you talk to anybody involved in Ireland or internationally who's involved in suicide research, they'll say exactly the same thing. So somebody who's up to date with the literature and knows the actual facts would be reluctant to actually give an opinion.

Deputy J. O'Keeffe: To tidy that up, while it is clear that you do not accept the risk of self-destruction as being a real and substantial risk to the life of the mother, you do accept that there can be other real and substantial risks to the life of the mother and, in that situation, do you accept that the medical practice is and, in fact, the constitutional and legal framework should provide for termination in such situations?

Dr Sheehan: Again, this is not my area of expertise because you're back into the area of what probably the masters of the different hospitals would have … you know, so it's just opinion I would be giving you. I can't give you any facts.

Deputy J. O'Keeffe: I would be interested in your opinion. You have studied the issue, obviously.

Dr Sheehan: Well, in a sense if you define abortion as the deliberate sort of termination of a pregnancy ....

Deputy J. O'Keeffe: Yes, in this instance there would be a deliberate termination of the pregnancy because of the real and substantial risk to the life of the mother.

Dr Sheehan: But if you go back before that and say .... If you look at the concept of abortion being the deliberate termination of the pregnancy but for no other apparent reason, in a sense, I'm not aware of any medical condition that a person would just, in a sense, terminate the pregnancy. I think there are clear medical conditions when one would intervene as part of a treatment of the mother. The part of the treatment may be bringing the pregnancy to an end.

Deputy J. O'Keeffe: Yes.

Dr Sheehan: So I think that, you know … I can't give you a case now. I've never seen one.

Deputy J. O'Keeffe: Well we have had evidence of such situations. You would have no problem with a termination in such a situation, would you?

Dr Sheehan: In a sense, you see, it's so crucial on the language you use because, in other words, if what you're describing is in accordance with the current Medical Council ethical guidelines, I've no problem with that.

Deputy J. O'Keeffe: Well, you will appreciate we cannot frame the Constitution in accordance with the Medical Council's ethical guidelines.

Dr Sheehan: Yes, but if what you're describing is in accordance with that, I've no difficulty with that. So, I'm not sure I can help you with the constitutional side.

Deputy Kirk: Thanks to Dr Sheehan for coming in. If I might ask him, a psychiatric assessment of a patient who had 'suicidal tendencies', the actual assessment, how dependent is it on what the patient will tell the psychiatrist with whom he is dealing about his emotional feelings or his state of mind, or is that combined with certain outward symptoms which somebody in your position would have developed over a period of years, that they would add up to suicidal tendencies?

Dr Sheehan: Yes, for example, in the Mater Hospital we'd see maybe 600 people a year who are suicidal in the accident and emergency department. It is an everyday occurrence. In a sense the assessment is, you assess what the person tells you. You also assess objectively what you see, what you hear and what you find in the person. You also obtain what we call a collateral history. If a family member has brought the person into hospital, you get a collateral history. Often you'd talk to the general practitioner, so you would ring the GP from casualty department and get the background information. An assessment is really in a sense composed of four different strands, but you are only partially relying on what the person tells you. You have to look for information elsewhere and that is where you get a lot of information.

In terms of assessment, the majority of people who threaten suicide have transient suicidal thoughts and, for example, 24 or 48 hours later when you talk to them, they will say they may have taken an overdose of tablets, but they will say to you 'That was a very stupid thing I did and I am very sorry I did it.' The majority of people who attempt suicide or threaten suicide are actually not mentally ill. The group that actually make very serious attempts at suicide – in other words, if you look at the other end of the spectrum – have what we call suicidal intent. At least 90% of those are actually mentally ill and they are usually suffering from quite severe depression. If you look at the tragedy say of a woman who commits suicide after having a baby, by and large you would expect that woman to have what we call a psychosis, which would be, her believing that she is an inherently bad or evil person and that perhaps her little baby is inherently bad and the only way to save herself and the baby from the world is to end their lives. So, you see how thinking is distorted and changed, but that's the exception. By and large when you look at the hundreds we see each year, it's people who have temporary suicidal thoughts, which in the space … it is often in relation to a sort of situational type crisis, which is very different 24 or 40 hours later. That is sort of spectrum that you are looking at.

Deputy Kirk: We often hear the phrase 'copycat suicides'. Is there such a thing as that?

Dr Sheehan: Absolutely. In fact, the Royal College of Psychiatrists, the Irish division of the royal college, just this year have published a booklet relating to the media and suicide and the media and psychiatry and looking at how careful one has to be in the reporting of suicide because again it is widely known that a widely publicised, maybe dramatic, suicide attempt can frequently lead to maybe two or three copycat attempts. In a sense, giving vulnerable individuals a picture of suicide, which is maybe glamorised, is exactly the wrong thing and can cause terrible problems.

Deputy Kirk: Are we saying that suicide could be triggered if a story is written up in a certain way in the media and a person who is vulnerable reads it?

Dr Sheehan: Yes. For example, copycat suicides have been seen after the deaths of prominent pop stars and that sort of thing, as with Michael Hutchence.

Chairman: There are no further questions. Dr Sheehan, I thank you for your assistance to us this afternoon. I very much appreciate the fact – we all do – that you took time to talk to us about this difficult area. I will suspend the sitting until 4.20 pm when we take Senator Henry.

SITTING SUSPENDED AT 4.15 PM UNTIL 4.20 PM

Senator Mary Henry

Chairman: I welcome Senator Mary Henry to this meeting of the Oireachtas Joint Committee on the Constitution. We received a submission from you, Senator, which appears on page 163 of the brief book. Have you received a copy of the brief book?

Senator Henry: Yes, I have, thank you.

Chairman: We circulated your presentation to the members. The format of this meeting is that you can elaborate on your statement if you wish and that will be followed by a question and answer session with the members. Do you wish to elaborate on your submission?

Senator Henry: Just a little, Chairman. First, I thank you

for having me here today. I was appointed to the Rotunda Hospital in the late 1960s as a consultant to look after women who had venous problems. The most important of these was the development of deep vein thrombosis from which a patient could get a pulmonary embolus. It was the highest cause of maternal mortality then – the death of the woman during pregnancy or shortly after delivery – and it still is the highest cause of maternal mortality in the United Kingdom.

At no time would an abortion be useful to solve these maternal mortalities. But when I was appointed, I realised very rapidly that a great number of our women who died were in a very poor situation to avoid that death because older women with very large families were those who died. In the early 1970s … in 1975, I reviewed the maternal mortality figures in Ireland and what I had suspected was indeed true.

We've been congratulating ourselves a lot on the very good medical care that women get in this country. But it's important to remember that only 30 years ago, about 30 women a year were dying in this country and that some of them had a very high risk of dying. Between 1966 and 1973, 210 women died and 23 of these women died from pulmonary emboli. At the same time, we were saying we were giving excellent medical care. I will just point out one year to you. In 1966, the women in this country who died from pulmonary emboli were as follows. There were six. One was 33, she had 11 children; one was 40 and had 12 children; one was 43 and had nine children; one was 42 and had 13 children; one was 31 and had eight children; one was 33 and had 12 children. In fact, those six women left 65 children behind them. That was in one year.

So I thought that despite our good medicine we had very serious problems which, in fact, meant that the whole of society had to become involved in medical care. This was, indeed, why I became involved in trying to support the availability of contraception in this country. The pill was available at the time. It was called a cycle regulator but this was quite useless for my patients because, of course, it was the high dose pill in those days and could have promoted deep vein thrombosis and pulmonary emboli in these people.

The reason I tell you this, is because while we are congratulating ourselves about the great medical care women have now in pregnancy and in the post-partum period, it is important to remember that the population in general, not to mind the legislators within Dáil and Seanad Éireann, have been extremely important in promoting the good care. It was put to some of the obstetricians earlier that perhaps the availability of abortion in England also contributes to that good care. I think maybe we'd have to accept that. There are four or five women every year who go to England and have abortions for medical reasons. I don't know what those reasons are but perhaps our figures wouldn't be quite so good if we had to care for those as well.

The only other thing I want to say before taking questions is that one thing concerns me. I didn't hear anyone who spoke this morning and certainly I wouldn't put this criticism to the three masters, but I got a sense from some of the obstetricians who spoke that their word would never be questioned, that if they made a decision, no one would ever question it. If they said something was not an abortion, no one – a nurse, some other person of the paramedical staff, anyone who was involved in the care of this woman – would say to them: 'hold on a moment, there's not going to be a baby at the end of this. You may not describe it as an abortion but to me it's an abortion'. I got no feeling that they ever thought anyone would object to what they were doing. I think now, and I think the masters recognise this, you wouldn't have that. I regret to say that the decisions people made in the past are being questioned far, far more and in a very critical manner in other areas of medicine at the moment and I don't see that it wouldn't happen in obstetrics as well.

Chairman: In relation to your own specialty, pulmonary embolisms, has that diminished with the years, that particular ....

Senator Henry: It has. I just hope that Micheál Martin does not find out the size of my clinics now. I know I am speaking to a discreet audience, so I am sure you won't tell him.

Chairman: Well, it's all being transcribed and recorded.

Senator Henry: Well, he's a very busy man at the moment and I'm sure he won't get time to read it. I had five patients yesterday morning in the Rotunda. Years ago I'd have 30 to 40. Now, I mean, they weren't all having a pulmonary embolism but these were the sort of high risk people I was having to look after. So, it's of that sort of magnitude.

Chairman: But, of course, that is not to suggest that there are not other new threats and new developments which pose a threat to the life of the mother.

Senator Henry: No, and I would like to bring this up because improvements in medicine – and medicine is changing all the time – have actually meant that we have to take a more dynamic view of this. We have to be very careful, as you know, discussing individual cases. The committee has talked mainly about Eisenmenger's syndrome, a very serious cardiac condition, but we are now getting young women who have had congenital heart defects corrected.

I think, if you saw in the papers, 70 children went to England last year for cardiac operations. Well, you may reckon half of them are girls. Those 35 children are going to be growing up and certainly some of them will want to have children. If they are operated on after two years of age we know that the possibility of pulmonary hypertension – this is high blood pressure in the lungs which is a serious problem – is already there, so we're going to have to look after those young women if they want to have children. We're having to do it already. Please God, all will go satisfactorily but I do think we have to recognise that there will be the occasional case where maybe, medically, we have to terminate the pregnancy. If there isn't a living child at the end of it, I think you would have to have some sort of exception that the fact that what you did was an abortion. There'll be other things too.

I wrote in my paper about cancer. Of course, breast cancer is one group and leukaemia is the other and maybe the lymphomas. Now the treatment for those years ago was really very limited. You performed surgery in the

case of breast cancer but there was very little adjunctive therapy to give the patient, but this, now, has improved greatly. We all see the demands for Taxol to be made available for all women if it's prescribed, even though very expensive.

Suppose this … some new treatment is found which has a devastating effect on the child. It's all very well to say that the Medical Council guidelines say you can go and given any treatment even if it does kill the child. But, suppose the woman knows that with each treatment the child is going to, let us say, die a little bit more. She may find it emotionally very difficult to go ahead and have this treatment even though it's a curative treatment – I'm looking to the future, I'm not thinking of what we're doing here and now.

Again with leukaemia, I read about acute leukaemia that there's now a 50% cure rate in adults. This really is quite incredible. Now, I have no idea how that treatment … that chemotherapy would be administered to the woman. Suppose she has to get it away .... I think you have to think of the situation where each day she knows the child will be getting worse and worse while she's getting better and better. Chronic myeloid leukaemia – again, good results being reported. The Medical Council guidelines say that, you know, women must be given the treatment that is best for them, but I do think we have to take into account that even though these cases will be maybe one every five years, one every three years – acute leukaemia is an uncommon condition but let's allow for one every three years – I think she has a right to be considered as a special case. We'll have to look forward, not just looking at what sort of chemotherapy is available now, what sort of radiotherapy is available now.

Deputy J. O'Keeffe: Senator Henry, it is refreshing to have somebody who is not just a medical expert but who is also a parliamentarian, and our first woman witness to give evidence. You are triply welcome.

Senator Henry: Thank you.

Deputy J. O'Keeffe: We've had a lot of debate and discussion on the issue of what is an abortion. I think you've looked at that issue yourself. You're fairly clear … quite clear in your own mind as to what is an abortion. Would you like to put on the record of how we should define the term in dealing with the issue before us?

Senator Henry: Well, I put down what's in most medical dictionaries 'the termination of a pregnancy before the child is viable' because if you do any of what are being described as these treatments, the one thing you do not have at the end of it is a live baby. So, I think describing something as 'a treatment' is very dangerous. Suppose someone starts doing some sort of treatment which, in fact, is going to cause an abortion. How are we going to challenge them if they say 'Well it's only a medical treatment'? Say, for example, someone starts doing foetal surgery in very severe cases of spina bifida and you'd see that they're having a 100% failure rate. Let us say that abortion for foetal abnormalities is not allowed but suppose that person says to you 'But I'm only doing a medical treatment'.

I think it is always dangerous to have euphemisms. Say what you mean – I think it's safer in something like this. We ran into this sort of trouble with the 1983 amendment that people said 'This could be interpreted any way', and, indeed, it eventually was. I do see that going with the word 'treatment' that you could end up with people saying 'But it's only a treatment'. You're into a whole new challenge again.

Chairman: I suppose in 1992 we attempted to provide a clarity of wording but it did not appeal ....

Senator Henry: That's right.

Chairman: .... to either side of the debate.

Senator Henry: That's right.

Deputy J. O'Keeffe: I think what is fairly clear from your submission, indeed from your evidence, is that taking that definition of abortion – the medically accepted, commonly agreed medical definition – that you would be greatly concerned at any proposal for a blanket prohibition on abortion, whether constitutionally or statutorily

Senator Henry: I would because I think it would be dangerous for the woman, I think it would be dangerous for the child, possibly, and I think it would be dangerous for the doctor. For the woman, you could have the doctor who proposes to do the medical treatment challenged quite easily and someone say to them 'But what you propose to do … we'll have no viable child at the end of this. That's an abortion.' For the child, as I said, with foetal abnormality, you know, you just want to be careful that you wouldn't run into some situation there where a person did what they described as a treatment, actually ended the life of that child. I would be very anxious about that. For the doctor as well, I think you really need to have a bit of clarity as to where you are because I do think doctors have to have cognisance of what other professionals may think, not to mind even the members of the general public who could make a challenge as well.

Deputy J. O'Keeffe: Talking about foetal abnormalities, would you give us the benefit of your views. There was a distinction last week between what was referred to as a 'lethal foetal abnormality' and I presume then the other is a non-lethal one. I also found myself somewhat horrified earlier today with evidence as to how a certain type of abnormality was dealt with in that regard. Could you give us your views as to how you feel, what is the practice and how you feel, either constitutionally or from the point of view of legislation, we should deal with that issue?

Senator Henry: It depends a lot on at what stage the abnormality is discovered. The most important lethal ones really are anencephaly, that's – you talked a lot about that – where the child has no top to its head ....

Deputy J. O'Keeffe: No brain.

Senator Henry: .... or its brain. No brain … well a rudimentary bit of a brain down at the end but, I mean, it is impossible for the child to live outside of the womb.

Another one is Potter's syndrome. This is where the child's organs don't develop – like the kidneys, the bladder and so forth. That's diagnosed quite early on, too, because the child has no fluid around it and then you see that there's no kidneys there, there's no bladder there. That child cannot live either. There are another few very rare ones like Edwards' and so forth.

Dr McFarlane talked about hydrocephaly and spina bifida. Now, I cannot speak about what is done in Letterkenny Hospital but I have not known the method of treatment that he proposed. Not that I am criticising, for if it is his method of treatment, I have not known it done in my time because normally you diagnose this much earlier now. Of course that child actually will be viable, perhaps only for a few days, a few weeks. I think he did recognise that in his statement, so one would not attempt a vaginal delivery, I don't think, there.

Deputy J. O'Keeffe: What would you do?

Senator Henry: You'd do a caesarean section.

Deputy J. O'Keeffe: A section?

Senator Henry: A section, yes. Of course this is not good for the mother because the risks to the mother are much greater after a caesarean section than if she has a vaginal delivery.

Deputy J. O'Keeffe: Would the option of termination arise?

Senator Henry: It would. Not in this country but at least 50% of women, I would say, who find they have this sort of abnormality do go to England. No one says to them, you should go to England and have a termination but, you know, when they look at it and they say gosh, will this child live? Well, it may live a few days at best, Dr McFarlane said, maybe even a few weeks. I would say 50% definitely go to England for termination. It is a rare condition fortunately and would be rarer still if we had folic acid in our bread. We have a genetic predisposition in this country towards neural tube defects. It used to be much worse. We used to have quite a lot more. Better nutrition and so forth has helped. There are about 70 cases of spina bifida a year and it is reckoned it could be halved if there was folic acid in the bread.

Deputy J. O'Keeffe: Do you distinguish between lethal and non-lethal?

Senator Henry: Yes.

Deputy J. O'Keeffe: And from the point of view of medical practice where there is a lethal deformity – termination in this country, is it normal practice?

Senator Henry: No, it doesn't occur. Some are induced early, after the child, if the child was going to live, would be viable, at about 26, 28, 30 weeks, something like that, which at least saves the woman the other ten weeks of pregnancy. But I really couldn't say to you there were abortions done when the child is not viable.

Chairman: Sorry, Deputy, I am interrupting but in those cases where the early delivery takes place, the non-viability is even more ....

Senator Henry: It is. It is but a child with anencephaly is not viable. I do not think anyone has suggested to you that the child is. It's not.

Chairman: When you speak then of early delivery, what is the distinction between an early delivery ....

Senator Henry: A vaginal delivery would be induced.

Chairman: Yes.

Senator Henry: You would give the woman prostaglandins or ergometrine or whatever, you'd induce the delivery early.

Deputy J. O'Keeffe: What is the distinction between what you referred to as an early delivery there and an abortion?

Senator Henry: Well, it would be after the stage at which the child if normal would be viable.

Deputy J. O'Keeffe: All right.

Senator Henry: It would be certainly after 26 weeks.

Chairman: But it is a notional viability.

Senator Henry: A notional viability.

Chairman: You are making a comparison there of course. There is no viable hope in such an instance and it is even less so because of an early delivery.

Senator Henry: Yes.

Deputy J. O'Keeffe: The other issue that we have discussed on and off over the last seven or eight days is the issue of rape and incest and the medical practice in that situation and indeed whether you have any views as to whether we should have a change in our laws to cover that. First of all, there is the question of the morning after pill, which I gather is a 72 hour after pill, which could be a more correct name. I gather from Dr McFarlane that he would have a reluctance in prescribing it more than one hour after intercourse. Am I right in thinking that in fact it is quite freely prescribed?

Senator Henry: It is very freely prescribed in this country.

Deputy J. O'Keeffe: It is virtually automatic for any rape or incest case?

Senator Henry: Indeed it is and it's used for more than rape too. I don't think a pregnancy has started until you can know a pregnancy has started. You really won't know a pregnancy has started until implantation has taken place because you really can't go searching around in the uterus for a fertilised egg that may not implant. I do think to say a woman is pregnant, you have to be able to diagnose that she is pregnant. You have to be able to get the start

of hormonal changes, something like that. I wouldn't have a problem about the morning after pill because it really makes the lining of the uterus unreceptive to the implantation of a fertilised egg. It might have been unreceptive anyway in the first place.

Deputy J. O'Keeffe: To get the timing right here – implantation – what is the normal time for it?

Senator Henry: It normally implants within about 72 hours. The fertilised egg burrows into the lining of the uterus and one wouldn't want to be putting an hour this way or that.

Deputy J. O'Keeffe: I know but that would be the point from which you would consider that conception had taken place.

Senator Henry: I would consider the pregnancy had begun. I think that is easier than saying conception because when you have the egg fertilised, well you have a fertilised egg but the pregnancy is what we are really talking about. You want to deal with the pregnancy.

Deputy J. O'Keeffe: And how early can doctors know whether the woman is pregnant or not?

Senator Henry: I read some very interesting work by Dr Prendiville and Dr Daly recently. What will become the placenta starts to produce hormones and as well as that, from the ovary there is an increase in progesterone to maintain the pregnancy and really quite early on, within days, you start getting changes. What was interesting about their work was that within about 10, 12 days, they were able to show that hormone levels weren't so good in pregnancies which were going to fail because about 20% of pregnancies end in a miscarriage, a spontaneous abortion. Things are changing all the time, as I said to you. You might be able to predict at one week after a missed period whether the pregnancy was going to be maintained or not. I mean this is all new.

Chairman: You're talking about the probabilities of a miscarriage here.

Senator Henry: You are but as well as that you'd know if it was going to go on as well. There was quite a dramatic difference in the levels. I can't give them to you now but they were very obvious.

Deputy J. O'Keeffe: Could I explore further then the situation in relation to a rape victim? You say that it would be common practice to prescribe them the morning after pill if the victim wanted it. Is there any common practice after the 72 hours in relation to a rape victim from the point of view of a D & C or anything of that kind as well?

Senator Henry: Not that I know of. Not that I am aware of. I'm sure I'd be aware of it if there was. I mean they would come back for a pregnancy test if they missed a period and then there would be private decisions made by them as to what they decided to do.

Deputy J. O'Keeffe: But there wouldn't be any intervention normally?

Senator Henry: No, there would not. No, I can honestly tell you there would not.

Deputy J. O'Keeffe: Do you have a view as to whether, from the point of view of the legislative framework, there should be some arrangement in place to allow for the wishes of the victim in rape cases?

Senator Henry: I don't want to sound heartless but there is a great deal of legislation in other jurisdictions and I do wish we didn't just look at the UK. I'm sure your committee hasn't just looked at the UK but it's been referred to all the time but we would have to accept that legislation for abortion, which has been based on rape, has sometimes not been – there hasn't been total truthfulness by those who were brought forward as cases. To be honest with you, I have so much concern about the life of the woman in medical situations that I don't know that the extension into that area of rape, tragic as it is, would be wise because I think what we are doing at the moment with all the cases of rape that we get is certainly doing the very best we can to lower the pregnancy rate. I didn't ask the sexual assault unit in the Rotunda what percentage of cases of rape have gone on to be pregnant. I know there have been some but I don't think it's many. I know many people would say it's very hypocritical of us just to use the situation in the UK as the solution to our problem, but when we have such a serious issue as the life of the mother I think I'll just have to leave it at that.

Deputy J. O'Keeffe: You're aware that Professor Anthony Clare did have a view that we should have some form ....

Senator Henry: Professor?

Deputy J. O'Keeffe: Anthony Clare.

Senator Henry: Yes, indeed, I am and I have the greatest respect for Professor Clare's opinions.

There is one disadvantage here. I don't have to deal with these people but Professor Clare may have to. I have the pleasure of being able to speak from a hands-off situation. Another thing I was slightly alarmed by too was that one obstetrician said – not one of the masters – that non-obstetricians who dealt with pregnant women didn't have quite the same feeling perhaps for the foetus as ....

Deputy McGennis: Was it Doctor Clinch?

Senator Henry: Dr Clinch said, 'These sort of things arise and the doctor is always trying to do his or her best for both people. That is the way medicine and obstetricians have always looked at it, not always non-obstetricians because they do not actually have to do some of the procedures they expect obstetricians/gynaecologists to do. I would see no difficulty whatsoever in being able to look after my patients meaning both lots properly.' I think all people who look after pregnant women, all doctors look after them properly. I think they're very cognisant of the fact that the child is there. I would not be treating the pregnant patients I have with deep vein thrombosis the

way I do treat them, which is far more complicated, having to give them injections of heparin to thin their blood rather than tablets of warfarin to thin their blood because I know the warfarin will affect that child – not in all cases, but in some cases. I really would not like the committee to think that those of us who are not obstetricians aren't really cognisant of our responsibility to the developing child. We're very cognisant of it and modify our treatment as we go along.

Deputy J. O'Keeffe: Thank you, Senator. You were very helpful.

Chairman: Thank you. That's actually clarified a lot for me. Thank you, that last few sentences. Senator O'Donovan.

Senator O'Donovan: I too would like to welcome my Senate colleague here to meet us and tender her views. I have read her paper. I'm quite interested, Senator Henry, in your views with regard to the definition of 'abortion'. If we go back historically and look at the 1861 Act, the unlawful procuring of a miscarriage, the words 'illegal' and 'unlawful' were paramount. I have understood from most of the professional medical witnesses that come here that for many years, even since the 1861 Act up through centuries – that is 120 years ago almost – it would have been seen as a sort of a lawful act where one has to save the life of the mother. One of the experts referred to the paramount importance of the mother's life, the sanctity of the mother, etc., obviously in situations where there was a major risk to both.

Could I ask you the question seeing as you are sort of a political as well as a medical expert? Have we improved on the situation since the 1861 Act? Have things changed a lot in reality on the face of it?

Senator Henry: I think it was most unfortunate that we had the 1983 amendment. I campaigned against it because I remember saying on television that mothers and babies were safe as we were. There were no challenges that I can ever remember to the medical treatment of the mother and at the same time with my hand on my heart I can tell you I never remember an abortion for socio-economic reasons being done, never. I think we were fine as we were, but there was apparently a feeling that it would be challenged here as in the Bourne case in England. Personally, I doubt it very much because you see quite a few countries where abortion is available on a really very widespread scale in one country and a country nearby can have pretty rigid abortions laws.

I know there's resentment in, let us say, the country to which people go. They say we're sending our social problems there, but this really is a sort of fact. I really wish we could get back to the 1980s, the pre-1983 situation but I don't think we can because we've had several constitutional referenda since then. I think it was probably improved by the ones in 1992. There was a bit more clarity brought in but I regret what happened in 1983 because I don't think it improved the situation. I think it made it much worse.

Senator O'Donovan: Just to follow on on that, I made a point of asking a number of questions that if we were to allow more liberal abortion here I gather that you see certain exceptions where you can use the word 'abortion' or termination of pregnancy in whichever way, that you would like to see that allowed but in very restricted circumstances.

Senator Henry: Actually I don't think that's what I'm saying. What I would like to see … I'm not looking for liberal … I'd like to see us clarify what is legal from the point of view of the life of the mother so that if a person who really feels they are terminating a pregnancy before the child is viable to save the mother's life, that there can be no question of a challenge, that this is lawful. The more I think about it that lethal congenital abnormalities – and they'll easily be defined – that we should look at that very seriously because in her moment of greatest grief it seems to be terrible that we should then sort of let the mother down at that stage and tell her that she must go to Cardiff or to London or wherever but that's … My main concern is the life of the mother, that a doctor who may now feel that they can never be challenged about what they're doing because it is genuinely to save that woman's life, that they can't be put in a situation where someone says, 'Hold on a moment, you're terminating this pregnancy, that child isn't viable, that's an abortion'. That's my really serious worry.

Senator O'Donovan: Okay. Just one final point. From all the witnesses we've heard here today there seems to be a lot of common ground. I would say practically every one of them, number one, don't want a liberal kind of system of abortion like you have probably in use in Great Britain or the United States. I think everybody is *ad idem* on that regard. I think that and I would ask your opinion on it if a proper terminology could be got at to, I suppose, sift the grain from the chaff because there is a lot of various uses of terminology here on the word 'abortion', 'termination', 'miscarriage', etc.. There is a lot of confusion in that area and if it's confusing for, say, 50 or 60 gynaecologists/obstetricians in Ireland, if it's confusing for these experts what is it likely to be for the general public? I am a lay person. I have a legal background. I have some knowledge but, obviously I bow to the expert knowledge but the problem I see is that there's a lot of confusion out there.

A lot of people will say that where let's say a woman has cervical cancer she has to get treatment and as a consequence of that there is either termination or an indirect abortion, that's not abortion at all. That is the big question and that is the thing I can see ending up again in the Supreme Court somewhere. Would you like to see clarity on those simplistic issues?

Senator Henry: I would like to see clarity. I'd go very much with the constitutional review group's final paragraph which said they felt we should bring in legislation to clarify what we mean. We have to. You have to have some clarity about what we mean.

Chairman: Very good. I think there are more than 60 or 80 obstetricians in the country.

Senator O'Donovan: I suggest 100.

Senator Henry: Ninety five, I think.

Chairman: Remember, as a rural Senator if you will, that many hospitals insist on having this service so that their county can remain---

Senator O'Donovan: All I am aware of is that our maternity unit in Bantry in west Cork was closed down so we have to travel a long way for it.

Deputy J. O'Keeffe: By Fianna Fáil.

Chairman: As an urban Deputy, I can safely point out that one of the difficulties about keeping maternity units in provincial locations is that you must always have three obstetricians available because, of course, it can happen at any time of day or night, it's not like some other discipline.

Deputy McGennis?

Deputy McGennis: Thank you, Chairman. I know we're running out of time. I just want to make one or two comments on the question.

I welcome Senator Henry. At the outset, I would like to commend her on her work with Cherish, because Cherish was instrumental in forcing the Government to put its money where its mouth is. We can sit and talk about supporting women in crisis pregnancies, etc. but it took a long, long time to actually put our money where our mouth is and my understanding is that the Cherish group is to the forefront of that.

Senator Henry, you have made it very, very clear in your submission and, again, with your oral presentation, that you would have grave concerns about a complete ban. I think, from my own point of view, your oral presentation today, hopefully, has cleared up in the minds of people who misunderstand what your position is. If I can read just two and a half lines from your written submission, and it's in the context of adoption, 'Abortion can never be the preferred end to any pregnancy but society has a major role to play in reducing the number of socio-economic abortions sought by Irish women'. That encompasses the views of everybody that has spoken but, I think, puts on the record your position which, I think, is probably very often misrepresented.

I started off with the problem regarding the definition and, again, we are at that but you have even complicated it further by saying that you would have a very grave concern about using the term 'medical treatment' because it can be certainly used in a way that would, in fact, see people performing abortions or, if you like, what's called, even in the ethics guidelines, a side effect of which is not … but you mention in the use of RU486 and other medical abortifacients, or drugs, such as Cytotec. Now, I know nothing about these drugs, which are used for medical conditions but produce abortions. You obviously have concerns that, in fact, this is happening as things stand.

My final question is maybe something that I should ask as we leave, but I have a grave concern because I listened to Dr McFarlane in relation to anencephaly. Are you saying that, depending on the ethos or the view of a particular professional, a woman may be subjected to something which would not … and the baby … to a delivery which would not be the norm in Dublin?

Senator Henry: I will start at the end. I think I must be very careful about criticising other people's medical practice.

Deputy McGennis: I do not mean that you would be critical.

Senator Henry: I think it would be .... It's just not the sort of treatment I have seen so I'd have to leave it.

Deputy McGennis: Okay. It is nothing.

Senator Henry: Thank you very much for your kind words about Cherish, thank you very much indeed. Do you know I've never referred anyone for an abortion in my life and no one has ever asked me to, which I think is very interesting? Another thing as well is I would not be involved in non-directive counselling because I would not be non-directive. I would be putting them into the back of the car and telling them to come home with me and they'd be fine and I might be wrong, so I'm not the type of person who should get involved with that at all.

I am glad you mentioned about adoption. I think it's very unfortunate that, for a while, perhaps women were made think that if they didn't keep a child, somewhere they were an unnatural mother.

I am worried about the situation regarding oral abortifacients, and I won't mention by name the other tablets in case I am accused of telling people how to procure abortions because they are quite commonly available, but they could become, and perhaps have become, a street drug. We have got to recognise that. Now, you saw the Irish Medicines Board was giving out the other day about the availability of various pharmaceuticals – drugs – on the Internet. I don't know how this is going to be dealt with internationally. In the US the other day I saw there were 83 sites which would prescribe Viagra without prescription. Now, I don't know how many would prescribe RU486 internationally without prescription. This is a whole area that neither you nor I can do anything about.

The main thing that I've put that in for is I think it's very important that young women who may take them should know that there are side effects. If you don't recognise that this may be happening, they may think that this is the solution to all our ills. Some of the ones that I mentioned are quite widely used in South America, in Latin America in particular, and I have read in the journals where, when the abortion failed, some of these children were born with limb deformities. People just have to be given information and told that maybe this is available but this is not a solution.

Chairman: Senator Henry, I would like to thank you for taking your time to assist us today.

Senator Henry: Thank you very much for having me.

Chairman: It is very much appreciated. With your testimony we have ended our list of medical experts and psychiatric experts who assisted us with our deliberations. Certainly, I was impressed, first of all with the concern for definition, because I suppose it is important that we have clear thinking in any area. I was impressed with the

passionate concern that was shown about maternal health and also with the practical approaches that were proposed in relation to trying to reduce the actual rate of abortion that we have.

Senator Henry, I thank you again for your assistance. We anticipate meeting again on Wednesday 17 May but at this stage, legally speaking, I understand I have to adjourn the meeting *sine die* until we formally set that date.

Senator Henry: Thank you very much.

THE JOINT COMMITTEE ADJOURNED AT 5.05 PM SINE DIE.

Appendix IV

SUBMISSIONS (MEDICAL)

Appendix IV

SUBMISSIONS (MEDICAL)

THE INSTITUTE OF OBSTETRICIANS AND GYNAECOLOGISTS RCPI
29 FEBRUARY 2000
PROFESSOR JOHN BONNAR MD, FRCPI, FRCOG
CHAIRMAN

1 The Institute of Obstetricians and Gynaecologists is the professional body representing the speciality of Obstetrics and Gynaecology in Ireland. The Executive Council of the Institute has examined the Green Paper on Abortion and the members have been consulted. We welcome the Green Paper, which provides a comprehensive, up to date and objective analysis of the issues arising in the care of the pregnant woman. Our expertise is in the medical area and our comments are confined to these aspects.

2 In current obstetrical practice rare complications can arise where therapeutic intervention is required at a stage in pregnancy when there will be little or no prospect for the survival of the baby, due to extreme immaturity. In these exceptional situations failure to intervene may result in the death of both mother and baby. We consider that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example for social reasons, and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother.

3 We recognise our responsibility to provide aftercare for women who decide to leave the State for termination of pregnancy. We recommend that full support and follow up services be made available for all women whose pregnancies have been terminated, whatever the circumstances.

JOINT COMMITTEE FOR FAMILY PLANNING INSTITUTE OF OBSTETRICIANS AND GYNAEGOLOGISTS AND IRISH COLLEGE OF GENERAL PRACTITIONERS
DR MARY CONDREN
CHAIRMAN
25 NOVEMBER 1999

The Joint Committee for Family Planning wishes to reply to the recently published Green Paper on Abortion.

The Committee as constituted, reflects the diversity of views of the members of our respective parent bodies. In view of this, we are not in a position to make detailed responses to each of the proposals set out for discussion. This will be done in due course by the parent bodies.

However the Committee has expressed the strong view that any proposed legislative or constitutional changes must not render illegal currently accepted medical practice ie post-coital contraception and the IUCD.

FRED LOWE
CLINICAL PSYCHOLOGIST
HUMAN RIGHTS AND THE ABORTION DEBATE: THE SPECIAL NEEDS OF RAPE VICTIMS
NOVEMBER 1999

In a recent book, Michael Ghiglieri suggested that 'we humans carry a legacy of instincts from our primeval past.' He claims that one of man's overriding instincts is to sire a succeeding generation, and, he further asserts, there will always be some men who will take more aggressive steps to pass on their genes. He claims these men are driven by a primitive instinct to 'steal copulations from unwilling women and thus increase the odds of siring offspring.'[1] He does not say how many rapes are caused by this primitive instinct, and he would concede that rapes are crimes caused by a complicated mix of circumstances and motives, but his theory may be correct for some rapists. The proposed instinct to have offspring could be an explanation for the behaviour of a doctor, a few years ago, in the USA. Working in a fertility clinic, he stopped using sperm donated by the husbands, and used his own sperm in a bizarre bid to populate a large number of women with his offspring. His scheme was discovered when several of the babies resembled each other and not their supposed fathers, and also bore a strong resemblance to the doctor at the fertility clinic. The women so impregnated were outraged, and sued, and early pregnancies were terminated.

Women need to want what is growing inside them, and there is evidence that acceptance or rejection by the mother before birth does effect the maturing foetus. For this reason, most countries accept it is a basic human right that people's bodies are their own, and that no one else has the right to use them against their will. Most of

1 Michael P. Ghiglieri, *The Dark Side of Man: Tracing the Origins of Male Violence* (Perseus, 1999).

Ireland's laws respect this as a basic human right. Operations cannot be performed without consent. Should a surgeon remove a diseased organ without permission, it is deemed in law to be an assault and is punished in civil law by making the surgeon pay damages. This right to the integrity of our own bodies is so important that it is respected even after death, when organs cannot be removed without the prior consent of the person who once lived in that body.

There is only one notable exception. Only pregnant women who must endure by law something happening to their bodies that they do not want. Even if the pregnancy were the result of violent rape by a man driven by an instinct to steal copulation from unwilling women in order to sire offspring, the law would uphold the rapist's right to enforce childbirth. In the case cited above, where the doctor used subterfuge to impregnate the women in the fertility clinic, the weight of Irish law, and of the Irish Constitution, would have forced the women to back his mad scheme by making them have his babies. Despite the fact that the method of impregnating the ova is against Church teaching, the Church's dogma would still see the pregnancies as 'God given', rather than the product of misused science and depraved practices.

The more important belief is the Roman Catholic dogma that life begins when the sperm enters the egg, and when the egg begins to divide. This moment, says the Church, is the miracle of life, created by God, and should not be interfered with, either by contraception, or abortion. To maintain this belief, the church has to ignore all sorts of facts that make nonsense of the dogma. For example, about 25% of all fertilised eggs miscarry, usually without the women being aware that she has had a miscarriage. These millions of miscarriages are not seen as 'lost babies', either by the state or the Church. Only miscarriages after the foetus is deemed capable of independent life have to be recorded as births and deaths. Foetuses miscarried early in pregnancy, before 24 weeks, or before the foetus weighs 500 grams, do not have to be registered as having lived, nor do they have to be christened, or given a formal burial. They are non-beings, not deemed legally to have become a citizen. The Church's burial practices accept this fact. However, the Church then ignores this embarrassing detail so that it can preserve its dogma that God creates a life in body and in soul at conception. The Church may refuse to Christen and bury a foetus, but it nonetheless insists the unborn foetus has a constitutional right to exist inside the mother against her will.

When abortion was legalised in Great Britain, thirty years ago, Lady Warnock tackled this problem. Her solution was to say that the foetus only gained equal rights with the mother when it became capable of independent life, and so the foetus could be aborted up to that time, which was originally set at 24 weeks. The Warnock report, however, did not give the woman the right to decide herself on whether to terminate the pregnancy. As a result, British law gave the woman no choice in the matter, and that remains the case today. Only two doctors can make the decision whether an abortion is needed, and then only if they think the woman's psychological or physical health necessitate the termination of pregnancy.

The result is that women confronted with pregnancies against their wills are still treated in British law as too irresponsible to decide for themselves. Doctors are given the right to decide for her. It is a kind of medical absolution. It is not the wishes nor the needs of the woman, but 'medical grounds' that inform the decision as to whether she should have a child against her will. It is the risk of mental illness, or death, which alone allows the doctors to say, 'This pregnancy should not be happening to this woman's body.' Thirty years later, Britain still refuses to take the step taken by most of Europe of saying the circumstances of conception and the wishes of the woman are also central issues in reaching such a decision. Rape, and its effects, are a social problem, and the termination of a pregnancy after rape is a social need and not a medical one, and Ireland should have the courage to accept this fact.

No law can take account of the grotesque and terrible situations that can arise. Murphy's law, 'Whatever can go wrong will go wrong, and at the worst possible moment', applies to pregnancies as well as to machines. Had that doctor practised in Ireland, the women would still have got damages, but in Ireland their pregnancies could not be terminated. Even the 'morning-after' pill has posed dilemmas here. One hospital, when asked if it would give the morning-after pill to rape victims, declared it would do so 'only if the woman was not ovulating at the time of the rape'. This solution fitted in with Church's teaching on the safe period for birth control, and allowed them to say they were not interfering with a God given creative process, but if also implied that the violent rape was also part of the divine plan. To believe this, we must indeed believe that God moves in mysterious ways, his wonders to perform. Yet this odd thinking still prevents the sale of the morning-after pill over the counter at chemists. We must still pretend it is not the woman but the doctor who knows best.

There is no simple solution to the abortion problem, because it is a clash between two rights, the right of the mother not to have something invade her body against her will, and the right of a foetus to be protected. When the foetus has got there by force, as in cases of rape, or by deception, as when a man cuts the top off his condom, or claims he has had a vasectomy, the woman should have the right to refuse to carry the foetus. To force the woman to relinquish control over her body is to deprive her of a basic human right, the right to own and control what happens to her body. The crime of rape exists because someone has taken away that right, and the law sees it as almost as serious as murder. For the country then to pass a constitutional law to force the rape victim to endure the effects of rape, by making her give birth to the rapist's child, is to make her the victim of a kind of secondary rape, which should perhaps be called 'state rape'. It is an odd constitution indeed that upholds the right of a rapist to force a woman to have his child. It is time it was changed.

The change, however, must not be a new form of wording. Another abortion debate, with threatening confrontations between pro-choice hordes waving banners, and pro-life mobs waving plastic foetuses, will produce only more meaningless hatred. Every form of words will be inadequate for some case at some time. We need the courage to admit this fact, and remove the matter from the constitution altogether. We can then see each case as an individual woman's personal dilemma. The constitution has no right to intrude into private tragedy.

If that dictator were to seize power in the Republic of Ireland, however, he would not need to pass such laws. While rape itself is a crime, once his sperm has fertilised the ovum, our laws and our constitution support the rapist's right to force the woman to carry his offspring. The woman is given no say in the matter at all.

MOUNT CARMEL HOSPITAL
PAEDIATRIC CLINIC
24 NOVEMBER 1999
BRIAN DENHAM MB, FRCPI, DCH, FRCPCH
VISITING PAEDIATRICIAN

I am writing this letter, for the information of your committee, on a personal basis and it is founded on my thirty years of experience as a specialist in diseases of the hearts and lungs of children.

One patient of mine who lives in Donnybrook and is almost three years of age is only alive because her twin sister was terminated. This is an extremely rare condition known as an acardiac twin pregnancy where one twin does not have a heart and lives on the blood supplied by the circulation of the other twin. Inevitably the twin without a heart dies and when they do the normal twin dies also, (extremely rare survivors are inevitably severely handicapped).

If the umbilical cord of the acardiac twin in clamped (using keyhole surgery) then that foetus dies but the other lives and is normal. I actually sought the advice of the Medical Council as to whether the referring doctor in this particular case was acting ethically or unethically but they were unable to help me saying only that they do not deal with specific cases.

The second type of case I would like to mention are those patients of mine with severe congenital heart disease known as Eisenmengers Complex where the heart defect is complicated by high blood pressure in the lung. This is one of the blue heart conditions and when these patients grow to adulthood they leave my care but for them pregnancy is a very serious risk indeed with literature quoting a maternal mortality rate of 20%-30%. In the rest of the world this particular condition is regarded as a mandatory indication for termination of pregnancy and the vast majority of my ex-patients with this condition who become pregnant do seek termination overseas. Occasionally patients with this disease choose to go ahead with pregnancy despite the risk and in my experience with the excellent level of medical care provided in our maternity hospitals the mortality in this condition is at the lower end or probably somewhat below the range quoted above.

I would like your committee to consider the position of one of my patients with this condition who having embarked upon a very high-risk pregnancy with a gratifying outcome of a healthy and normal baby then unexpectedly finds herself pregnant once again, what is she to do, if she does through with a second very high risk pregnancy there is a serious risk that she will be dead and that her healthy baby orphaned.

The third type of case which I come across relates to families with cystic fibrosis. I was prior to my retirement Director of Cystic Fibrosis care of the National Children's Hospital and I am a past President of the Cystic Fibrosis Association of Ireland. Cystic Fibrosis is a fatal disease. Ireland has the highest incidence of this disease in the world with one child in 1,500 being affected (30 new cases per year nationwide). It is a life long life threatening disease requiring hours of arduous daily care, physiotherapy, exercise programmes, 40-100 tablets daily, special dietary requirements and so on. The resources and free time of families with a cystic fibrosis child are entirely consumed by caring for that child.

Cystic Fibrosis is an inherited condition and both parents are carriers of a single copy of the cystic fibrosis gene. This is harmless to them, it is only when a child receives a double copy of the gene, one from each parent, that they have the disease. When a family have had a cystic fibrosis child the chance of any subsequent child in that family being affected by cystic fibrosis is exactly one chance in four for each and every pregnancy.

In my experience half of all parents of cystic fibrosis children who find themselves pregnant once again seek ante-natal diagnosis that they may know whether or not the foetus is affected. When the foetus is diagnosed as having cystic fibrosis I have no way of knowing how many of them seek a termination overseas. Some do so because they cannot face the prospect of the birth of another fatally and chronically ill child, others however may seek a termination entirely out of interest in protecting their existing child who has the disease. Because it is a sad fact that where two children in a family are affected by cystic fibrosis both children will do less well and their lives will be shorter than where a single child is so affected. This is because of problems with cross infection, contamination and so on, not to mention parental exhaustion with the amount of care that a second chronically ill child requires which inevitably detracts from the level of care given to the first.

In the rest of the world it is extremely rare to find two or more children in one family with cystic fibrosis, whilst this is relatively common in Ireland and is part of the reason why the incidence of this terrible disease is higher and the life span of our patients shorter than in other countries.

I have mentioned these three conditions because they are the ones with which I have experience. Other specialists would have different areas of expertise.

SOLUTION

In my opinion it is almost impossible to legislate either constitutionally or through the Oireachtas in the flexible and sensitive way that dealing with individual cases such as these requires. In my opinion the best solution would be to go for the liberal option in the White Paper but to restrict it by simply making the Offences against the Person Act not applicable in:

Regional Hospitals
University Hospitals
Maternity Hospitals

So that terminations would be confined to these centres where there are already well established ethical committees. Then to monitor the situation by having centralised reporting of each and every termination of pregnancy

with an annual review of those reports by a committee of the Department of Health or such as your own. Indeed as long as there was nothing in the reporting that allowed individuals to be identified there would be no reason why the reported information should not be made public.

The Hospital Boards of Management with the already established Ethical Committees are so deeply involved in guiding the quality of inpatient care that it is unlikely in the extreme that one would seen any abuses of the potentially unrestricted access to abortion arising. Centralised reporting and scrutiny would however provide a mechanism for dealing with such an abuse were it to occur, or providing additional resources if cases hat clearly warranted termination were not receiving care.

I hope these thoughts on the subject which are based entirely on my own limited experience may prove of some use to your committee in its deliberations.

DR ALISTAIR McFARLANE MRCOG, FRCS (ED)
OBSTRETICIAN GYNAECOLOGIST
25 NOVEMBER 1999

I did make a submission before the green paper. It was quite lengthy, for having worked as an Obstetrician/gynaecologist for 22 years in Ireland and having been trained in Britain in units where many abortions were performed, I had plenty to write about! I enclose a copy of it in case you wish to refer to it again.

Unlike many of your correspondents, I had the above experience to help me in composing that submission and trust that what I wrote was fully appreciated when the Green Paper was being composed. As for the Green Paper itself, I thought that the issues were carefully and fairly set out in it. It was noted that the medical organisations themselves, especially those of the doctors who would find themselves being asked to do abortions did not make submissions.

Page 54: 4.32. Availability on request. I do agree with the remark 'in practice there may be little to choose between the two in terms of access …' One of the themes of my previous submission was that abortion is freely available in Britain in spite of an apparently rigid set of required reasons. I would add that it is difficult to see how it could be made more accessible! One point which I did not notice in the paper is the giving of any role to the father. I wonder if anyone suggested that the father of the baby legally should be asked for his views. At present in Britain a wife can get an abortion without the husband even knowing about it at the time.

Page 60: 5.08. Certainly my submission was one of those which 'do not regard those procedures currently accepted under existing medical ethics as abortions.' I also strongly rejected the views of those given in the next sentence. 'Others, however, are concerned that an absolute constitutional ban on abortion might be regarded as encompassing these procedures unless specifically exempted.'

The theme of this submission is that the chief cause of confusion is varying usage of the key word **Abortion**, which I note is not defined in the glossary!

Words have uses **not** meanings, so we should try to decide how to use the word abortion and all the other related terms, such as miscarriage, ending a pregnancy and termination. Words are powerful and I am sure that you will already have noticed that the Pro-Life Movement (anti abortion) uses different words from the Pro-Choice Movement (pro abortion). Thus Pro Life talk about the little human being or the baby, whereas Pro Choice avoid these awkward words and talk about pre embryo, embryo and foetus. For Pro Life he or she is alive from the beginning, whereas for Pro Choice it becomes really alive when the cerebral cortex develops, or 24 weeks is reached or even as I once read when the first breath is drawn. One pro abortion doctor solved the problem by writing that it could be regarded as alive if the mother wanted the baby and not alive if she did not.

Words also change their usage; we often carelessly say that their 'meanings' have changed. Thus once, if we wrote in a patient's case notes that she had had two abortions, we meant that there had been two miscarriages. The work miscarriage was avoided in notes as being a lay term. Now however it is readily used, because abortion now has come to mean in both medical and lay usage the destruction of an embryo or foetus at a hospital or private clinic (usually in Britain). We do need a term to apply to **the deliberate ending of the life of a little human being by whatever means, the action having been taken before birth and where he or she could have survived with recognised ante natal care.** So why not use the word 'abortion' – after all this is now we mostly use the word nowadays.

This definition would then exclude cases where the embryo or foetus was already dead and cases where he or she was doomed and could not be saved. One would have to be careful not to leave a legal loophole. Thus simply to say that the embryo could not be directly killed before birth would allow premature induction of labour at e.g. 18 weeks with modern drugs and death would not occur till after birth from prematurity.

If you refer to my previous submission, you will see several examples where normal practice does result in the death of an embryo or foetus, but these are already doomed and one should not call these abortions. Naturally the pro abortion movement *does* want these to be called abortions, because they wish to be able to say that abortion can be a medical necessity. If this be done though then we will still need a word for abortion as I have defined it. I suggest that some neutral term could be used to cover these cases such as 'ending the pregnancy when embryo/foetal viability is not possible'. This should be safe.

One has to remember that a minority of doctors are determined to get abortion on demand introduced and one only needs a minority to get it all started. Thus to specify that abortion be allowed if severe hypertension is endangering the mother's life is all they would need to do an abortion when the blood pressure is raised (as it often is). They would simply say, if challenged, that there had been a spike of hypertension when they took a reading and in their judgement they felt that it was wiser to proceed. The Gardaí would be wasting their time if they took a test case as it is certain that it could not be proved that an abortion had been done. In case you think that I am exaggerating, I once met a gynaecologist, shortly before the British abortion act was introduced, who was known to put a woman in early pregnancy on the operating list,

as a case who needed a curettage to investigate her secondary amenorrhoea. There would then be a feigned dismay at her unexpected pregnancy.

You will be getting submissions from those claiming that a woman has a 'right' to an abortion and those claiming that the unborn child has a 'right' to life. As these are not reconcilable, I suggest that you translate these claims to 1) that it is right to do an abortion on demand and 2) that it is right that the unborn person be allowed to live. If the submissions do not then go on to say why it is right, then they are not really saying anything meaningful. For clarity the word right should be used as an adjective not as a noun.

It will be tempting to 'let the people decide'. Thus the referendum would have a list of options. One of these will be to let the doctors decide if it is medically necessary to do an abortion – as I have used the word. This will just be a version of the British act and we all know how that came to be interpreted. A clear list of reasons would in practice amount to the same. The only way is to have no abortion, again as I have defined it. The GMC could if necessary allay the fears of those expressed in p. 60: 5.08 with some sort of list, for those who need something on paper, though I have always managed perfectly well without it.

To conclude: I urge that the word abortion be defined and used as I have suggested. Otherwise all sides will use the word differently and confusion will reign in the months to come.

DR PJK CONWAY MB, DPH, FRCOG
CONSULTANT OBSTETRICIAN GYNAECOLOGIST
24 APRIL 1999

I enclose a review of the medical literature particularly that from our own country which clearly shows that there is no 'medical or psychiatric reason' for direct abortion. In the world today many countries provide 'legal' abortions for:

1 Population control (The Former Soviet Union since 1918, the former Eastern block countries, Cuba, China and Japan (since 1945) and
2 'Social' reasons – this is the reason for 99% (1% eugenic and other reasons) of abortions in the United Kingdom – the number approaching 200,000 annually, up from 22,000 9for 8 months) in 1968 the first year of abortion operations after the passing of the 1967 Abortion Act. The same applies to most 'Developed' countries, all or whom have changed their laws since 1967 – Spain and Portugal the most recent to do so.

The UK law, like all others, are passed on the understanding and assumption that they will be restrictive in their application. It was not restrictive nor are any of the other laws relating to 'legalising abortion' – they always end up with 'Abortion' on demand.

Ireland still adheres to traditional 'compassionate' values in this field. The medical profession through the medical council sees no medical reason for abortion. Our doctors and nurses and particularly obstetricians and midwives have viewed pregnancy as caring for two people – the mother and her unborn child.

In my view you cannot practise maternity care with any other approach – you cannot try to have healthy mothers and babies on the one hand and on the other advocated killing the baby under the plea of 'compassion' or the euphemism of 'Pro-choice'. This latter word is an attempt to justify actions destined to kill one of the two people whom we should be caring for. Medical practice for centuries has prohibited abortion (Hippocratic Oath).

In my own lifetime working in obstetrics/gynaecology (35 years, 21 years as a Consultant, 18 of which have been here in the Midlands). I have worked in developed (Ireland/UK) and developing (Nigeria) countries so I have a good practical view of this subject. I worked under Professor O'Driscoll in Dublin whose commitment and enthusiasm for maternity (looking after the mother and her baby) was so healthy and stimulating, that when I arrived in England as a 'RAW' Irishman, I found the 'Abortion' culture profoundly 'shocking', 'horrifying' and 'disturbing'. This was in 1967-1968. The Out Patient Clinics, gynaecology wards and the theatre were dominated by young healthy unmarried girls with healthy babies, in hospital for abortions – this undermines a 'caring' profession (ultimately also society) as it is soon taken as 'normal'.

The 5,000 Irish mothers approximately who have abortions in England annually is a tragedy – this 5,000 are principally (80%) unmarried, young, and healthy with healthy babies. The majority are referred to England by agencies such as 1) Irish Family Planning Association 2) Well Woman clinics 3) Maria Stopes clinic. All are branches of international organisations whose goal is to provide abortion on demand world wide as part of its plan to control population.

In conclusion I would strongly advocated the maintenance of full protection for the mother and her baby. I believe that this requires a referendum – as the two recent cases 1) *X* case '92 and 2) *C* Case this year have cast a 'shadow' and are a real threat to future unborn babies in this country. Both these judgements are medically wrong and for me impossible to justify. They have undermined my own confidence in the Judicial System in this country. I also enclose my 'own prescription' for the social circumstances related to this field as I have reported them in the Portlaoise Maternity Report since 1980.

Thank you for 'listening'. This protection for vulnerable human life is a core value that cannot be tampered with. Abortion kills the baby, *adds* further physical but especially mental trauma to the mother (grief, guilt, depression). It undermines society's values, also the medical, nursing and paramedical values.

SENATOR MARY HENRY MD
NOVEMBER 1999

The Green Paper on Abortion is a most useful document, addressing the issue from all angles. My one criticism, however, is that in the glossary of Medical Terms 'abortion' is not defined and this, after all, is the nub of the whole matter. The paper deals with a topic without defining it although the word is repeatedly used. This serious fault

should be the first issue the Committee on the Constitution should address. Abortion, the first word in the document's introduction, is never defined.

For the purpose of this submission I will define 'abortion' as is frequently done in medical dictionaries as 'the termination of a pregnancy before the child/foetus is viable'. In the Offences Against the Person Act 1861 the phrase 'Abortion, the unlawful procurement of a miscarriage' is used.

In Appendix 5, *Extract from the Report of the Constitution Review Group, 1996*, the section '*Possible Approaches*', subsection (a) *introduce an absolute constitutional ban on abortion*, the difficulty of the lack of a definition is discussed and this, I believe, is most important. The section follows:

> This must rest on a clear understanding of the meaning of abortion. The 1861 Act prohibits 'unlawfully procuring a miscarriage' which might nowadays be rendered as 'illegal' termination of pregnancy' but, in either case, the words 'unlawful' and 'illegal' are significant. If an abortion can be either lawful or unlawful, the work on its own must be understood to refer neutrally to the termination of a pregnancy or procurement of a miscarriage. To ban abortion *simpliciter* could thus criminalise medical intervention or treatment necessary to protect the life of the mother if such intervention or treatment required or occasioned the termination of her pregnancy.
>
> According to a press report (*The Irish Times*, 10 September 1992), the Pro-Life Campaign considers 'a complete prohibition on abortion is legally and medically practicable and poses no threat to the lives of mothers'. Reference is made to 'the success of medical practice in protecting the lives of mothers and their babies', and it is claimed that 'a law forbidding abortion protects the unborn child against intentional attack but does not prevent the mother being fully and properly treated for any condition which may arise while she is pregnant'. Either of two hypotheses seems to be involved here – that the termination of a pregnancy is never necessary to protect the life of the mother or that, if it is, such medical intervention is already protected by law and that this protection would not be disturbed or dislodged by a constitutional ban on abortion. It would not be safe to rely on such understandings. Indeed, as explained later, if a constitutional ban were imposed on abortion, a doctor would not appear to have any legal protection for intervention or treatment to save the life of the mother if it occasioned or resulted in termination of her pregnancy.
>
> It would not, therefore, be reasonable to propose a prohibition of abortion (understood as termination of pregnancy) which did not expressly authorise medical intervention to save the life of the mother.

The impossibility, for medical reasons, of bringing in an absolute ban on abortion, as I have defined it, is made plain by the argument in Chapter 1 of the Green Paper on *Pregnancy and Maternal Health*. Women with conditions which require the termination of a pregnancy before the foetus is viable are treated here. For example, the treatment of ectopic pregnancies by laproscopic microsurgery which requires only the removal of the products of conception without removing the Fallopian tube is common practice here. Indeed, patients would not tolerate the unnecessary removal of the fallopian tube which would reduce the chance of a subsequent successful pregnancy.

Very occasionally the pregnancy of a patient with eclampsia has to be terminated even though it may be doubtful if the child is viable. The same with serious haemorrhage. Cardiac disease is another problem and very occasionally in serious cases, termination might be considered necessary to save the mother's life. Similarly cancer. Invasive cancer to the cervix is dealt with by hysterectomy with the developing child included. But the treatment of pregnant patients with breast cancer of leukaemia is less clear here. While the Medical Council guidelines recommend that to refuse treatment to the mother by chemotherapy or radiotherapy is unethical even if the developing child is killed or affected (Green Paper, page 16, 1.13), there is no guidance on what to do about a mother who may refuse treatment which would kill or injure her child but who would prefer an abortion and then treatment.

Only five abortions were carried out in England in 1996 on Irish residents which were defined as being necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman, or where the mother's life was at risk. One would like to know the medical conditions of these women. Were these cardiac or cancer cases perhaps? One would expect a similar number of cases each year. When we boast about our excellent maternity care and low maternal mortality figures we should remember that even as recently as the 1980s the number of maternal deaths was in double digit figures.

The committee will be aware that the international scientific literature does not support the view that the termination of a pregnancy before the child is viable is never necessary to save the mother's life. The new treatment of ectopic pregnancies mean, indeed, it will be relatively common, untreated ectopic pregnancies being a major cause of maternal mortality through haemorrhage. The issue of mental health and the threat of suicide is a very difficult area. The prediction of suicide in anyone is always problematic. Threats should not be ignored, however.

It is not possible to have an absolute ban on abortion. The other options put forward in Chapter 4 for legislation in this area are really political decisions. The more widespread use of emergency contraception as described in 4.14 page 49 would be useful in rape or incest, although incest is so rarely reported at the time, perhaps the age of the girl and the duration of the pregnancy could be taken into account. The use of RU 486 and other medical abortifacients (or drugs such as cybotec which are used for other medical conditions but produce abortions) are likely to become more easily available as street drugs anyway.

Dealing with the whole area of abortion for congenital malformations or genetic defects is going to be a great challenge with more and more prospective parents demanding knowledge of the physical status of their developing child. The easy availability of abortion in these cases in some countries is an example of international thinking by ordinary people whether we like it or not. There has been little or no debate on this serious ethical issue in this country. Professor Denis Gill has written on the subject but few others have done so.

Chapter 6, *The Social Context*, is most useful. If the dramatic drop in the number of teenage pregnancies, which was shown in the recently released figures by the EHB for this area, continues next year we really can feel

we are getting somewhere with the group where an unplanned pregnancy has its greatest effect on the girl's life. The cause of the reduction may be due to better job opportunities for girls and with our economic boom set to continue according to economists the decrease in teenage pregnancies may continue also.

Most socio-economic abortions are carried out on women in their 20s. As President of Cherish, an organisation for lone parents but mainly single mothers, I profoundly hope the effects of economic factors on a young woman's decision to have an abortion are not forgotten. The report '*Women and Crisis Pregnancies*' by Evelyn Mahon and her co-worker in Trinity College, makes clear how serious is the threat of social isolation in women's decisions.

It is a pity that adoption is not considered more frequently and the recent Baby A and Baby B cases where girls appear to have been tricked into giving their children up for illegal adoptions with, I regret to say, what appears to be the assistance of a general practitioner and barrister will cause even more to abandon this idea. Abortion can never be the preferred end to any pregnancy but society has a major role to play in reducing the number of socio economic abortions sought by Irish women.

I wish the members of the committee luck in their deliberations. I would suggest that you have hearings in public, televised as those of the Public Accounts Committee were, and I would like to come before the committee. An absolute ban on abortion, which must be defined, is impossible without interfering with medical practice, but from then on the decisions for you, as for the women who choose to have abortions or not, are difficult.

EAMON O'DWYER MB, MAO, LLB, FRCPI, FRCOG
PROFESSOR EMERITUS, OBSTETRICS AND GYNAECOLOGY, NUI GALWAY
16 OCTOBER 1999

THE ABORTION DEBATE

This debate is concerned with procured abortion, ie the deliberate, intentional destruction of unborn human life. It is as well, at the outset, to outline the law, in Ireland, in relation to abortion. Abortion, in this country, is still a criminal offence under the provisions of the Offences Against the Person Act 1861, section 58, which provides:

> Every woman being with child who with intent to procure her own miscarriage shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony. And on being convicted thereof shall be liable to be kept in penal servitude for life.

The need for intent is stressed by Peter Charleton, Senior Counsel, in his textbook, *Offences Against the Person*, Dublin Roundhall Press, 1982 at p 183:

> Under s.58 the accused must intend to procure her own miscarriage or, if a person other than the pregnant woman is alleged to be the offender, must intend to cause a miscarriage in another, whether she is actually pregnant or not. Intent in this context requires the accused to act with the purpose prohibited by the section of procuring a miscarriage.

The Abortion Act, 1967 made abortion lawful in England and Wales where it was considered necessary by two registered medical practitioners, acting in good faith.

> However, if a miscarriage is intentionally procured, and is not a lawful abortion within the terms of the Abortion Act, 1967, s.1, the procurer will be guilty of the offence of criminal abortion. (Clarkson CMV and Keating HM *Criminal Law: Texts and Materials*. London, Sweet and Maxwell, 1994 at p 595).

As I understood it at the time, the purpose of the 1983 Referendum was twofold:

1 To confer the constitutional protection deriving from citizenship on the unborn human at all stages of its development
2 To prevent the striking down of the provisions of the Act of 1861, relating to criminal abortion, at some future date, as happened in the United Kingdom with the 1967 Act. In other words it was to 'copper fasten' the 1861 Act.

However, the Supreme Court in the *X* Case interpreted Article 40.3.3° of the Constitution as permitting abortion where there was a substantial risk to the life of the mother – as distinct from her health – if the pregnancy were to continue. In this case the fear that *X* might commit suicide was the deciding factor.

Subsequently the Government, in the 1992 Referendum, sought to make abortion legal where there was a substantial risk to the life of the mother, excluding the risk of self-destruction. This was rejected by the electorate. Politicians and others are worried, and rightly so, that because of a conflict of interest between the mother and her unborn child, women would be denied all necessary treatment during pregnancy.

There are no grounds for such concern – there is no conflict between the welfare of the mother and her child during pregnancy. Furthermore, the well being of the mother is paramount.

Every woman must be afforded appropriate medical or surgical treatment during pregnancy, without regard to the possible adverse effects, including intrauterine death, of such treatment on her unborn child. To withhold necessary medical treatment is unethical and altogether indefensible. This also, is the view of the Irish Medical Council.

It is essential that the fundamental difference between abortion, procured with the intention to procure ('deliberate, intentional, destruction of unborn human life.') where the pregnancy is terminated for quasi-social reasons, and death of the unborn child, at whatever stage of development, incidental to necessary medical or surgical treatment of the mother be recognised. Such a situation might arise in the case of ectopic pregnancy, or treatment of cancer of the breast or neck of the womb, for example.

Charleton (*Offences Against the Person*) states the position clearly:

> Where an ectopic pregnancy occurs or where a hysterectomy has to be performed because, for example, of cancer, it is normal practice in this jurisdiction to proceed with the operation, despite the incidental destruction of unborn life. In a situation where a medical condition requires treatment, and that treatment involves, as an incident, the possible destruction of the foetus, the doctor does not intend to procure a miscarriage. His purpose is to operate in order to cure pressing medical conditions.

After forty years as a consultant obstetrician/gynaecologist I can state:

- There is no conflict of interest between the mother and her unborn child.
- There are no medical indications for abortion
- There is no risk to the mother that can be avoided by abortion
- Prohibition of deliberate intentional abortion will not affect, in any way, the availability of all necessary care for the pregnant woman.

There is therefore, a fundamental difference between abortion procured *with intent* to abort, for social reasons for example, 'deliberate, intentional destruction of unborn life' and destruction of unborn life incidental to requisite medical treatment, which is lawful and ethical, however distressing.

The Green Paper on Abortion, which is to be welcomed, raises three important points which are central to the abortion debate:

1 The low rate of maternal mortality in Ireland, which has not been influenced by the absence of abortion. It is worth noting that in the five-year period ending 31 December 1996 over 36,000 women (10 per cent of them teenagers) were confined in the National Maternity Hospital, without a maternal death.

   In addition, the Green Paper found no evidence that doctors in Ireland failed to treat pregnant women with cancer or other illnesses for fear such treatment might injure the unborn child.
2 Of four thousand eight hundred and ninety-four abortions carried out in England and Wales on residents of Ireland, five (0.1 per cent) were considered necessary to prevent 'grave permanent injury. This accords with figures from England and Wales. The United Kingdom Secretary of State for Health informed the House of Commons that in over three and a half million abortions carried out over a thirteen-year period, risk to the mother's life was the stated indication in one hundred and fifty-one cases – 0.004 per cent. (Hansard, 13 May 1992). Hence, abortion is not necessary to safeguard the life or health of a woman.
3 Suicide in pregnancy is a rare event.

Under the heading 'Medical conditions which pose a risk to the life of the pregnant woman' the Green Paper states:

> The following are mentioned as ones where induced abortion may be indicated in certain circumstances: cancer of the breast and female reproductive tract, leukaemias and lymphoma, heart disease, hypertension/pre-eclampsia and Eisenmenger's Complex.
>
> However submissions which take a contrary view, including submissions from medical professionals, quote from research which states that abortion does not play a role in treatment of the above conditions (s.5.15)

In practice, cancer of the breast, leukaemia and lymphoma during pregnancy are treated as these conditions are in the non-pregnant patient. Cancer of the female genital tract is treated usually by hysterectomy if diagnosed in early pregnancy and by Caesarean section followed by hysterectomy if not diagnosed until late in pregnancy. For almost fifty years abortion has not been considered, worldwide, as the appropriate treatment for heart disease during pregnancy.

Pre-eclampsia is a condition which almost always occurs in the second half of pregnancy. With it, as with hypertension, I have never seen the need for intervention before the child was viable. In other words, in no case while I was a practising obstetrician/gynaecologist did I see any need for termination of pregnancy before viability. Eisenmenger's complex is frequently mentioned by those who favour abortion. It is well to remember that this is an extremely rare condition during pregnancy. To my knowledge only one case has been recorded from the Dublin Maternity Hospitals, all of which issue annual clinical audit reports, in almost forty years. This represents about one case in approximately eight hundred thousand deliveries. I am assured by cardiologists that, with more sophisticated intensive care, they would anticipate a satisfactory outcome in such pregnancies, and this is supported in recent literature from the United States and elsewhere.

Dealing with 'Suicide and Pregnancy' the Green Paper states that:

> Suicide in pregnancy is a rare event. … The incidence of suicide in pregnancy has decreased; in the first half of this century more than 10 per cent of women of childbearing age who committed suicide were pregnant, compared with only 2 per cent today. The 2 per cent corresponds to one suicide per five hundred thousand births. (1.25)
>
> With regard to suicide and maternal mortality, the epidemiological evidence suggests a protective effect against suicide from pregnancy (1.29)

The Report referred to the commission of enquiry chaired by Lord Rawlinson in 1994 into the operation and consequences of the Abortion Act 1967 which concluded as follows:

> The Commission heard from witnesses representing the Royal College of Psychiatrists who stated that although the majority of abortions are carried out on the ground of danger to the mother's health, there is no psychiatric justification for abortion. Thus the Commission believes that to perform abortions on this ground is not only questionable in terms of compliance with the law but also puts women at risk of suffering a psychiatric disturbance after abortion without alleviating any psychiatric problems that already exist. (5.22)

A report from Finland, where abortion has been legal since before the Second World War, (*British Medical Journal* 2 December 1996 p.313) compares the suicide rates among women of reproductive years where the mean annual rate was 11.3/100,000. The rate following childbirth was 5.9; it was 18.1 following spontaneous miscarriage and 34.7 following abortion.

Rape

The Green Paper states:

> Statistics on rape collected by the Gardai and the Dublin Rape Crisis Centre are available. However it is difficult to gauge the extent to which cases of rape and incest may be under-reported and the actual number may be higher than the official statistics indicate. Likewise no information is available on the extent to which such cases result in pregnancy or the outcome of the pregnancy. (4.11)

Rape has been described as 'an expression of a violent act, a victimisation of a person against his or her will, with sex as a component', where the sexual element is secondary to the essential violence of rape, described in Roman Law as a 'crime of force (*crimen vis*) Paul Tabori. *The Social History of Rape* (London. The New English Library ed. 1971).

It is generally recognised that pregnancy following a single at of forcible rape is rare. In a prospective study of four thousand rapes in Minnesota, no pregnancies were reported. In a retrospective study, the States Attorney of Cook County, including Chicago, reported no pregnancies during a nine-year period of prosecutions for rape (Diamond F, MD, Chicago. Personal Communication 1998.)

The Green Paper lists seven options, any one of which might be favoured by the Oireachtas:

i) An absolute Constitutional ban on abortion.
ii) A Constitutional Amendment restricting the application of the Supreme Court ruling in the *X* Case.
iii) Retention of the status quo.
iv) Retention of the constitutional status quo with legislative restatement of the prohibition on abortion.
v) Legislation to regulate abortion in circumstances defined in the *X* Case.
vi) Reversion to the pre-1983 position
vii) Permitting abortion on grounds beyond those allowed in the X Case

It should be noted that option (ii) was proposed by the government in 1992, was rejected by the electorate, and the government of the day stated that in the event of its rejection it would introduce legislation as in option (v). This has not happened. Retention of the status quo would leave the abortion question in a state of 'limbo' and would be an indication that the Oireachtas lacked the political will to 'grasp the nettle'.

Adoption of option (iv) would leave Article 40.4.3° still open to challenge because of the doubt surrounding the clause 'with due regard to the equal right to life of the mother' while option (vi) would remove constitutional protection altogether. Adoption of option (vii) would legalise abortion on demand.

From an analysis of the various options, option (i) alone would satisfy the common good, so long as it was clearly understood that insertion of an appropriate clause into the Constitution could not, and would not, deprive any pregnant woman of necessary medical or surgical treatment during her pregnancy.

What is at issue is whether procured abortion, as defined, should be lawful in the state.

Article 6 of the Constitution provides that all powers of Government 'derive, under God, from the people whose right it is … in final appeal, to decide all questions of national policy, according to the requirements of the common good.'

Does the abortion question not involve national policy to be decided by the people according to the requirements of the common good?

What is needed is the political will to put the question to the People in a Referendum. Finding a suitable addition to Article 40.3.3° should not provide an insuperable difficulty. All that really is necessary is the insertion in Article 40.3.3° after the phrase ' … vindicate that right' of the following words: **'Nothing in this Constitution shall render lawful the deliberate, intentional, destruction of unborn human life'**

This is designed solely to ban procured abortion, as defined, and poses no threat to the life or well being of an expectant mother.

SUBSEQUENT LETTER FROM PROFESSOR O'DWYER 17 JANUARY 2000

In a draft letter addressed to you the newly-elected Chairman of the Institute of Obstetricians and Gynaecologists of the Royal College of Physicians, Professor Bonnar states that 'in current obstetrical practice rare situations arise where to protect the mother's life the pregnancy has to be terminated at a stage when there will be little or no prospect at present for the survival of the baby due to extreme prematurity … this is not an intentional destruction of the life of the foetus'.

He lists the following rare complications when such intervention may be necessary:

1 Fulminating pre-eclampsia or eclampsia with liver or renal complications developing prior to viability
2 Invasive cancer of the cervix, uterus or ovaries
3 Ectopic pregnancy, occurring in the fallopian tube, the abdomen or the cervix uteri
4 Heart disease, specifically severe pulmonary hypertension.

Pre-eclampsia is a condition, which usually arises in late pregnancy, except in the case of molar pregnancy or occasionally twin pregnancy, and in my experience (apart from cases of molar pregnancy) the pregnancy can be carried on until the baby is viable ie has a reasonable chance of survival.

Invasive cancer of the reproductive organs, as with cancer of the breast, should be treated surgically or by chemotherapy irrespective of the effects of such treatment on the developing child.

Ectopic pregnancy arises because of disease in the fallopian tube and is usually treated surgically.

However, with pulmonary hypertension (including so-called Eisenmenger's syndrome), many authorities recommend termination of pregnancy in the early weeks of pregnancy (by abortion) because the maternal mortality following abortion is less than that where the pregnancy is allowed to continue.

Professor Bonnar is probably relying on the triennial report into maternal mortality in the United Kingdom *Why Mothers Die* (Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1994-1996).

Of eight maternal deaths (not seven as appears else-

where in the Report), four followed termination of pregnancy in the early weeks and four where pregnancy was allowed to continue. The Report states 'Termination of pregnancy is not without risk in patients with pulmonary hypertension'.

I can only conclude that it is in such a condition as pulmonary hypertension that Dr Bonnar feels that 'to protect the mothers's life the pregnancy has to be terminated.' Surely such a termination is a deliberated intentional act and constitutes abortion, as defined by the Medical Council or under any other definition.

A report in the *European Heart Journal* (16, 460-464, 1995) reviewed the outcome of 13 pregnancies in 12 women with Eisenmenger's syndrome from the Heart Institute of the University of Sao Paulo, Brazil.

Of the ten women who had had intensive prenatal, postnatal and intrapartum care in hospital, nine survived which bears out the advice in *Why Mothers Die* –'pulmonary hypertension is very dangerous during pregnancy and requires careful management … in specialist centres' as was the case in Brazil.

No mother should be denied necessary medical or surgical treatment during pregnancy, even if such treatment should endanger the life or health of her unborn child. However, termination of pregnancy does not constitute treatment.

I know of no condition where the life of a mother can be guaranteed only by aborting her unborn child.

MICHAEL SOLOMONS FRCPI, FRCOG
OBSTETRICIAN GYNAECOLOGIST, RETIRED
25 NOVEMBER 1999

As a retired consultant in gynaecology and obstetrics with over 45 years experience in Dublin teaching hospitals and private practice, the Green Paper on Abortion is timely and of great interest to me.

I would *oppose* options (i) to (vi) inclusive as unrealistic in the Ireland of today.

Option (vii) indicates understanding of the current problems associated with:

- irresponsible sexual activity
- inadequate sex education and family planning
- decision to travel to England to have an abortion.

I strongly *support* the subsections of Option (vii) with modifications/reservations as follows:

(a) Insert the adjective 'Major' before 'Risk' e.g. a few cases of life threatening cardiac disease and breast cancer; and of mental retardation requiring constant care, were referred to me with a strong recommendation to arrange abortion.
(b) Agree
(c) Additional wording to read ('Congenital Malformations') incompatible with an acceptable quality of life
(d) Disagree
(e) Disagree

I would like to congratulate the Committee on the time and energy expended in attempts to resolve such a troublesome problem.

Appendix III

Public Hearings on Abortion

Verbatim Transcripts (General)

Appendix III
PUBLIC HEARINGS ON ABORTION

VERBATIM TRANSCRIPTS (GENERAL)

WEDNESDAY, 17 MAY 2000, 11.00 AM
MEMBERS PRESENT:
DEPUTY B. DALY, T. ENRIGHT, S. KIRK, M. McGENNIS,
L. McMANUS, J. O'KEEFFE, SENATOR K. O'MEARA.

DEPUTY B. LENIHAN IN THE CHAIR

Dr T.K. Whitaker

Chairman: I welcome Dr T. K. Whitaker, who chaired the Constitution Review Group in 1995, to this meeting.

The format of this meeting is that you may make a very brief presentation if you wish, which will be followed by a question and answer session with the members. Your attention is drawn to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you.

Dr Whitaker made a submission on the Green Paper dated November 1999 and I propose to read out that submission for the purposes of the record of the committee:

> Abortion Submission on the Green Paper.
> 1. As Chairman of the Constitution Review Group I studied the abortion issue (Article 40.3.3) and subscribed to the section of our report 'Rights to Life (Unborn and Mother)' which is reproduced as Appendix 5 of the Green Paper on Abortion.
> 2. I admire the careful, comprehensive and balanced analysis in the Green Paper of the issue and the relevant options.
> My personal views below are not at variance with that analysis and are offered only by way of supplement or emphasis.
> 3. I am opposed to abortion but I am also opposed to waste of public energies and resources. Given that the freedom to have recourse to abortion elsewhere would continue, I would prefer to focus national resources on organised help for women in crisis pregnancies, help for them to bring their 'unwanted' children safely to birth and help for them to find foster or adoptive parents afterwards if necessary. I welcome the attention given to services for such women and to strategies to reduce recourse to abortion in Chapter 6 of the Green Paper.
> 4. Not surprisingly, experience has confirmed the impossibility of upholding equality of rights to life if and when they come into conflict. Most of us, I believe, favour priority for the mother's right when it is seriously endangered. It is not possible to accept the claim that abortion in the broad sense of termination of pregnancy is never necessary to save the life of the mother. Medical procedures which result in termination of pregnancy are regularly performed in the vital interests of mothers, e.g. in cases of cervical and womb cancer. For those who make this claim, abortion appears to be understood in the limited sense of termination of pregnancy otherwise than as an unavoidable consequence of medical action to save the life of the mother. The word abortion has not, as far as I know, been defined in legislation in that limited sense, nor is it so defined in any dictionaries I have consulted. That it still has a broad neutral sense is indicated by the proposal that it be qualified in any constitutional ban by the adjective 'induced'. The older term 'procurement of a miscarriage' appears to have had a similar breadth of meaning: what the 1861 Act prohibits is the unlawful procurement of a miscarriage, the inference being that procurement of a miscarriage could in some circumstances be lawful.
> 5. Allied to the presumption that abortion is to be understood in a restricted sense is a belief in the existence of a recognised and legally valid convention protecting necessary medical treatment of the mother even when it results in termination of her pregnancy. In the context of any constitutional ban on abortion, it would seem most advisable that the wording should make this protection legally explicit.
> 6. By the 1861 Act and the 1983 amendment of the Constitution, abortion is banned in Ireland, subject to the exception allowed by the X case decision, that is to say where there is grave danger to the life of the mother even if this, as with threatened suicide, may be a danger posed by herself. Most people would, I think, still want to give prior protection to the mother in a life-threatening situation, but many would not recognise suicide as such a situation. Suicidal dispositions can be feigned and in any case psychiatric illness tends to be less well understood than grave physical illness. The result is a confused and divided public opinion as shown by the 1992 referendum.
> 7. In essence, what the advocates of a new referendum desire is to annul the X case decision. Legislation is opposed on the supposition that it would extend from the particular to the general the application of that

decision and thus confirm the legality of abortion in Ireland where necessary to avert a real and substantial risk to the life of the mother. Generalising the effects of the X case decision does not, however, appear to be the only legislative option. It would seem that legislation could significantly restrict access to the X case authorisation, e.g. by requiring that a number of medical experts, including in threat of suicide cases at least two psychiatrists, certify that termination of the pregnancy is unavoidably associated with medical treatment or action necessary to protect the life of the mother. It could also provide for a delaying treatment and counselling course for a suicidal mother and it could confirm the legal protection for doctors mentioned earlier. The result would be both a substantial qualification of the effects of the X case and a reinstatement of the intent of the 1983 amendment of the Constitution.

8. If a referendum is decided upon, the wording will need the most careful consideration. There should be as few adjectives and adverbs as possible because their meaning is arguable – 'induced', 'indirect' and 'intentional' are examples. My own attempt at a formula is the following: 'It shall be unlawful to terminate or put at risk the life of the unborn except where this is unavoidably associated with medical treatment or action necessary to protect the life of the mother'. This formula would provide the desired protection for doctors. In any disputed case, it would be for medical experts to confirm that the terms 'unavoidably' and 'necessary' validly apply.

9. The question arises whether 'unborn' should be defined in the Constitution, or whether the Constitution should devolve expressly on the Oireachtas the power of definition. It is to be feared that either course would stir up contention, given the definitional difficulties and implications. 'Unborn' implies 'on the way to being born' or 'capable of being born': implantation might be thought to satisfy this condition more surely than conception. What of *in vitro* fertilisation? While the Oireachtas should not be paralysed by the difficulties, it should accept that its definitional efforts might not be conclusive – might have to be amended or extended later – and would be subject to judicial and even perhaps constitutional review.

Dr Whitaker, thank you very much for your submission. I read it so it is on the record and enjoys the absolute privilege which it deserves. I ask you to elaborate on that submission and then take questions from the Members, and also perhaps to look at the history of the matter from the point of view of the review group before the submission.

Dr T.K. Whitaker: Very good. Thank you, Chairman. In preparation for coming here I noted six points that perhaps might be coming under review. The first was confusion over the meaning and application of the term 'abortion' and the need for medical protection if abortion were prohibited. I add to that how inappropriate it might be to rely on medical ethics as such. That was my first point.

Deputy J. O'Keeffe: Appropriate or inappropriate?

Dr Whitaker: Inappropriate. The second point was how to deal with incest, rape and deformities. The third point was how to deal with the mother's suicidal disposition. The fourth was whether legislation could suffice. The fifth was, if a referendum is necessary, the possible wording. The sixth was the last question I touched on, the question of definitions.

Chairman, I am happy to say a few words on all these things if that would help. Could I start anyway with the confusion over the meaning of abortion? That came to light when in the constitutional review group we first began to examine the problem. I found that all my colleagues on that group became quite conscious of the confusion that was being caused by the use of different interpretations of the word 'abortion'. We were confronted by one slogan which was that abortion is never necessary to save the life of the mother, and this appeared to us to conflict with all the medical evidence of intervention by doctors to save or protect the life of the mother when there was an unavoidable consequence of termination of pregnancy.

The very word 'abortion' in the older sense was a very wide and neutral term meaning the premature expulsion of the foetus. Doctors – the GPs of my generation – were constantly using the term abortion, even to refer to miscarriages. So when you go back to the 1861 Act, as I said, you find that – surprisingly in an Act – they are using the term 'unlawful' which introduces an inevitable distinction between what is lawful and what is not lawful. What they described as unlawful was intervention to procure an abortion of a healthy infant before its term. We really have what I have described as an Alice in Wonderland situation where Humpty-Dumpty says the word means whatever I say it means.

I think the evidence I've seen .... Yesterday afternoon I was able to skim through the reports of the interviews you had with some of the medical experts and it's quite clear from that that there is a confusion which needs to be dealt with. In that connection there is also need, I think, for a clear protection for medical intervention to protect the life of the mother, even where it results in the termination of a pregnancy.

I mentioned ethics. At present the doctors are placing great reliance on conforming with the ethical guidelines laid down by the institute of gynaecology. That was the situation under the 1861 Act, both here and in England, but in England according as ideas about ethics evolved it became possible to have a situation where abortion or deliberate termination of a pregnancy was allowed even where the mother was in … there was no threat to her life, it was just a threat to her stability. I think, obviously, one could not rely entirely in any public policy aspect on medical ethical guidelines. It is up to the Houses of the Oireachtas to decide what under the law is permitted and what is not.

Would you like to pause there or should I keep going?

Chairman: No, I think that's the first point really.

Dr Whitaker: That's the first point.

Chairman: Continue on the other point.

Dr Whitaker: Okay, on the other point. The next one was how one might deal with incest and rape and deformities, these special cases. Incest and rape are particularly difficult issues, arousing much sympathy because of the absence of the mother's consent, indeed, the invasion of her body and her probable abhorrence

about being pregnant at all, especially with an unwanted child. However, having brooded over this, my view remains that the innocent life is entitled to protection but, on the other hand, that the State should be generous in the help offered to the mother during pregnancy and in providing for the care and upbringing of the child afterwards, whether by the mother, foster parents or adoptive parents. Unborn babies with spina bifida, for example, should be no less protected I feel than the children or adults who are their counterparts. In other words, if the unborn could lawfully be deprived of life why not the child or the adult suffering from the same disease?

On the question of what is called 'lethal deformities' one of them is anencephaly, which is a condition where there is no hope whatever of the infant, even it it's born, remaining alive and I find myself in a quandary about that situation where I might be induced to say yes, once that is clear, one could allow the termination of the pregnancy in that case but I remain somewhat doubtful about that. There are other cases like cystic fibrosis and so on where it may be fatal in the long term but there is a reasonable prospect of a span of life in which the brain would still be active and alert and I couldn't bring myself to agree to the termination of pregnancy in such cases.

If I move on then to the third point, how to deal with the mother's suicidal disposition. I have to start by admitting that lay persons tend to regard physical disease as in some sense more real or more understandable than mental illness. So, I'm immediately put on guard against a tendency to write off manic dispositions. I confess I wasn't aware until I read the medical submissions that pregnant women are even less disposed to suicide than other women or that, as somebody has said, suicides are as rare as 3% amongst them. I would have to qualify the interpretation of that by saying that it doesn't exclude the possibility that the 3% might be composed to a high degree of pregnant victims of rape or incest and behind all this there's the possibility of a suicidal tendency being feigned.

The way in which I would deal with this problem would be legislation to restrict the X case decision by imposing a requirement of a certificate of at least two specialist psychiatrists that a suicidal disposition was present, posing a real and imminent threat to the life of the mother, and that the disposition had persisted despite the mother having had expert counselling or therapy. I accept that a case in which such a certificate was forthcoming would still pose for many a dilemma of conscience. Can the loss of one life rather than two be accepted as the lesser of two evils? That's the conscientious dilemma. It might be some salve not to allow the abortion of a viable foetus in such cases, in other words, limiting the intervention to the first 14 weeks, but I am clear that in all other circumstances doctors should be expressly protected by law when termination of a pregnancy at any stage is unavoidably associated with treatment necessary to protect the life of the mother.

The fourth point is I'm asking the question whether amending legislation would be sufficient and it's clear from what the Chairman read out of my submission that I would prefer, if at all possible, to avoid the expenditure of public energy and resources on a referendum. The kind of legislation I would have in mind is restrictive legislation and it would say, first of all, where suicide is the threat to the mother's life, require that two specialists psychiatrists certify that the suicidal disposition is genuine and poses a substantial and imminent threat to her life, despite her having had expert counselling and therapy. That is not in proper legal terminology but the meaning of it I think is clear enough. The second paragraph would … even where such a certificate is given no termination to be allowed after the first 14 weeks of pregnancy. The third element in the restrictive legislation would be in all other cases of substantial threat to the mother's life, termination of pregnancy at any stage is lawful only if it is unavoidably associated with medical treatment or action necessary to protect the life of the mother.

It is arguable that provisions in law on these lines would be reconcilable with the Article 40.3.3 requirement that we respect and, as far as practicable, defend and vindicate the right to life of the unborn with due regard to the equal right to life of the mother. I say it's arguable – it's not for me to decide whether it could be substantively relied upon. Or is a referendum necessary, and possible wording, I have made a submission … I have included a formula in the submission I have made to the Select Committee and brooding over it since hasn't given me any greater enlightenment, so I had to leave it as it was.

As regards definitions, which is the final item, I expressed great caution about that controversial matter in the submission. Nevertheless, I do believe that the time has come to begin to attempt some definitions and I would favour doing this legislatively. I don't think the Constitution is the place for definitions, particularly definitions that must be tentative and be subject to review in the light of advances in science.

I think perhaps a start could be made with the term 'pregnancy'. That is what we are dealing with – termination of pregnancy. It is clear to everyone when it ends, but when does it begin? When does an unborn come into existence? Should there not logically be some clarity as to what we want to protect? Here endeth my comments.

Chairman: Dr Whitaker, thank you very much for your submission and for the clear amount of reflection you have given this topic. I have just one or two short questions I wanted to ask you, before I ask the members, in relation to one or two difficulties I see. First of all, on this whole question of medical certification, the evidence suggests that in our medical practice it is the clinical judgment of a doctor that is decisive. There are ethics committees in individual hospitals but the question of clinical judgment … a lot of importance is attached to that by our medical practitioners and those who are in the difficult position of having to make decisions in this area. It doesn't seem to be traditional in the experience of our medical profession to have some form of prior clearance or written authorisation of that type. I was wondering, could you comment on that?

Dr Whitaker: I am afraid the only comment I could make is that if that is so then what I am proposing, which I think is a reasonable proposal, would just shrivel up for lack of use. I certainly wouldn't abandon the need to require such a certificate before one did such a drastic thing as terminate a pregnancy, in the case of suicidal disposition.

Chairman: The other problem in relation to suicidal disposition was that Dr Sheehan suggested to us that no

reputable psychiatrist could put a procedure in place that would have predictive force on this issue. Dr Clare expressed the view – I want to summarise him fairly – I think he expressed the view that before the enactment of the 1967 Act in the United Kingdom the psychological ground was possible under a particular interpretation of the 1861 Act, and that the psychiatric profession were abused, essentially, in providing opinions to justify terminations which had no real foundation in the literature and reputable psychiatry.

Dr Whitaker: You see, the purpose of what I am suggesting is simply to put reasonable blocks in the way of easy resort to termination of a pregnancy where the suicidal disposition may be feigned, or where doctors may seriously doubt whether it would actually be put into effect. I am afraid I can't get away from the need for resort to the doctors, nor can I, of course, compel them to comply.

Chairman: Thank you very much. Senator O'Meara.

Senator O'Meara: Thank you, Chairman, and thank you, Dr Whitaker, for coming here today to speak to us on what is clearly – I think we know by now – a very difficult and complicated matter. I want to ask you one specific question in relation to your suggested wording, or your suggested formula, on the last page of your submission in which you say, or you propose, 'It shall be unlawful to terminate or put at risk the life of the unborn', etc. Can I ask you to clarify why you use the phrase 'or put at risk' there? It seems to me that could open an extremely broad vista whereby if the Constitution suggests that it would be unlawful to put at risk the life of the unborn, it raises a whole range of scenarios legally, I would have thought.

Dr Whitaker: It's in a negative context. I'm saying that it's unlawful to terminate or put at risk the life, except where this is unavoidably associated. So, putting at risk where it is associated with medical treatment would be covered and exempted by this. But I take your point about using the expression outside that saver clause, because I agree that 'put at risk' is capable of very wide interpretation, and perhaps one should qualify it and put 'at fatal risk' ....

Senator O'Meara: Fatal risk, yes.

Dr Whitaker: .... or some such term.

Senator O'Meara: Thank you.

Deputy J. O'Keeffe: Dr Whitaker, thank you very much for coming to us today and, indeed, may I compliment you on the clarity of your analysis, thought and presentation. Before we get into your six-point approach that you have used in your oral submission, am I right in thinking that your general view is that there is an air of unreality to the debate when we talk about constitutional amendments or, indeed, even legislative changes because of the practical situation that so many Irish girls and women – up to 6,000 a year – are now going to England for abortions?

Dr Whitaker: I am very conscious of that and I have to remind myself that, notwithstanding that, it is incumbent on us to put the law that applies in Ireland in whatever is the proper shape according to our own likes. But it sort of infects all our thinking, that there is an escape route. Even if we seem to be harsh or seem to be doing the right thing, it is always open to people to take a different route. What it would influence me towards, mostly, is not going to tremendously expensive or troublesome procedures here, because it is in a sense unnecessary gilding of our lily, and we have to remember that no matter what structure we set up here there is an escape route. I think that, nevertheless, our own structure should be what we want it to be in accordance with our own likes.

Deputy J. O'Keeffe: Following up that point, would I take it that if we had a lot of money to devote to the problem and if we want to expend a lot of energy in using it to best effect, that your approach would be, at least initially, to tackle the reality of the problem and, therefore, to spend the money and to expend the energies in programmes on ensuring that boys and girls receive education in relationships and on sexuality, that there is a proper approach in relation to the availability and distribution of contraception, in the areas of counselling – all these other non-constitutional and non-legislative areas? Would it be fair to say that you would think that there should be a major, primary focus on that area if we are genuinely to deal with the reality of the problem?

Dr Whitaker: Deputy, you expressed exactly what is my viewpoint on this. I think, since resources are not unlimited, we should be devoting them primarily to those purposes that you have just described. Therefore, I would, if at all possible, try to avoid having a referendum. If the legislative restrictions that I indicated stand up, I would be very happy not to have money or time spent on a referendum and more and more resources devoted to all the purposes. First of all, trying to ensure that there aren't unwanted pregnancies and then, if there are, that they are carried to completion with every help that the State can give and that the children of these pregnancies are helped to have good parents, whether their own mother or foster parents or adoptive parents. I entirely support, as I said, the views of your committee in the Green Paper on the services that should be available to cover those needs.

Deputy J. O'Keeffe: In relation to the question of a referendum and, after all, our starting point is that we are a committee on the Constitution, are you making it absolutely clear that you don't accept the simplistic slogan that it's never … that an abortion is … that it's not possible to accept the claim that abortion is never necessary to save the life of the mother? In your view, is it – and this is borne out by a lot of the medical evidence – that in fact in some circumstances abortion is necessary to save the life of the mother?

Dr Whitaker: Of course, as you know, I'm not a medical doctor ....

Deputy J. O'Keeffe: Yes.

Dr Whitaker: .... but I've searched all the evidence and it's quite clear to me that that statement that abortion is

never necessary to save the life of the mother is true only if you read abortion in a very limited sense, namely, abortion that is not medically necessary to protect the life of the mother. So it's a misleading statement to make that abortion is never necessary to save the life of the mother because it is.

Deputy J. O'Keeffe: It's misleading in your view?

Dr Whitaker: Yes.

Deputy J. O'Keeffe: Looking at the proposal that's presented to us, that we have a blanket prohibition on abortion in all circumstances, in your view that would put the life of the mother at risk?

Dr Whitaker: That would be an appalling mistake to make.

Deputy Kirk: Thanks, Chairman, and thanks to Dr Whitaker for coming into us today. In many ways he has replied to or dealt with some of the questions I had prepared in his submission. The definition of abortion, Dr Whitaker, you feel that it should be set down in legislation. Maybe I'm misreading what you said, but the question of doing it tentatively and also endeavouring to define when life begins, do you think that can be encompassed in legislation?

Dr Whitaker: I would draw a distinction between those two types of definition. I haven't suggested that 'abortion' as a term be defined in legislation. What I have suggested is that what the Constitution should prohibit, or law should prohibit, is the termination of a pregnancy otherwise than unavoidably associated with medical treatment to save the life of the mother. Implicit in that is the definition of what abortion is. It's doing a termination that hasn't that excuse, but I do think, coming to the pregnancy one, I'm just tentatively suggesting that perhaps we should start in legislation defining things, and the question of when pregnancy begins is something that is still up in the air. At some stage we will have to come to grips with that and that means deciding whether it's at the time of implantation or earlier.

Deputy Kirk: Medical ethics … you obviously looked at the medical ethics we have in Ireland and the medical ethics in the UK. There clearly is a difference between the code of ethics in both places. How relevant do you think that is to the debate on the issue?

Dr Whitaker: As I said earlier, I wouldn't be happy having the law of the country determined by reference to a medical ethics code because, first of all, the members of a Parliament don't have any say in what goes into that code but, secondly, it's something that can evolve over time in a way that might not meet with general public approbation, so I think what one should be relying on is not medical ethics but whatever clear prescription we make in our own laws.

Deputy McManus: First of all, Dr Whitaker, thank you very much for coming here this morning. I think it's been very informative. When we were given this task I felt it was a considerable task to achieve all-party consensus considering that, within most parties, there isn't consensus on this issue but I was interested that the review group was able to achieve consensus. Was that a difficult achievement or was it something that came relatively easily to you?

Dr Whitaker: I think Jim O'Donnell would confirm that we had more drafts of that particular thing before the group than any other.

Deputy McManus: Okay. In relation to the point ....

Dr Whitaker: Not necessarily because of diversity of view but because of the need to tease out all the rather difficult problems that we confront in relation to 40.3.3.

Deputy McManus: In relation to your position that you've put forward, which I take is your personal viewpoint in relation to abortion, many of the points that have been raised, or some of the points that have been raised by the medical presentations are ones that are outside the idea of the very simple clear-cut choice – a woman's life is at risk, therefore, her life must be saved. There are one or two others that I would ask you to respond to. For example, a cystic fibrosis case where, as I understood it, Dr Denham wasn't talking about simply the point that a woman was given a choice to have an abortion where her foetus was diagnosed with having cystic fibrosis. He was putting forward the case where it was a second pregnancy and where a second child would have an impact on the first child, particularly in terms of cross-infection, which were very likely to lead to a shortening of the life of the first child and that there was a major dilemma for the mother in those circumstances where, having delivered a second baby of this type, could have a very negative impact on the family but, in particular, on the first child.

The other case is the one of rape. Now I can respect your view but I have … I think these things are challenging to us. For example, if one's daughter is 12 years old, is savagely raped and becomes pregnant and is unable to travel, can we honestly say in those circumstances that one should not envisage abortion at the early stages as being an appropriate measure? Where a woman is pregnant with an anencephalic foetus, where pregnancy itself creates an additional danger for the woman in terms of her health because this is clear – you're safer if you're not pregnant, as a woman. There's no chance of the foetus surviving. I mean, there are moral dilemmas there that I would appreciate a response from you.

Dr Whitaker: In fact, I touched on these points already. For example, cystic fibrosis. As I understand it, from reading, fairly rapidly I must say, yesterday afternoon the medical submission, it's a case where there is some reasonable span of survival in prospect and also the brain is not affected, as I understood the situation and, therefore, you have children who are not, in any sense, lethally handicapped – well, not in the full sense lethally handicapped – and there is a dilemma, I admit, but my choice in the dilemma would be in favour of life for all those children, even a succession of children, admitting the risks that arise from having several affected children in the one family. I am most sympathetic but I feel I have to take the

moral line that such life as they have is something we should not deny them.

Deputy McManus: One last question ....

Dr Whitaker: On the other points you raised about rape ....

Deputy McManus: The same applies.

Dr Whitaker: My reply on rape and incest is that I would encourage as far as I possibly could, the carrying of the child to maturity and give every help. I would not allow termination in those cases here. I admit one has always in one's mind the possibility that the other choice is open and different; nevertheless, even if there was no other choice open, I would have to come down, perhaps rather harshly on the side of not allowing … in the cases of rape or incest.

Deputy McManus: That is certainly clear. Thank you. I want to put a couple of points I picked up and into one question. You set a limit of 14 weeks – I am curious in terms of where there might be a case for abortion. Maybe I will just raise the other two points so you can cover all them together, I am curious as to how you fixed on 14 weeks.

Dr Whitaker: I can tell you immediately. I did not invent it. I gathered from reading the medical stuff that was the time before a foetus became viable.

Deputy McManus: I see. Let us say the choice was made by the Government to go the route you are recommending, where you would have legislation restricting the conditions in terms of complying with the constitutional amendment? Do you think it serves a purpose to have that legislation put to the people?

Dr Whitaker: Yes. I forgot to mention that point. I am not sure, no matter how hard one tried, how well understood the situation might be. In the end it could amount to very much the same as a referendum if you have to give equal resources from the State for each side and you have to produce a whole lot. I would think – and this is a point I have made in relation to referendums generally – the procedure that is being gone through here is the proper procedure for dealing with all referendum issues, namely, that a joint committee would examine the issue – say it is a new treaty like the Maastricht Treaty – and would invite evidence from outsiders and representations from interested groups and would then make a report setting out what are the arguments. That report then could be – and should be – the only document released, or having to be released, from State sources to the public. Anybody else can, at their own expense, have propagandist documents but I think the State's obligation to inform the public on issues of public importance would be discharged by having a report of a joint committee that had examined itself, held evidence and come to a report.

Deputy McManus: There is a thought. I am sure somebody would object to that.

Chairman: What would be the prospect of me completing my mission here?

Deputy McGennis: I thank Dr Whitaker for coming in from his very busy retirement, to make time available to us. The point you made at the beginning was one that struck me, probably not the first day but the second day of hearings where you mentioned this Alice in Wonderland type scenario.

Dr Whitaker: Where Humpty Dumpty decides what the word means.

Deputy McGennis: Exactly. We were told with absolute conviction by several different doctors in different days that they knew precisely what was abortion and what was not and it is quite clear that it is not that clear, if you know what I mean. My question was a follow-on to Deputy Kirk's. It is just that you have stated, and I am glad you have made the point, that you would not favour an absolute constitutional ban and I am saying, because of the risks that it might pose to a mother's life, I think that is a very reasonable point.

Definition has been the problem – we had one, or at least I thought we had one problem in terms of defining abortion but you have actually posed another difficulty for us and that is defining unborn. If I understood what you said in response to Deputy Kirk it was that it might not be necessary to define abortion because if you went the route of constitutional referenda, the wording itself might explain what is your intention. But if you were to use the term 'unborn' at all in that, as you do in your own suggested wording, then you will have a need to define 'unborn'. You stated that certainly unborn should be defined legislatively and not within the context of the Constitution because of medical changes, technological changes. So, is it going to be possible to have a constitutional wording without having brought forward legislation which defines what is unborn and when pregnancy begins?

Just a quick follow-up point. You mention that there should be legislation and not ethics committees in hospitals deciding on procedures and I think we have references made in other hearings about the British system and how it became so liberal, and that was not intended at the beginning. Yet, the restriction you are suggesting is a restriction of the X case, you say that you would have two … at least you would have medical people and psychiatrists, etc., doing maybe precisely what happened in the British system in its inception. Would you be happy enough that that would not, in itself, lead to rubber stamping, to somebody saying, yes, we have a threat to suicide, and that means two psychiatrists and a medical person have to do this. Would you be confident that in fact it would not go the way of the British system?

Dr Whitaker: Your first point, Deputy, concerned the word unborn which, as you know, is in the Constitution since 1983 without any attempt to define, either in the Constitution or in legislation, what it really means. Perhaps people are happy to leave it in that state but I can anticipate, and I am sure members of the committee could anticipate, there being, at some time, the need to establish exactly what is an unborn. It is a very peculiar word

anyway. It is an adjective essentially rather than … you expect to find unborn human being or an unborn child. When that comes, are we expecting the courts to decide when a pregnancy begins? If the question of unlawful termination of a pregnancy ever arises it will have to be shown that there was a pregnancy to terminate – when did it begin? I feel that we might, if we are bold enough, anticipate that difficulty by attempting a definition in legislation.

You rightly say that I am not anxious to define the word abortion except inferentially by forbidding termination except in well defined circumstances where it is associated with medical treatment to protect the life of the mother. To define abortion would raise perhaps a whole host of difficulties we do not foresee at the moment because there is a wider interpretation allowed by all the dictionaries in English. We are not going to change all those by one sweep of our hand.

On the second question, which was were you introducing some kind of elasticity by requiring certificates from doctors given that they might be guided by their own ethics, one has to take a risk. All my instinct was to, as I said, provide a few hurdles that have to be legitimate hurdles to cross. If you find that the hurdles are knocked down or are useless, then you have to think again but, for the moment, I would have to go along with those.

Chairman: Are there any other questions? Deputy O'Keeffe? Deputy Enright?

Deputy Enright: Very briefly, again I'd like to be associated with everybody who's thanked you for attending this morning. Your views certainly are very worthwhile and we'd be very conscious of what you've stated in your direct evidence statement and what you've said also. I think the Minister for Health should have a close look at your views expressed in paragraph 3 because it is of importance that national resources would be focused on organised health for women in crisis pregnancies. I think that's very, very important and there should be an emphasis on that particular matter.

I heard what you said about, we'll say, mothers who are expecting children who are likely to have cystic fibrosis. After Dr Denham had spoken here, I took the opportunity of talking to some parents who have had children with cystic fibrosis and I also spoke to some of the people who actually are suffering cystic fibrosis and their views are similar to yours.

Dr Whitaker: They were happy to have the children.

Deputy Enright: They were happy to have the children and, even in the future, some of the young women I've spoken to feel they would prefer that the pregnancy would continue and the child be born, especially after our considerable advances in medical skills. The one thing is, you mentioned a foetus that would not be viable and suffering from some disease. I didn't quite get the….

Dr Whitaker: Inadequate brain.

Deputy Enright: Yes. You said you had some doubts about whether or not that pregnancy would terminate. The question posed by Deputy McManus to you about whether a girl of 12 or 13 years of age who was raped, supposing there is a girl of 12 or 13 who is actually raped, by somebody who is suffering from or who has a disease such as AIDS and it is likely that a child will be conceived through the rape and would have a disease, would you – and this is a difficult one – even in that instance, feel it should be allowed to proceed to full pregnancy?

Dr Whitaker: You're posing very harrowing instances to me.

Deputy Enright: It's a difficult situation but, I'll put it this way, rape is harrowing for everybody involved.

Dr Whitaker: I'm afraid that, however reluctantly, I'd have to stick to the principle that the little, innocent child, even if suffering from some disease, is entitled to life, entitled to be born and to take its chance.

Deputy Enright: Okay, that's answered my question.

Deputy Daly: Dr Whitaker put forward wording he feels would be appropriate if we decided to have a referendum. If it was to be decided that you would have a combination of legislation along the lines that you have been suggesting, which I take it is restricting the result of the X case decision, would you substantially change the wording of a referendum if, for instance, there was to be legislation along the lines you're suggesting and a constitutional referendum too?

Dr Whitaker: If there were legislation along the lines I'm suggesting, I would've thought it unnecessary to have a referendum. I was hoping that the legislation would suffice to deal with the outstanding issues. I wouldn't have a referendum.

Deputy Daly: You wouldn't see a situation where you might have a combination?

Dr Whitaker: I'm sorry?

Deputy Daly: You wouldn't see a situation where it might be necessary, even to allay some public anxiety, to have a referendum and legislation, a combination?

Dr Whitaker: I can see that there might be a case for allaying public anxiety. I wouldn't be enthusiastic myself about it but I can see that there might be a case. If there's a referendum undertaken, whatever wording is proposed should do the job. I'm not sure but I don't think I'd bother with legislation in those circumstances.

Deputy J. O'Keeffe: I've listened very carefully to your views, which I've always respected, Dr Whitaker. Could I put another possibility to you for consideration? It is essentially related to the possibility of a package which might involve the *status quo* plus a substantial package by way of support for the measure that you initially outlined from the point of view of the help for women in crisis pregnancies and proper education and counselling and so on.

Could I just sketch out a scenario and ask you to comment on it? It seems clear to me that there's no chance of

a consensus in relation to a new referendum. You're probably aware that this committee received about 100,000 cards or petitions ....

Dr Whitaker: Yes, I sympathise.

Deputy J. O'Keeffe: .... with a simple demand for an absolute ban on abortion. Now, that demand seems to be predicated on the proposition that the termination of a pregnancy is never necessary to protect the life of the mother. All the medical evidence … not all the medical evidence, but much of the medical evidence we're getting, and a lot of the objective comment we're getting, would seem to reject that simple proposition, unless one distorts the medical definition of what is an abortion. On the basis that there seems to be no consensus on the issue of a referendum, we then have to look at what we might do elsewhere.

If we take the one part of the package where I see a lot of support for this question of measures in the social context, from the point of view of education and so on, and if you take the other, you've raised the issue about the difficulties about definition, possibly then that we should tackle the question of putting into legislation a definition of when a pregnancy begins. Now, taking into account the fact that any limited theological reading of it does seem to suggest that that issue has been a cause of debate going back over many, many not years but centuries, if not millennia, and that we have a court system that essentially, at the end of the day, interprets and defines law, is there anything too far wrong with a package which would involve substantial support for crisis pregnancies coupled with the *status quo*? Would you like to comment?

Leaving the situation as it is, option number three in the Green Paper, which hasn't really been looked at to any great degree, and I was wondering … in the Green Paper there it says that retention of the *status quo* without legislation has the disadvantages that the courts would become the ordinary forum for resolving issues – definitions in other words. Is that not a function of the court anyway?

I merely put forward that package for your views on whether it would be an evasion of responsibility on the part of the Oireachtas or a possible solution to what is a knotty problem, particularly as it now presents itself and the reality is, as you said in your opening remarks, those who want an abortion will travel to England to have one.

Dr Whitaker: Frankly, I have to say I regard it as an evasion of responsibility. I don't think it would be acceptable to the public because it means leaving to the courts awkward decisions, like the X case, and the public in general were not too happy with the X case decision. I think the responsibility of the Parliament is to set the guidelines of law as clearly as they can and not to leave deliberately to the courts the settlement of a whole lot of obscurities.

As regards the particular thing we were talking about, the definition of pregnancy, of course I understand how that has been debated down the centuries. My instinct, frankly, would be to dodge it on this occasion because you have enough … we talk about going to the public or seeing what the public want, but the public are obviously in a state of great confusion. Its going to require an awful lot of effort if we go by the referendum route to make sure that the issues are fully understood. Therefore, I would not complicate them further at this time by introducing a new area of controversy about when pregnancy starts. I merely mention it here as something that will have to be addressed sooner or later and the proper way to do that is by legislation and not by leaving it to the courts. I don't think it would be acceptable now to leave things as they are, which was the question you put. I think people expect there to be some clarity, some proposals to emerge from this very careful study of the issue over several years. There would be grave, not only disappointment but a feeling of being let down by the legislators if they were unable to come up with a reasonable set of propositions.

Deputy J. O'Keeffe: You use the fact that the Supreme Court came to a view on the 1983 amendment in the X case. Do you accept that no matter what is put into the Constitution or the law, that if a dispute arises on interpretation, the Constitution provides that the dispute should be resolved in the Supreme Court? When there is a dispute on the effect of the Constitution, legislation or on definitions, the only route, as provided by our Constitution, is the courts and, ultimately, the Supreme Court. Irrespective of what is done, the courts have the last word on the interpretation of definition.

Dr Whitaker: I fully accept that but, equally, I would maintain that it is up to the Legislature to express very clearly and with every due regard to the possibilities of misinterpretation what it wants to be the law of the land. If the courts are in the ultimate position of deciding between disputing parties or disputing interpretations, but that does not … the first requirement is that the law be set out in its original form with the utmost clarity so as to avoid, in so far as is possible, recourse to the courts.

Deputy J. O'Keeffe: Would you say that even in a situation where we can get no evidence of a consensus on a basic definition of abortion? We have no agreement on it.

Dr Whitaker: Surely, you will accept that 160 Members of the Dáil and the 60 Members of the Seanad are in a better position to decide what the law should be and to arrive at a consensus than a haphazard group of five judges.

Deputy McManus: Hear, hear.

Deputy J. O'Keeffe: The point is well made.

Dr Whitaker: I may have expressed that in terms that might suggest lack of reverence for the Supreme Court. The proper approach is to leave as little as possible for resolution by the courts.

Chairman: Dr Whitaker, you have anticipated my final question to do with the five ladies and gentlemen who compose the Supreme Court. I do not have a difficulty with the general statement of law in the Supreme Court, which is that a real and substantial threat to the life of the mother is a justification for all necessary medical intervention. I have a considerable difficulty with the facts of the case because we have learned from medical evidence that the suicide risk is not postulated as a serious risk and

a procedure has not been advanced to us, as legislators, which would enable us to act on the strength of that. In the X case, the Supreme Court said the Legislature should address this question. In fact, that was one of the criticisms made by the late Mr Justice McCarthy in the X case. Does the Oireachtas not have some measure of discretion to determine what risks qualify for the purposes of the X case?

Dr Whitaker: The awkward fact is that the X case decision by the Supreme Court is now part of our law. In fact, there could be some doubt as to how far legislation can change that law. I am trying to keep within the bounds of accepting that that was the decision and then trying to make it difficult of access in the doubtful cases, in other words, in the suicide cases. The devices I am proposing are hurdles set up to be crossed to make for difficulty of access than in any way implicitly accepting that doctors can decide whether there is going to be a suicide or not. Psychiatrists are probably in a better position than anyone else to offer an opinion, but that is as far as it goes.

Deputy McManus: I hope I did not pick up the Chairman incorrectly, but notwithstanding what happened in the X case, I did not get from the medical evidence that, while it may be rare, that it isn't an issue on occasion – that there is such a thing as the possibility of suicide in pregnant women and that it is a real possibility even if it is rare.

Chairman: I did not get that impression from the evidence.

Deputy McManus: I have to disagree with the Chairman.

Deputy J. O'Keeffe: Was it not clear that there is a reduced risk?

Deputy McManus: Yes. It is clear that there is a reduced risk in pregnant women of carrying out a suicide but it was also clear to me that one cannot say there is no risk. That is an important difference. We are clearly talking about very rare occasions but it must be recognised that such a thing is possible and has happened. The likelihood is that part of the reason there has been a reduction in suicide among pregnant women is because they can travel to England to have an abortion. That is my opinion. In terms of the medical opinion, we cannot presume there is no such thing as the possibility of suicide.

Chairman: We cannot presume there is no possibility of suicide in any person. I would not dispute that. I asked Dr Sheehan on this issue and he said there is no procedure in the literature which would establish or demonstrate the risk of suicide in the case of a pregnant woman. There is no test or, in a sense, there is no fail-safe way of saying the person will or will not commit suicide. It does not exist. That is the issue I am exploring with Dr Whitaker. How can we ....

Deputy McManus: Sorry Chairman, I do not want a dispute and I have no dispute, I just want to put my own position. Just because the medical profession is unable to develop – and we all know psychiatry is in a very primitive stage – a fail-safe method does not mean that it does not recognise there is a risk, in the same way as doctors have come here and said even with physical illness – even in the case of Eisenmenger's – they cannot say 100%, 'This woman will die if we don't carry out an abortion.' It is a medical judgment.

Dr Whitaker: I mentioned earlier … I picked up somewhere in my reading of medical evidence that the risk was very, very small amongst pregnant women … of suicide – it might be as low as 3%. Three per cent was mentioned by somebody. The point I made was that one has to ask oneself in the case not just of pregnant women generally but women who are pregnant and victims of rape or incest, what is the risk? They might figure largely in constituting that 3%. That is the point I am making. I wouldn't get the impression that it has been ruled out completely; it's very rare, but as I rate the thing … it's not impossible of course, but it should be perhaps evident in a particularly severe case that there was a serious likelihood of suicide.

Chairman: But the psychiatric evidence I and we heard was that there is no demonstrable procedure available to psychiatry to establish that.

Dr Whitaker: I do not think the particular question was put in the case of women who are pregnant and who are victims of rape or incest, what is the risk.

Chairman: I put that question to the witnesses and there was same conclusion.

Deputy McManus: I think you will recall that Dr Clare did make the point that even when there is an absence in terms of absolute clarity or knowledge, that psychiatrists have to do the best they can and often they are wrong in terms generally of saying, 'This person is suicidal or not' but no doctor I am aware of came here and said, 'There is no risk to pregnant women ever of suicide.'

Chairman: No doctor could say that. I accept that.

Deputy McManus: Right. We have to accept that.

Dr Whitaker: Equally, Chairman, it's not possible to eliminate the factor of the X case because the referendum that attempted to do that was squashed, so we're stuck with it, whatever it means.

Deputy McManus: Exactly. The people have spoken.

Chairman: Thank you, Dr Whitaker, for your very interesting reflections on this subject.

Dr Whitaker: Thank you. I wish you well.

SITTING SUSPENDED AT 12.23 PM AND RESUMED AT 12.30 PM.

Mr Peter Emerson, Mr Phil Kearney, Dr Sieneke Hakvoort and Mr John Baker

Chairman: I would like to welcome Mr Peter Emerson, Mr Phil Kearney, Dr Sieneke Hakvoort and Mr John Baker to this meeting of the Joint Committee on the Constitution. The format of this meeting is that you may make a presentation which will be followed by a question and answer session with the Chairman. Your attention is drawn to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you. I take it you have nominated a spokesperson for the purpose of this hearing or do you wish to participate generally?

Just to focus the mind, we are considering the question of abortion and I see in your submission you've outlined the manner in which a preferential voting system could be applied on this question. Introduction of that system would in itself require an amendment to the Constitution, unless a non-binding referendum was adopted.

Who would like to elaborate on the submission?

Mr Phil Kearney: To begin I will introduce members of this delegation and each of us will speak briefly. My name is Philip Kearney. I am a member of the committee of de Borda. To my left is Dr Sieneke Hakvoort who is a public health doctor, Tom Baker is a member of the faculty of politics in UCD and Mr Peter Emerson is the director of the de Borda Institute.

We are here to make a submission on the methodology of decision making. We are neutral on the substantive issue of abortion and we assume we have been invited to make this submission because of the presentations we have made to the committee before in the area of decision making.

Our recommendation is that if there is a referendum on the topic of abortion it should be preceded by a non-binding multi-option vote in which all the preferences are counted. In the longer term we would, of course, seek to change the Constitution to cater for binding multi-option preference voting. Our presentation will be divided into that question of using a multi-option vote – Mr Baker will address that; Dr Hakvoort will address the idea of all preferences being counted and Mr Emerson will give our conclusions.

Chairman: That is all clear in your submission – I mean your submission is taken as read.

Mr Kearney: Okay, this is a revision and summary that we are about to give.

Chairman: But how long will it last?

Mr Kearney: Five minutes.

Chairman: Perfect.

Mr Tom Baker: What we have put forward are the main reasons a multi-option vote in advance of a referendum would be a good idea. The first is that each of the proponents of each significant position would be able to put their views before the public so no one would feel their views hadn't been given a proper hearing. Second, this would make effective participation for all concerned because it's a complex one – there are a number of reasonable positions and it allows each position to be heard. Third, the final agenda for a binding referendum would be decided by all the people in a multi-option preferendum. Finally, and this I think is a very important point from the point of view of the committee as a whole, in a multi-option preferendum the winning option would be a moderate option that represents the centre of Irish public opinion as a whole. So that would greatly enhance the status of any final referendum result.

What we've argued is that it's important that in a multi-option referendum there should be a proper procedure because if you have a spread of options ranging from, say, the most conservative to the most liberal – say five options – the first preference, the support for each of those options, could be fairly evenly spread among those five options. If the winner were decided simply by plurality then you could easily have a position at the end of the spectrum being endorsed. That's why we think it's important to have the right methodology for deciding a multi-option preferendum.

Dr Sieneke Hakvoort: It is important that all preferences are counted. Suppose we ask what the voters' full set of preferences are among the five options in the example. We set out a simplified but plausible answer with nearly equal division of the first preferences amongst the five options. You can see from the table that if option A is put up for ratification in a referendum it would be defeated because 59% of the population prefer the *status quo* which would, in our example, be option C. The same 59% prefer D to A as well, or even E to A. Another method of counting preferences is one we are all familiar with, namely, PRSTV and there are problems with that because if you look at how an STV count would proceed under the same assumptive vote we see that the result would be not really satisfactory. So you can see in the first count D is eliminated and the votes go to E – E is the second preference of the D voters. In the third count B is eliminated – votes go to A. In the fourth count C is eliminated and all those votes go to E. It should be noted that the third preference of anybody is not counted, so it's the fourth preference of only a small part of the voters who decides the outcome.

Chairman: Is this document among the papers you've submitted to us?

Dr Hakvoort: Yes.

Chairman: Because to produce it in the transcript it is necessary ....

Mr Kearney: We are aware of that and we will also provide it on disc.

Chairman: Very good.

Dr Hakvoort: This count procedure results in one or either end of this spectrum being endorsed and what we're looking for is the common ground and the count we're proposing – the de Borda count or the Condorcet count – will come up with option C which as you can see is neither the fifth nor the fourth preference of anybody, but the first or third preference of the whole electorate in this example. So it will form an option that is more likely to be acceptable to everyone. That's all I'm going to say.

Mr Peter Emerson: The important thing, even on a multi-optional basis, is to try to identify the best possible option .... It is … sorry I've got a little bit more here ....

Chairman: Will we turn that off or is there more?

Mr Emerson: It's very important and there you'll see that if you do have the different voting systems you do actually get ....

Chairman: I'm not sure you can be heard ....

Mr Emerson: Sorry, if you do use different systems then you are likely to get different answers and we are trying to suggest that a democracy should look very closely at the different methodologies and that there are a number that do exist. Therefore, some are more democratic and some are less. Given the very divisive nature of this topic and also of the divorce issue, for example, we think it might be a good idea to heal the wounds in society, to have a non-binding, multi-option vote even if you do not have a referendum, even only as a guideline for the Legislature to do whatever it then decides. We feel that such a process might be a healing process.

We also note, as we said in our earlier submission, that multi-option voting has been used in other countries, and always successfully by the way. Even though they didn't use preference voting we think for this particular issue because it is so divisive in many ways that it would be advisable to use the preference voting and we're asking Ireland to take a first step.

Chairman: Yes, just one or two questions arising from that. You're finished your submission, are you?

Mr Emerson: Yes.

Chairman: When you say preference voting, I had understood the presentation was that the simple transferable preferential system was not desirable, that the transferable preference should not be used in this exercise.

Dr Hakvoort: Yes, but we are talking about ....

Chairman: Just focusing on this issue of abortion. That's what we're talking about here.

Dr Hakvoort: That's right.

Chairman: Your submission is that we should not use that system.

Dr Hakvoort: That's right. We're talking about a specific form of multi-option preference voting where all the preferences of all voters are counted ....

Chairman: Yes.

Dr Hakvoort: .... namely the de Borda or an alternative would be the Condorcet count but ....

Chairman: You must understand that the voting by preference is so well established in our political culture that when people talk of preferential voting they think of transferable preferences and that's not what you're proposing in terms of a referendum. Isn't that correct?

Mr Emerson: For the voter it is very similar because the voter will go through the process of saying 'This is my preference, this is my second and this is my third' and we also, as outlined in our earlier submission, spoke about partial voting. Some will be prepared to go down the whole list and some most definitely will not ....

Chairman: But the counting system is not the same. Isn't that the point? The weight that's attached to each vote varies depending on whether you use one of these other systems.

Mr Emerson: The point being that as cynical as saying that in a single transferable vote the count looks at some of the preferences cast by some of the voters. When you move into de Borda or Condorcet you're looking at all preferences cast by all voters.

Chairman: I'm familiar with the literature on this subject. I know what it means. I just want to clarify for the record what exactly you're proposing, that it's a non-binding, multi-option referendum in which the voter would express a preference for various defined options in relation to the abortion question. Once ....

Mr Emerson: Yes, a number of preferences.

Chairman: A number of preferences. Once those votes were cast and collected they would then be counted in accordance with a scheme which assigned a particular weight to each preference. Isn't that correct?

Mr Emerson: Yes, although the weighting is in direct proportion. I mean if it's five options then it's five, four, three, two, one. We're not fiddling with the weighting system. It is a straight ratio in the de Borda count.

Chairman: Yes, but assuming your first preference at unity, a fraction is then assigned to the remaining preferences. Isn't that the position?

Mr Emerson: What we're saying .... Yes in effect but with the … that in a partial vote if you only vote for one option you only exercise one point.

Chairman: Can you plump in this referendum, to use

the language of political culture here, can you just express a No. 1?

Dr Hakvoort: Yes.

Mr Emerson: If you want to, yes, but the influence you will have will then be reduced. If you participate fully in the democratic process you will have full influence. If you want your option to get all five points then you should express all your preferences. So this system encourages the voter to express all the preferences or at least some.

Chairman: But in the counting of the votes .... If you simply cast one vote, a No. 1 and a large number of other citizens do the same does that not give that particular option an advantage because the total number of votes has also been depleted?

Mr Emerson: Essentially, it's a disadvantage. We do have literature on this because it means in effect that one option only gets one point and you're saying zero, zero, zero, zero about the other options.

Chairman: Yes.

Mr Emerson: If you want to .... If you're voting for A, for example, you would presumably prefer B to E or to C or D or whatever.

Chairman: One of the problems in this question is that a lot of people who believe in A don't see B, C, D and E as acceptable at all.

Mr Emerson: Indeed

Chairman: So if they're going to vote in that way could you translate what that will mean in practical terms?

Mr Emerson: Yes, it means the chances of their option coming out as the most favoured option for society as a whole will be to a certain extent reduced.

Chairman: How does the counting process produce that result?

Mr Emerson: The counting is quite simple because on the de Borda side it is a five, four, three, two, one and the outcome will be the highest number of points, so obviously the success of your particular favourite will be increased if you're able to give it five. I accept that the difference between five and four is only one point and the difference between one and nought is only one point, so you could say that the influence is still being fair and to the person who does want option A then they're not being put at any unfair democratic disadvantage by this process but it does mean – do you accept my point – that as far as the other options are concerned that they will have less influence on that side of things but that is their prerogative. This system doesn't force a person to express all their preferences but it does encourage.

Chairman: Yes, what you're saying is that those who vote then for options B to E under your system, they have four votes, three votes, two votes and one vote on every valid ballot that's completed so those who choose only to exercise one preference are in effect only casting five out a total potential pool of 15 is it?

Mr Emerson: That's right.

Chairman: That's right, so they're only exercising five of the 15 votes available to them. Isn't that what you're saying?

Dr Hakvoort: Only one of the 15.

Mr Emerson: No.

Chairman: Can we first assign a scale to this? Would it be an acceptable procedure under your system to have five for the first preference, four for the second preference, three for the third preference, two for the fourth preference and one for the fifth preference?

Mr Baker: That's the basic procedure.

Chairman: How many votes is that in total? Fifteen, isn't that correct?

Mr Baker: Okay, yes, 15 points

Chairman: Fifteen votes?

Mr Baker: Fifteen points, but this issue that arises in the literature on this has to do with the question of what .... The question you're raising has to do with the issue of whether somebody only voted for one option out of the five options and the procedure that we propose in that case is not that because it's their first option it gets five points but because it's their lowest option it gets one point. In other words, you take all the options that a person has indicated a preference for, you give the lowest option they've indicated a preference for one point, the next lowest two and so on up to as far as five if they've indicated five options.

Chairman: But for those who only express one point of view only get one fifteenth of a vote.

Mr Baker: That's right, yes.

Mr Emerson: What was that? No, it's one point. It is still a vote

Chairman: Yes, but they lose a great deal of their weight in the entire system.

Mr Emerson: And if you look at the STV count there are some people there who have no influence on the result at all ....

Chairman: I know that.

Mr Emerson: .... because at the end of the day they get eliminated.

Chairman: There's the unexhausted quota in our electoral system, there's a certain number of votes that are not distributed at any stage. In a three seater it's at its highest, it's lower in a four seater and lowest in a five seater in

parliamentary elections, and in a local election with a nine seater it's very low. Haven't you now identified the cardinal defect of your system in the context of the current debate about abortion, that those who've a strong view on the issue are compelled to acquiesce in a strong philosophical view which they don't accept?

Mr Emerson: There is no compulsion at all. It is a democratic process and the voter can vote as he or she wishes.

Chairman: Sorry, you must identify yourself for the reporter before you speak. Each person must identify themselves.

Mr Emerson: Sorry, Peter Emerson. There is no compulsion at all. But consider, if you would, the opposite, almost as if the arguments that you are suggesting … that the person who votes for only one option, then exercises five points. If that was the case, the person who wanted A to win and who was worried about E winning instead, okay, gives his or her five points to option A and has a five point advantage over all the other ones. Now that system would actually encourage persons not to go down the whole list. What we are trying to do is to argue … is to encourage voters to participate in the democratic process fully.

We do all have second preferences, or most of us do. We are also using a process, we are trying to identify that option which is most suitable for society as a whole. We are not talking about a win or lose, we are not talking about a confrontational process. We are trying to find that compromise which is best for Irish society. In doing that, it is obviously advisable if each individual expresses their compromise option.

Now some will not be prepared to do that. We accept that but here is a methodology which encourages people to express a compromise option and then, by collating all the compromise positions of every single voter, it is possible mathematically in the process of the count to identify that option which is the best compromise for Irish society as a whole. But that only works on the basis of … if you exercise … if you vote for one option it is one point, if you vote for two options it is two and one, if you vote for three options it's three and two and one. If you vote for one option only you are actually saying nothing about the other options. You are saying something – singular, one point – about one option and nothing about the others – zero, zero, zero. But it still gives that one point advantage over your second preference and if that is the way you want, that is exactly what the person who is voting fully also gets.

Chairman: So if you were representing one of the strong partisan sides in this debate, you would urge as a matter of tactical voting that, having voted for your first preference, you then express your other preferences in the descending levels of closeness to your basis position. In other words, if you were totally opposed to abortion in all circumstances you would cast that as your number one, and you would then go through the various liberal options as two, three, four, five, ending up with the right of choice. Or, if you started off with the right of the woman to choose, you would go in the opposite direction, ending with number five of the absolute ban. That would be your advice to the tactical voter, if you like, if you were asked to advise the tactical voter on how to use this system?

Dr Hakvoort: Yes. You could call it tactical or it could be an accurate expression of your preferences.

Chairman: If you could identify yourself.

Dr Hakvoort: Sieneke Hakvoort. You could call it tactical voting or it could also be just an accurate reflection of that person's preferences.

Chairman: But what about those who would object to this procedure on conscientious grounds and say that they were, in effect, being compelled to cast preferences for options which they could not in conscious contemplate in any circumstances?

Mr Baker: There are basically two live methods for a fair way of counting all the votes in a preferendum. The one that we've been concentrating on and the one that we have been recommending is the De Borda count system, which is the one we have been subjecting to critical scrutiny. There are issues around that, though we think there are good answers to those issues. The other form of voting that the committee could consider is what is called the Condorcet system where each pair of options is compared in terms of whether there is a majority in favour of one option over the other. That option which has a majority over all the other options is deemed the winner of the vote.

In our view, it is likely that the Condorcet system and the De Borda system have the same result. But if the committee were particularly concerned about the problem that you are raising – that there is an incentive under the De Borda system for people to indicate preferences for options that they are conscientiously opposed to – then they could consider using the Condorcet count as an alternative way of counting which does not require … does not give the individual voter an incentive to vote for options that they are conscientiously opposed to at all. It simply counts their vote as ahead of every other option, if they go for one. It treats them as not having taken a stand on the comparison of two options for which they have cast no vote whatsoever. So, there is a technical alternative to the De Borda count that would deal with your objection if you wanted to proceed that way.

Chairman: But isn't there a philosophical problem here – that the question you ask is the question that is answered and who decides what questions are asked under this system? Someone has to make a decision on the range of questions and that decision in itself prejudges the answers, doesn't it?

Mr Baker: Can I just respond quickly to that? It's of course the job of the Oireachtas to put before the people a proposal, or a set of proposals, or possible proposals for deliberation. We couldn't possibly expect anyone else to take that responsibility. In an ordinary referendum the Oireachtas puts before the people a single proposal and takes responsibility for that proposal and the people then judge it. In a multi-option referendum the Oireachtas puts

before the people a range of proposals. They have to be satisfied that each of those proposals is a reasonable proposal, something that it would make sense to build into Irish law, but then give the people a wider range of choice in deciding which of those proposals would be the right one to build into Irish law.

Mr Emerson: Can I just come back to the earlier question and consider that if you had a plurality vote only on the five options – a, b, c, d, e – with only the voter allowed one preference, and if the opinion polls were saying it looks as if it is going to be 20, 19, 20, 18, 21, people would be in a terrible quandary as to which one to actually vote for. We see this in English general elections and so on, with all sorts of tactical voting. Once you move into preference voting you are actually using a system which is much more likely to enable the voter to express what is called a sincere opinion – to vote as he or she would like … would really want to, as opposed to having to take tactical considerations into account.

Chairman: You accept that this is a difficult issue for your system as well because of the very sharp philosophical disagreement that exists between the different points of view on it?

Mr Emerson: Yes. We fully accept the complications. We also feel that it would be even more dangerous to have a yes-no on just one option, that that would lead to much more discontent in society. By using this more inclusive multi-option procedure then you are much more likely to encourage – as we say in this submission – the idea that it is the people themselves who are helping to determine the final outcome and that people can participate in this because the IFPA have had their point of view taken into consideration and Professor Binchy has had his point of view taken into consideration and so on. It is much more inclusive methodology.

Chairman: But isn't the multi-option procedure, in a way, a variant of what we do as parliamentarians? Because there is a more engaged deliberative process we discuss, say in the present context, different options, we weigh them up, we try and see the merits and demerits of them and come to a balanced conclusion. That is the way you adopt legislation, whereas, as you say, in a referendum under our present procedure it is a direct yes or no answer to a particular proposal.

Mr Kearney: It is entirely consistent with the methodology that has been adopted by this committee and in the publication of the Green Paper. It has been as comprehensive a scan of the options as, possibly, has ever been undertaken. What we are proposing to you is you continue that inclusive approach by using an inclusive decision-making process, rather than reverting to a divisive and adversarial decison-making which will take us straight back to 1983. You have the opportunity to propose an entirely new method which … we hear from the reports of the submissions to this committee there is not the same tone of adverseness there is not the same contention. Maybe it is there under the surface but I understand there is more flexibility in the reports that I have been reading and in our consultations with the various organisations involved. Perhaps Irish society is ready for a more inclusive form of decision making on this issue.

Mr Emerson: Might we also suggest that even when debating this issue in the Dáil that you consider the prospect of using a multi-option vote in Dáil Éireann for resolving what is the best option, or the best options, on this policy matter?

Chairman: Given the difficulty of this issue, for us to propose a novel form of voting on it would be very difficult. I noticed in your literature you referred to the temperance question and restrictions on alcohol, and I think this method was used in a referendum in New Zealand ....

Mr Emerson: In Australia and Finland.

Chairman: .... in Australia and Finland on that question.

Mr Emerson: Yes.

Chairman: Haven't we enough difficulties with this question without introducing, trying to explain this new procedure to the people to resolve our difficulties on it? That's just a practical political point.

Mr Baker: I think practical political considerations are very much apropos. The procedure that you're currently likely to follow is precisely that, following great deliberation at the level of the Oireachtas, some compromise position is arrived at that has a large amount of support and if that requires a constitutional amendment, then that proposal would be put before the people.

The main practical political difficulty involved in that is that since that likely outcome is going to be in the middle of the spectrum, various groups at both ends of the spectrum will claim that they never had the opportunity to put their point of view to the people and that had they had the opportunity, it would have won or whatever. Now, this procedure allows you to put those points of view before the people and, since the spectrum of public opinion is a spectrum and there is a middle ground, the high likelihood is that once you put that number of options before the people, the outcome will be in the middle ground, but instead of being in a situation where you're accused, as politicians, of never having allowed the people at either end of the spectrum to put their point of view before the people, you have a procedure which allows you to put it before the people and if the people decide to endorse that by an overwhelming majority, well then you've called it wrong and your middle position was never the consensus, but the likelihood is that the preferendum will identify that consensus and yet all sides can be satisfied that their position did get a fair hearing and was put before the people. That's the beauty of the system.

Deputy McManus: As a politician I would have to maybe explain a little bit of what a politician does. You're presuming that what we are doing is trying to see – whatever the people want, we will deliver but of course that cuts out of the equation the idea that one has convictions oneself. There are clearly politicians in Dáil Éireann who may feel that they could not possibly put

forward the option of, you know, abortion on demand, and I could respect that. Equally, I could not agree to put forward an option to the Irish people which would endanger women's lives because of my conviction, and I would have a moral objection to putting forward that option. Now what you're saying is all these options should go out and if at the end of the day the people decide that women's lives should be endangered, that I as a politician must accept that. Now I can't actually feel that I'm an objective bystander. I'm not a facilitator without having a viewpoint which presumably enough people agreed with because they put me in this job. I just think that, you know, your perspective is rather different to the perspective of somebody who is having to make decisions and choices, guided by one's own convictions.

Mr Emerson: I think one has to, as all politicians, not necessarily agree with somebody else's point of view but to allow them to express that point of view nevertheless, and if you believe that democracy is a means by which we try and identify that option which is best for society as a whole, then your job, if you like, is to make sure that your option is actually there as one of the options and that you are advocating an inclusive system.

Now also, as part of our literature, we have often spoken about the need for all options to comply with human rights legislation and, as you may know, this whole methodology has been tested up North on quite a number of occasions with delegates of Sinn Féin, Ulster Unionists and so on, and we have never allowed total repatriation of Protestants or anything like that; that just is not on. Now I agree that when we come to this particular issue we are talking about human rights themselves, and it is as if we are in a learning process where, as a society, we haven't yet identified what is and what is not appropriate to human rights legislation but I think we also accept that it's not right for some people to impose their – what they consider to be their moral views upon others, and the idea of a majority being able to impose – ban fox hunting and ban this and ban that is a very primitive interpretation of democracy.

If we accept for the moment that we are looking for the consensus, that we do, in asking the Oireachtas to draw up the list of options, that they are drawing up a list of reasonable options which they consider do comply, and there are some things that will not be acceptable at all, but once you have decided that certain viewpoints are applicable, I think it is then fair to suggest that society as a whole should be asked, as I said earlier, to heal the divisions in society on this very sensitive issue.

Chairman: Suppose we came to the view that there were only two options that were in the realm of the politically realistic on this option. That is quite a possible conclusion, I think, on the evidence we've heard, that there are only two options available to us, and I'm not saying exactly what they are at this stage, but let's assume there are only two options possible that command some kind of political support on a reflective basis within the community. Can we put two options to the people rather than one?

Mr Emerson: As you know the Green Paper has already suggested that there are several with, as we said in our paper, one or two variations on one or two of those themes anyway. At the moment it is a multi-optional debate. If you decide that the society is only to be given two options, I think you have made a decision which is in disagreement with the authors of the Green Paper and I think if you want to keep it as a multi-optional debate, then it is in your remit.

Chairman: You see, the author of the Green Paper wasn't elected to any Parliament. We are and, I suppose, having heard all the evidence we decide that on that evidence and on our own political and philosophical convictions, there are really only two reasonable approaches that are possible. I'm not going to categorise certain positions as unreasonable at this stage but let's assume that that's the conclusion we arrive at, having heard all these doctors and tried to assess it with people like yourselves and others who've strong views on this question. Suppose we come to that point of view – there's only two options really here. I'm not saying whether they're constitutional or legislative, just two options. Can we have an unbinding referendum on those two options? What's objectionable about that?

Mr Baker: My own view would be that if you came to the conclusion that there were only two reasonable options, that you should go ahead and have a non-binding referendum on the two reasonable options. I don't think .... Of course, one question that will arise is whether one of the two reasonable options consists of the *status quo* or not and that would raise further technical problems about whether there were effectively three options, namely, the two you consider reasonable plus the one that we've got, in which case you've got a three option situation in effect.

I take Deputy McManus's point that it is the job of anyone who draws up the agenda for a referendum to put before the people only what are reasonable options. As it happens, it seems to us implausible that there are only two reasonable positions to take on the issue of abortion. But if you were to decide after all your deliberations that there are only two, I personally could not see that we can say add in another few options just for the heck of it.

Chairman: That is the point. If we have a referendum at present, we have one option and you can either accept it or reject it. Were we to take the view there were two options, how do we count the votes? We would have to say the option which commended more support was the acceptable option, isn't that really the position? I am not trying to persuade you to renounce your entire system, I am just exploring what occurs to me to be an interesting point.

Mr Emerson: As Phil was saying, we do at the moment have in Irish society an inclusive debate because so many options are on the agenda and in the full procedure, we would advocate that you would try to include as many as you feel you can. I know that begs the question that Deputy McManus was just raising but in the full methodology of this sort of preference voting, one goes through the debate, one allows all options which do not infringe human rights legislation to be on the table, you have the debate, the all-party Oireachtas committee or the Oireachtas itself or whatever draws up the options and

perhaps there are only going to be two of them but then goes back to those people who have been participants in the debate and ask 'do you feel that your option is here and represented'? I think at that stage you would find that you would be moving back to three and four, I suspect on this particular issue.

Chairman: You can see why I raised it in the context of this issue.
Mr Emerson: Yes

Chairman: But even that procedure, of course, of having two options is preferable to one option. In a way, this is an issue which does only lend itself to two options, reasonably put. That is the philosophical problem with it. Do you follow?

Dr Hakvoort: I follow it, yes.

Chairman: It is not like temperance hours where you say, well the pubs should be shut at 10, 11, 12 or 1 o'clock. It is a little bit different from that, isn't it?

Dr Hakvoort: But the fewer the options and two, in the campaign leading up to the referendum, cause a division by its nature, I think which in itself will have an influence on the voting and will be detrimental to the process of eliciting the common ground and the option that's ....

Chairman: Of course in the context of the philosophy of your system but it's still better than only one, you'd accept that.

Dr Hakvoort: Yes, I agree with you.

Chairman: Thank you very much for your assistance and certainly I benefited a lot from our discussion.

There being no other business, the committee will adjourn until Tuesday, 23 May at 11.30 a.m.

THE JOINT COMMITTEE ADJOURNED AT 1.14 PM UNTIL 11.30 AM ON TUESDAY, 23 MAY 2000.

TUESDAY, 23 MAY 2000, 11.30 AM.
MEMBERS PRESENT:
DEPUTY B. DALY, M. McGENNIS, L. McMANUS, J. O'KEEFFE, SENATOR D. O'DONOVAN, F. O'DOWD.

DEPUTY B. LENIHAN IN THE CHAIR.

THE COMMITTEE WENT INTO PRIVATE SESSION AT 11.35 AM

Professor Patricia Casey and Ms Breda O'Brien

Chairman: We are now in public session. I would like to welcome Professor Patricia Casey and Ms Breda O'Brien to this meeting of the Joint Committee on the Constitution. We've received your presentation which has been circulated to the members. It is our intention to lay it before the Houses at a subsequent meeting. The format of this meeting is that you may make a very brief opening statement, if you wish, which will be followed by a question and answer session with the members. I want to draw your attention to the fact that while members of the committee have absolute privilege, this same privilege does not apply to you.

I'd like to welcome both of you for the interest you've shown in this subject and for your submission. I understand that the submission was developed on foot of a conference you organised which was concerned with reducing the rate of abortion. I take it from your submission that that's the issue you wish to address the committee on today, the actual question of the rate of abortion in Ireland and whether it is possible to reduce.

I take it you both wish to exercise your right of audience. Do you each want to make a short opening statement?

Ms Breda O'Brien: The reason we were so anxious to address the committee is because you'd need the wisdom of Solomon to resolve this particular dilemma but no matter which option you go for there still is going to be a huge question of how do we reduce the numbers because there is no stomach, I believe, in Ireland for abortion on demand. Most of the people you've had in to speak to you already have been only addressing very small and very specific cases in which they would like utilisation of abortion or not, as the case may be. So the 6,000, as it unfortunately is now, remains something which needs to be addressed.

My interest in it goes back a long time. I am currently a columnist with *The Irish Times* but it predates that by a long time. Perhaps more relevant is the fact that I'm a job sharing teacher and that I've been involved in teaching relationships and sexuality education for 11 years. That is one of the things I would like to address. The other area I would like to address is the whole area of counselling, particularly in the light of recent developments in relation to accreditation of counsellors and so on. That is basically my interest in being here.

Professor Patricia Casey: My interest stems from the fact that I'm a psychiatrist, a practising psychiatrist in the Mater Hospital and I treat women who have had abortions and who suffer adverse psychological consequences. I, therefore, as a health issue, believe it's imperative that we do what we can to reduce the necessity for abortion and

the consequences that affect some women. Because of my concern about the abortion issue and wanting to reduce the numbers, I was one of the organisers, with Breda, of the 5,000 Too Many conference. On that basis I'm here.

Perhaps I could begin. I've prepared a brief document, it's one page and three lines long, that I'll circulate to you and you can read at your convenience. It's what I believe to be the first arm, and a very important arm, of reducing the abortion rate and reducing the interest that women show in abortion. It stems from research in the United States, done by a Dr Charles Kenny, and a number of years ago he did two major studies, published in 1994 and '97, in which he examined the reasons, the motivational factors behind women seeking abortion.

One of the very interesting findings that emerged was that women seek abortion because they believe that their life will end if they have the baby. By that they don't mean the physical life, but life in the broader metaphysical sense, in the sense of career, family, future, etc. The second important finding was that women who seek abortion acknowledge, in fact, that they are carrying a baby and that the foetus is a human being so programmes of prevention that are directed at trying to convince women that the baby is human are misplaced and unnecessary because women already know that.

On the basis of those findings, Dr Paul Swope, who is the director the Caring Foundation, launched an advertising campaign and the advertising campaign was carried on national TV stations in many states in the US. These adverts were conducted from the woman's perspective, not from the perspective of the partner or the baby, the foetus, but from the woman's perspective, painting a picture of the woman's turmoil and then giving images of possibilities that exist for that woman, the fact that women can overcome the crisis and can go on to live positive, fulfilling lives if they choose the option of continuing the pregnancy.

It would seem from pre- and post-assessment studies that there has been a reduction in the numbers seeking abortion in the states those advertisements were run in. That seems to be related. One of the measures they looked at was not just the crude abortion rates in the two different scenarios, but they looked at whether women could recall having seen the ads or not and it seemed that those who recalled having seen the ads were more likely to continue with a crisis pregnancy to term than those who hadn't. So those ads are continuing to be run in the United States. Along with the ads they carried a 1800, a free phone number so that practical help was available to any women who saw the ad and thought 'Yes, perhaps this is something I should consider'. There was a free number they could ring.

I think that this has very exciting possibilities for Ireland. Obviously one would have to design ads that were specific to the Irish situation, using Irish actors and Irish characters, but I think with careful management it is possible. That's the summary of my first submission and, as I say, you have one page on it there if you want to ask me any questions on it or clarify anything.

Chairman: On your covering letter … it was long subsequent to your original submission, and because of the slight of confusion about when it arrived … but it mentioned promoting positive images of motherhood.

Professor Casey: Yes.

Chairman: I take it that's what you'll be speaking to in further additional submissions.

Professor Casey: Yes, that's exactly it, that's right.

Chairman: You also mentioned adoption, counselling, relationship and sexuality education and further research. I wonder would you like to take each of those in turn and maybe say a few words.

Professor Casey: We were going to do turn and turn about on different issues if that's acceptable.

Chairman: I would take adoption first. I'd take you through those issues before members put questions on adoption.

Professor Casey: I'll speak to adoption as well and Breda then will speak to the other two issues. I'm struck by the fact that the public still seems to be very ignorant about modern adoption. The public is still working out of an adoption model that goes back to the '50s, I think, that everybody would now agree was harsh and cruel and thank goodness it's behind us. I think, however, there is a huge job to be done in informing the public, first of all, and then specific target audiences, particularly women who have crisis pregnancies, about modern adoption and how it works. I believe that that information process could be done along similar lines to the Swope campaign that I've just spoken to. You are all familiar with the Citizen Traveller campaign. I'm sure that a similar campaign to the Citizen Traveller campaign could be conducted in relation to adoption, to inform the public about the modern approach.

It also seems to me that there is a need for training of all personnel who're involved in women with crisis pregnancies. I don't think we can blame social workers exclusively for the problems that have been befalling the adoption process. I think all personnel need to be *au fait* with modern adoption procedures, particularly midwives and GPs. People write to me to tell me they have wanted to make their baby available for adoption but were given the impression that this was a very abnormal thing to do.

I do not know if some of you read an article by Brenda Power about two weeks ago in *The Sunday Tribune* on the whole issue of parenting and teenagers. She interviewed somebody from, I think it was, Cherish who commented that giving up one's baby was a very abnormal thing to do. It is a difficult thing to do and is not something most women, even with crisis pregnancies, would want to do but to stigmatise it as being a grossly abnormal thing is very unfair to women who might be considering it as an alternative.

All people concerned with adoption need to be *au fait* with modern procedures which are more open and transparent. I am an adoptive mother myself and I know how it works. We are in contact with the mother. We write to them, get cards, etc., so I am very familiar with modern adoption procedures at a personal level as well as professionally.

There is also a lack of resources. Many of the adoption agencies are now devoting all of their meagre resources

to contact tracing. I think that is most unfortunate. If more resources were available perhaps some of the bodies and organisations which have moved out of adoption might move back into the adoption area and do some groundwork in the national adoption scene; most adoptions now are from abroad. I think that is a summary of what I want to say on the adoption issue.

One thing briefly, I know there are proposals from the Law Reform Commission in relation to adoption and the issue of veto or non-veto on information. My personal belief is that there should not be a veto on non-identifying material such as birth weight, medical health of the parents, etc., but that there should be an optional veto on identifying material. That veto should not be written in stone so if, for example, a birth mother, at some point in the future, did want to make her name available to the adopted child she could do so. That is my personal view on the veto issue. I think it would be detrimental to women in the future who might be interested in making their babies available for adoption if they were not given the right of veto on identifiable information.

Chairman: Counselling was the next subject.

Ms O'Brien: May I make two brief comments in relation to adoption? The Department of Health has taken the positive step recently of agreeing to fund a leaflet on the lines of 'Pregnant and Considering Adoption'. That is very positive but it is only a beginning. Much more needs to be done in relation to that.

To reinforce what Professor Casey has said in relation to resources. Open adoption or semi-open adoption demands much more resources because the adoption agencies are, basically, undertaking to keep two parties – the adoptive parents and the original birth parents – in contact for a minimum of 18 years. That is obviously very demanding on everybody involved. Neither Professor Casey nor I would like to advocate that adoption would be a majority solution but that it could be a solution for more women than it is currently.

With regard to counselling, over the last year there have been some extremely unpleasant revelations about the nature of some pregnancy counselling agencies – manipulative, coercive methods and also some highly dubious practices in relation to actual children. We would all share a concern about the regulation of that. This is probably what prompted a recent move by, you will excuse me if I refer to it as the former EHB. It is a mouthful if I give it its proper title – the former EHB. They issued basically an ultimatum to every counselling agency that they fund – as you know, State funding to all the pregnancy counselling agencies is channelled through the former EHB – in which they said that all counsellors would have to be accredited to either the Irish Association of Counselling and Therapy or the Irish Council for Psychotherapy. This was greeted with tremendous shock by the largest of the agencies, CURA and LIFE, and also by PACT which, even though it is known as the Protestant adoption agency, also runs a separate pregnancy counselling service, for separate reasons. In the case of CURA and LIFE, they work with volunteers and it is quite demanding. I will run briefly through them.

If you want to register with IACT – I am choosing this one because ICP is much more demanding than this – you have to have done at least one year full-time or two to three years part-time course; you have to have a minimum of 100 hours supervised client work; a minimum of 350 hours, including skills hearing self-development; a detailed study of at least one major school of counselling; and from 2002 a minimum of 50 hours personal therapy – in other words dealing with your own issues. After training you must have completed 450 hours of individual client work with one hour of supervision for every ten hours of counselling and have been in ongoing supervision in Ireland with the same supervisor for one year immediately preceding application.

They are incredibly demanding for volunteers. It would actually mean that neither CURA nor LIFE – and PACT for a different reason because social workers were not considered to be qualified counsellors and they would have to obtain this as well – would not be in a position to receive the State funding which has greatly improved their service over the last four or five years.

An even more crucial point is that it does not seem to understand the nature of pregnancy counselling. It is quite different from counselling in the normal standard sense. If I go to a counsellor, the first thing, normally, is that we would negotiate a contract for, perhaps, six sessions. We would agree parameters, we would decide what we would be discussing, we would institute a review. It is an ongoing process in which deep seated issues would be looked at. That does not apply to crisis pregnancy. By its nature, crisis is short lived. Intervention will happen in the immediate future no matter which direction a person chooses to go. Very different skills are needed for crisis intervention counselling.

And I think it demonstrated the former EHB's lack of understanding that they did not demand that volunteers who do telephone counselling would have to have any qualification whatsoever. As you know, many women who are in crisis will only use the telephone. It may be the only contact. They may never come into a centre or to an agency. It also did not understand the nature of volunteerism. CURA and LIFE have actually been running their own training programmes. CURA particularly has a very intensive programme which is geared specifically towards pregnancy and towards dealing with that. They recognise absolutely that they are not qualified as counsellors. They are not qualified to deal with issues, for example, such as rape. If somebody has been raped they are referred on to the Rape Crisis Centre. That is seen as a separate issue to the pregnancy. I think it did not understand the nature of pregnancy crisis and it was an unfortunate way to deal with it. I think they have rescinded to some extent on that and they are now more open to negotiation. The former EHB should abandon what they are doing and go back to consultation – consult with the people.

If I could just tell you what CURA do. They have a formal 70 hour training course in personal development, counselling and telephone skills, given by accredited trainers who are knowledgeable about the particular requirements of pregnancy counselling. They have counselling supervision, usually through a supervised peer review group, once a month where verbatims, in other words an interview with a client, would be presented or relevant issues discussed. They have an ethical policy and a code of ethics. They have professional indemnity insurance. Their service is open to all and free to all and

they have a published annual report. I think that could provide quite a workable model and I would go so far as to say that even people who are accredited already, in the classical sense of counselling, perhaps might need to do this on top of what they are actually doing whereas volunteers would need to do this as a minimum. I would suggest that as a method of dealing with the unsavoury practices of some agencies, someone should not be able to advertise as a pregnancy counselling agency unless they can prove that their people have undertaken this.

We have had anecdotal evidence also of unfortunate practices regarding counselling. Emily O'Reilly, some months ago, referred to a friend of hers who was pregnant, had a number of children and who felt that she was rushed into an abortion, who subsequently decided that she did not want an abortion, carried the child and was quite angry about the way that she was treated. I have lots of anecdotal evidence of people not being counselled properly in relation to adoption. I think that anybody who is being given Government funding should sign a code of ethics consistent with our Constitution which demands respect for all life, born and unborn, the mother and the child and that they should sign a code of ethics saying they are going to pursue, as a consistent goal, the reduction in the number of abortions.

Obviously, this would have to be through non-manipulative and non-coercive methods, primarily through active listening. There is a mythology out there that some of the agencies do not discuss all the options. CURA, LIFE and the others discuss all the options. They simply do not give information such as names and addresses. I think it would be vital that those who do supply names and addresses would be required to also give a Government sponsored and Government produced leaflet on the side effects or the potential effects of abortion.

I have a model here; it is only a model. It is American and is slightly out-dated. The research is not bang up to date. I will leave it with people to have a look at later. It is called 'Making an Informed Decision About Your Pregnancy'. It has very straightfoward information in it, things like that by the 18th to 21st day there is a heart beat in relation to foetal development, abortion techniques, physical risks to women, risks to future childbearing, psychological disturbances and the fact that it is a permanent decision. Because of the material which Dr Casey has produced in relation to the effects on women of not concentrating on the foetus or the unborn child, I think this should only be given to women who have shown a definite interest in pursuing abortion. Obviously if somebody asks you for names, addresses and telephone numbers that is a definite interest in pursuing abortion. It should not be thrown around willy-nilly but it would help people to make an informed decision. We all want women to make informed choices and it would have to be peer reviewed and have the most up to date medical and psychological information in it.

The most common complaint of women worldwide, and I have done a fair amount of reading in relation to this, who regret abortion is why did somebody not tell me – why did somebody not tell me it would be like this? I think that would cover that very much. That is basically what I have to say in relation to counselling.

Professor Casey: Clinically patients say to me: 'why did nobody tell me this was going to be the situation' or 'why did nobody tell me I might have this side effect or that side effect?' That is a common theme that runs through the vocabulary of women who have emotional problems after abortion.

Chairman: As regards education and research, the submission is clear. What I take from it is that we must encourage young people to say no. Is that a fair summary?

Ms O'Brien: It is a fair summary but it is slightly more complicated than that. If it were a simple matter of just saying no we would not have the abortion figures that we have. Can I just put something on the record as a matter of interest? In the *Irish Medical Times*, the latest issue, Dr Ailís Ní Riain, in an address I think to the Irish College of General Practitioners, pointed out that the adolescent abortion rate in the Netherlands is actually higher than ours. It is 5.2 per thousand whereas ours is 4.6 per thousand and their birth rate is lower; theirs is around 6.9 per thousand and ours is around 16.7 per thousand, per thousand live births that is. In my research preparing for this I came across ....

Chairman: Do you have the reference for that?

Ms O'Brien: Yes. It is the *Irish Medical Times* 19/05/00, the last issue of the *Irish Medical Times*, last week basically. There is another figure that is important in relation to the Dutch experience which is that abortions up to eight weeks which are carried out in doctors' surgeries are not counted, there are no statistics available for them. I made stringent attempts to get statistics on them and was unable to do so. The Dutch Government was able to confirm to me that this was the case.

Professor Casey: They are termed 'menstrual extractions'.

Ms O'Brien: They are not termed abortions. There are no figures available on them so the Dutch abortion figures may not actually be as glorious as they may seem to be. Any abortion is one too many. According to the Council of Europe 1998 which looked at many, many countries, our abortion rate was 10.9 per thousand live births, Holland's was 11.9 per thousand live births. I am not going to be facetious and say perhaps Holland should be looking at what we are doing because I think there is so much more we could be doing but I think there is some degree of perhaps seeing the Dutch experience as the model or the ideal which may not be borne out by empirical evidence.

I am aware that we are taking a lot of time but I just want to say very briefly Douglas Kirby is recognised as the prime researcher in sex education in the United States. Unfortunately what he has come up with is that there is no magic bullet. There is no approach you can point to and say this will – you are familiar I can see, Chairman, with that concept in relation to these hearings but in relation to sex education it is, unfortunately, also true. He made an interesting comment in 1991 and I can leave this with you rather than reading out the sources and references. He said it may actually be easier to delay the onset of intercourse than to increase contraceptive practice. That has been borne out around the world. I have a

number of references which I will not go into but according to *The Guardian* on October 13 last year, the British pregnancy advisory service in a study of 2,000 women who had sought abortions said contraception cannot be relied on to prevent pregnancy in the UK; the New Zealand Medical Journal, 1994, a study of women – the British pregnancy advisory service of women presenting for abortion, 59% of them cited contraceptive failure. That was 38% condom failure and 17% pill failure. If contraception were the answer there would be no abortions in Britain and if contraception were the answer there would be no abortions in the US either.

A similar study in New Zealand – again, women presenting for abortion – 61% of women had been using a method of contraception in the month they got pregnant. Some 25% had been using the pill, 29% using condoms that experienced failure. The most interesting statistic for me in that is one-fifth, approximately 20%, had been using contraception perfectly. It was not human error. It was pure contraceptive failure. Then there is an Irish study by Dr Maeve Robinson which was 163 patients attending an Irish family planning clinic. Of 163 patients, 83 had used contraception and experienced contraception failure. So there is no magic bullet. It would seem intuitively that the way to go is to encourage young people to use contraception but it does not seem to be that way.

What is emerging from the United States … the American Government has recently mandated $250 million for what they call 'abstinence education'. I prefer the term 'delaying sexual activity'. The RSE – Relationships and Sexuality Education the proper term for it – is just a module within social, personal and health education. I think that is a much more healthy way of looking at it. As advocates of health, can we be advocating to young people that contraception is the answer to everything, particularly condoms particularly when we have a growth in the incidence of human papilloma virus which condoms do not protect against and which are implicated in cervical cancer?

The implications for young women engaging in sexual intercourse at an early age are much more serious than for young men. Young men do not escape unscathed but young women have much more serious consequences. Chlamydia, which has reached epidemic proportions in the United States, actually results quite often in pelvic inflammatory disease which results quite often in infertility. These are very serious things that we need to look at when we are advising young people. I think we have this … I was talking to a group of young people recently and this person, a very bright, articulate young woman, said to me the media are not remotely interested in the 70%. I said: 'what 70%'? She said the 70% that are not sexually active, the ones who do not go off the rails, the ones who are quite sane and sensible, we are quite boring, you never hear about us. We have concentrated all our efforts on the 30% and have assumed that the 70% are an aberration and that we cannot move the statistics in the other direction, that the 70% must become lower and the 30% must become higher. The evidence from the United States is very promising in that it can be done. The average age of losing virginity has increased by a year which is significant if you think of young people over the past number of years since the mandating of the DSA – delaying sexual activity – model. I think I have said enough.

Chairman: The only subject left in your submission relates to a study on women and crisis pregnancies. Did you want to comment on that study? It has been briefed to the members of the committee, as you know, and I see you have a short note on it. Perhaps you would like to elaborate on that.

Professor Casey: I will just briefly say that I don't think we should think that that study .... It was a very good study but it's the beginning rather than an end in itself. I believe that for the future we should have more long-term studies identifying any changing factors that will affect women's abortion decisions. In particular I am interested in measuring the psychological consequences of abortion in the Irish context. There are no studies on that. All of the studies that have been done so far on the psychological effects have been done in Sweden, in the United States, in Britain, in Japan, countries like that. There is none from Ireland, so I think we need ongoing research in that area.

The Trinity College study was a qualitative study. It was an interview type study in which different groups of women were asked for their opinions as to why they were choosing the course of action they were taking. That's a very good way of study but there are also quantitative studies in which more structured interviews are applied measuring depressive symptoms, anxiety symptoms, measuring attitudes, measuring cognitive styles and perception styles. I would like to see a combination of the qualitative and the quantitative methods in the Irish situation.

I think we also need to be evaluating the sex education programmes. In the document Breda will give you, you will see the difficulties but I do believe that we have to find techniques for evaluating the different models of sex education. In fact, what is striking, reading the literature on it, is how many different models are used. It's not just simply teaching people to be confident and to negotiate what they do in a particular way. There are about 20 different models of sex education. I think we should reflect on models we might use and how we evaluate them.

In relation to women seeking abortion and having abortions and women not seeking abortions, I do believe that we need ongoing and detailed research if we are to equip people to address these problems in the future.

Chairman: Thank you very much for your presentation and for the obvious reflection you have put into your submission to us here today.

Deputy J. O'Keeffe: I am delighted that you came this morning.

Professor Casey: Thank you.

Deputy J. O'Keeffe: I am hugely enthusiastic about an approach which advocates positive measures as an alternative to abortion. I suppose to a considerable degree our debates to date haven't focused on those areas but to a large degree I think your submissions get to the heart and core of what we are about because we do have abortion. You had a conference, '5,000 Too Many', in '98. This year, unfortunately, it will be 6,000 too many. I suppose the opening point I'd make to you is that I don't think there has been sufficient, adequate or indeed hardly

any debate on the issues raised by you. I would hope that we would have a lot more … that you might be rolling a stone down the hill that will gather a lot of debate behind it because I would say that some of the things you say are probably controversial in themselves, that there wouldn't be unanimity on the views that you present but that they certainly are focused on avenues which are alternatives to abortion and in which I would have to say very bluntly I am usually interested.

I wish to raise a couple of issues. On the question of adoption, you mentioned the resources that are needed. Have you any idea as to the kind of moneys that are at present available in that area and the kind of moneys that you believe would be needed to put into effect the approach that you are advocating?

Professor Casey: Deputy O'Keeffe, I wish I was an economist. I am not. I am afraid you'd have to do costings on that. We can do only so much for the committee. Seriously, I don't know but I do know that .... Social workers tell me they are spending a lot of time doing contact tracing nowadays. These are groups who have given up placement completely in favour of contact tracing but who would, if they had the resources, be willing to do placement. It's that kind of situation I think we need to overcome.

Ms O'Brien: In relation to that, I can't give you figures either but I could say that I have been speaking to some of the adoption agencies – the few that are still doing placing – and they are saying that they are so overstrained by .... I believe one of the agencies has a low call number and they actually could spend all their time on the telephone and all the other things such as ongoing practice which has become quite good in terms of maintaining links and maintaining contacts between birth parents and adoptive parents and adopted children are actually being squeezed as a result. I think the answer is significant additional resources.

Deputy J. O'Keeffe: On the question of counselling, what I gather from you and from personal knowledge is that it's very difficult for somebody to become a fully qualified counsellor. Is that the message ....

Ms O'Brien: That's right, yes.

Deputy J. O'Keeffe: Is it your view that in certain circumstances there isn't the need for the very high standards of qualifications that are laid down?

Ms O'Brien: I believe that there is absolutely a need for very high standards. I am just not sure that to go with the classic qualification .... The IACT and the ICP are voluntary organisations. There is legislation coming before the Dáil about registration of certain professions but I believe counselling is not in the first tranche of ten – I am subject to correction on that but that's my understanding – because it is so difficult to look at the area of counselling and how to regulate it. My main point is that there are different types of counselling demanding different types of ability and that the classic counselling qualification .... I would be totally in favour of counsellors being accredited if they are going to do ongoing counselling and I would be totally in favour of crisis pregnancy counselling being seen as a specialism, as something for which people have to have specific qualifications, and that that would be taken into account and that the expertise of people would be taken into account when designing such a module.

Deputy J. O'Keeffe: Do I take it then that you are obviously in favour of proper standards ....

Ms O'Brien: Yes.

Deputy J. O'Keeffe: .... but you feel that in different counselling sectors different standards should apply ....

Ms O'Brien: Absolutely.

Deputy J. O'Keeffe: .... that one needn't be a total expert, as it were, in bereavement counselling ....

Ms O'Brien: Exactly.

Deputy J. O'Keeffe: .... to be a counsellor in pregnancy.

Professor Casey: They are quite different approaches. By definition, pregnancy counselling is brief, its short, it involves one, at most, two sessions, if one is lucky. Formal counselling – we'll call it typical Rogerian counselling – involves ten, 15 sessions with a contract drawn up at the beginning, set appointment times. Specific issues are looked at and examined in great depth. That's quite different from the requirements for crisis pregnancy counselling. Whilst one has to have training in crisis pregnancy counselling – that's essential and has I think been a problem in the past – I believe it has to be quite different from being a full blown, full practising counsellor.

Deputy J. O'Keeffe: My last point is on the area of contraception.

Ms O'Brien: It is probably the most controversial.

Deputy J. O'Keeffe: You have seen the Green Paper ....

Ms O'Brien: Yes.

Deputy J. O'Keeffe: There were a lot of submissions expressing concern at regional gaps in service provision and factors such as cost, availability, access and so on. To sum up your situation, are you inclined to recommend less emphasis or no emphasis on the contraception side or more emphasis on education which would lead people to delay being involved in intercourse? Where is the balance that you are suggesting here?

Ms O'Brien: As a matter of interest contraception was an integral part of the '5,000 Too Many' conference. Both Patricia and I are aware of the place of contraception. What I was saying simply was – anybody who is a parent here will be aware of this – when dealing with young people if you say 'maybe' you have already lost.

Deputy McGennis: Have you ever tried saying no?

Ms O'Brien: It's very true but I actually believe that young

people quite often are looking for boundaries. There have been some very interesting studies in relation to young people who have engaged in sexual intercourse at an early stage. One this year in the British medical journal .... The number of people who regret early engagement in sexual intercourse is huge whether or not they used a condom. In this particular study there was – surprisingly I would have thought – quite a high incidence of the use of contraception on first intercourse. It is particularly strong in young women and particularly strong under the age of 14. This regret is so strong that one researcher actually said that he felt that being forced or being pressured was the primary reason that girls under 14 were engaging in sexual intercourse. I think that with studies like that available to us we need to be presenting a strong message.

Obviously you also need to make young people aware of contraception but you need to make them aware of the totality of the reality of contraception. Children – and I use the word advisedly – have this idea that a condom is protection against everything. There are three ways of looking at contraception: one is the perfect use failure rate, in other words. if you do everything that you're supposed to do; second is the actual failure rate and there is a third statistic which relates to teenagers. There is an 18.4% failure rate in condom use among teenagers. I think that they need to know things like that. They need to know that, in a sense, a condom is not the answer to everything.

However, I believe that people should make informed decisions. I'd be very much in favour of teaching about contraception but with the emphasis, from every point of view, on delaying sexual activity – the Americans have an interesting term – until self-sufficiency, in other words, until you are independent and responsible for yourself, until you're ready to have a baby and all that. Contrary to what we might think, babies do not result from failed contraception. Babies result from sexual intercourse. That message needs to be put across very strongly.

Deputy J. O'Keeffe: You are presenting a dual message in a way, that it is all in a package of educational measures.

Ms O'Brien: I want to make it very clear that I'm not saying that I would suggest to young people 'abstain from sexual activity and if you can't, use contraception' in that kind of black and white fashion. What I would be saying is that the positive message should be that it is possible and healthy to abstain from sexual activity and to make them aware of the reality of contraception as well. It's not giving a dual message in one sense; it's giving a very strong positive message. I think it's extraordinary that the United States have a drop of a year. Their figures are still very high. The average age for first sexual intercourse is 16 years and four months, which I think is young particularly in an Irish context and particularly with our legal situation. But it's a heck of an improvement in a sense on 15 years and four months. They have actually managed to turn it around.

I think it's possible that we could learn from what other countries are doing in that positive sense and not assume that all young people are madly desiring to be sexually active. Somebody who works in this area whom I'm very familiar with said to me that quite often it's quite sad to talk to young girls particularly about their sexual activity because for them it's not a particularly enjoyable process a lot of the time. That's sad. It should be an enjoyable experience. It should be something positive.

Chairman: At what age can we say 'if you can't be good, be careful'?

Ms O'Brien: I don't know. Certainly the minimum is the legal. We cannot be advocating something that is not legal in the country. We've an extraordinary situation in the western world in that people in other cultures are married and mothers and fathers at such an earlier age. We have a very prolonged adolescence.

I think that there would be a lot more unanimity about people in their 20s being sexually active because they would have a degree more maturity. Now how do you present that to young people? Do you advocate that at 23 everyone should go out and lose their virginity? You have to give a very consistent message. I think a consistent message would be to be quite directive. If you receive a question in a classroom like, 'what time should young people start having sex?', my response would be 'you're too young'. And here are the reasons why you are too young: if you're female, increased chances of cancer of the cervix, increased chances of chlamydia which can actually lead to infertility, and the fact that women still, in spite of everything, regard sex as an integral part of a relationship. Perhaps we should be educating boys to regard it that way as well. That was something I didn't come to. I think education of boys is very important.

Chairman: I was going to ask you next if you would tell males that as well as females. Of course you do. Do you need to elaborate on that?

Ms O'Brien: No.

Professor Casey: That is another aspect of the education, if I may just mention it. It seems that many unplanned and crisis pregnancies result from alcohol misuse. I think emphasising the role of alcohol in the education programmes is hugely, hugely important.

Ms O'Brien: To be fair, that's already being done in substance abuse programmes like 'On My Own Two Feet'. However, something interesting is emerging, again from the United States. The self-esteem model doesn't work fully. I can give you all the references for a thing called 'Project Dare' which was a long-term US Government sponsored thing which was about self-esteem and enabling young people to say no to drugs and alcohol. They discovered that this increase in self-esteem may give them more confidence sometimes to make the wrong decisions. It actually helped them to negotiate with drug dealers. They were much more confident about approaching a total stranger.

The model I think is good is self-efficacy. It is a bit of a mouthful but what it means is that you concentrate on skills, the skills of refusal. Are you confident that in the situation you can find a way to do what you want to do, that you won't be subject to peer pressure? Bandura is the main researcher in this area and I think it is an interesting model. I think it's one we should be looking at. In a sense our relationships and sexuality education is

in the schools, even though it hasn't been implemented everywhere. It would be interesting to research it, to build evaluation into the programmes. It is really important so that in ten years time we can say 'well, this model didn't work either, let's try something else or this model works extremely well, we need to put more resources into it'.

Deputy McManus: Thank you for coming here. The conference '5,000 Too Many' was ground breaking and I was honoured to participate in it. It just reinforces the difficulty about this issue that we are now at a figure of 6,000. However, it was an important conference in terms of highlighting the issue and breaking out of the illusion that somehow we did not have such thing as abortion.

I have no problems with your points regarding adoption, having a more positive approach to it and, indeed, in terms of delaying. To be fair to the Dutch, regardless of whether it was intentional, the effect of their work is that they have succeeded in delaying the age to some extent, certainly in comparison with Britain. It is an important aspect and it is important that we do the same.

However, I am still concerned that in your recommendations you do not include contraception. My own view is that it is part of the package and that it is wrong of us to isolate one aspect and take it out of the picture, particularly so when one reads the Evelyn Mahon research. It shows that many of the young women were not using contraception or were using it too late. In one case that struck me, fear seemed to be a large element in not using contraception – not being able to go to the doctor and not being able to talk to the parents. Another example was a girl saying that where it was a one night stand she did not feel confident enough about herself to be able to say they must use contraception. She could only do so when she knew the boy well. That attitude is extremely risky and must be faced up to.

I am concerned at the fact that this is the missing piece. Why have you done that?

Ms O'Brien: To clarify that, in the recommendations that went forward from the '5,000 Too Many' conference, the contraceptive aspect was an integral part of it. We selected four issues that we felt very confident about speaking about because of our interest or expertise in relation to that. I understand exactly where you're coming from. I would simply put to you that the research shows that it's not a panacea. My worry would be the idea that if you have perfect contraceptive use, if you have lack of fear, if you have assertive behaviour that you then have no abortion problem. I don't think the research shows that anywhere and is actually quite conclusive in the other direction, including research from family planning organisations. That would be my concern about it.

Deputy McManus: I accept that fully. However, is it not a very important part of the measures to combat the high level of abortion? It is not as if contraceptives are available uniformly everywhere, quite apart from their efficacy. I suspect that if men got pregnant, we would have perfect contraceptives. However, allowing for the imperfections and the fact that they do not always work, they are not always available.

Ms O'Brien: It's extraordinary really. There is an ONS – office of national statistics – study in Britain which I was quite stunned at. In some senses we are similar and dissimilar to Britain. It showed a very interesting statistic. Among the highest risk age groups for abortion which would be 16 to 24 – that does not mean older women don't have them, they do and they are a very particular case – it showed that young people had an extraordinarily high level of knowledge of contraception, an extraordinarily high level of usage of contraception but they did not have any knowledge worth speaking about of, say, a disease like chlamydia. That would be one of my concerns, Deputy McManus, that this would be part of it, that if we're going to emphasise this, we emphasise the whole story about it and that we allow people to make informed choices on that level.

I don't think we're that far apart actually in that sense, but I feel that out of respect for people – I suppose I'm coming very much from my hat as an educator and talking about young people – and I think that the mixed message, you know, 'well, here you are, don't do it, but if you can't, you know, whatever', doesn't work. Young people quite often like boundaries. They kick against those boundaries but some young people find them extremely reassuring.

I'm sure you've all had the experience of a young person who says on the 'phone, 'my mother won't let me'. It's a great protective thing and the same with the studies that show that parental disapproval and parental communication are the two key things for people to delay sexual activity.

Professor Casey: In fact, one of the features of the Dutch model is the involvement of parents in the delivery of sex education. That seems not to be a feature of our RSE. My eldest boy has just started doing it and I certainly haven't been involved in any of it, although he gets it from me subsequently, but not as part of the RSE programme. That's something that should be incorporated in any future models, I think, that parents would be empowered, would be trained, would be taught how to discuss sex with their children because parents find it extraordinarily difficult, very, very difficult.

Chairman: I'd understood the practice was that parents were written to and consent was given.

Professor Casey: No, I do not mean in that way. They give consent but I mean actually engaging in discussion with children about sex, different aspects of it, values, what's right, what's wrong, different approaches to the issue. That doesn't happen at all.

Ms O'Brien: As part of the planning for RSE, all parents were supposed to be consulted and involved in producing the school policy. Now, that has been very, very patchy.

Professor Casey: The actual delivery of the programme, I believe, should involve parents a lot more.

Ms O'Brien: Yes, there are two aspects to it.

Deputy McManus: In the programme in Holland, everybody got engaged in it.

Professor Casey: Yes.

Ms O'Brien: Yes, and that's the key in the approach they're taking in the United States. Everybody from parents to youth leaders to community groups.

Professor Casey: And they have older children involved as well.

Deputy McManus: It's called ganging up on them.

Chairman: You don't just write to parents.

Ms O'Brien: No, and you might even have parents involved in the delivery

Chairman: You encourage them to get involved

Ms O'Brien: One model that works quite well is older teenagers working as role models for younger teenagers. You could have parents involved in the training of older teenagers. It would be quite unnerving to see your mammy arriving into the classroom to deliver the RSE, but it would be an entirely different thing to have, you know, an involvement, say, in weekend training workshops for the ones who have just gone on to college or gone to work who would come back in.

Deputy McManus: Thanks.

Deputy McGennis: I'd like to thank both of you for being here today and for expanding on, I've an idea of your views already. I will just go through the four headings that you mention. Promoting positive images of motherhood, I think that's a very good suggestion. I think it's one that we certainly should look at very seriously, you know, of getting a message to somebody who's in a crisis pregnancy because I've a feeling there actually aren't a lot of messages getting to women in crisis pregnancies.

I think what we've discovered from medial evidence we got as well is that women in crisis pregnancies who decide to go for abortion seldom, if ever, will go to a hospital. It's to an agency they will go so, you know, there's a need to get this, to get a message across. There's always the risk, of course, then that those who don't like messages going out at all will object and will see this as something which maybe glamorises lone parenthood or, you know, highlights the fact or even suggests that there is the option of abortion. So, we'll always be, I think, battling against that.

On the issue of adoption, I would have great concerns also about the drop in the number of children who are available for adoption and I've made that known for a number of years. I had occasion with a friend of my daughter's, a very young girl – they were both 14 – who gave birth to her first child. When I went to visit the mum, and it wasn't to deal with lone parents allowance or anything like that because the mother was adamant that they were going to support her and she was going back to work and she wasn't getting her book as she titled it, but I just asked, during the course of visiting and seeing the baby and the very young mother, if the social worker in the hospital – I'm presuming that she has to have had a social worker at that age – had mentioned alternatives and I meant specifically adoption.

The grandmother's reaction was furious, we are not .... there was no question of giving our baby away. It was not an issue which was being discussed by social workers in maternity hospitals. It's maybe being discussed at agency level but it is not, to my knowledge, something that is discussed. Now maybe there's a reason for that, maybe it's that the social workers feel that they are being directive and if they open their mouth at all, that they're going to be in difficulties. I understand that but certainly it is, I think, not happening and it's something that needs to be looked at.

You mentioned that quite a lot of the adoption agencies are spending a considerable amount of time on the tracing aspects and that is, obviously, not to catch up with difficulties but there have been difficulties associated with the older adoption scene. I'm not absolutely sure now that even if we were to decide, or if there was a great movement towards adoption, that it is the older adoption agencies or the adoption agencies that are in place at the moment would be the ones that we would go to. I think there's a credibility problem there.

Professor Casey: May I comment on that very point? Pardon me for interrupting you. I believe there is a strong case to be made for allowing charities and other outside adoption agencies, accredited agencies, to become involved in adoption in the future. I know at the moment there are only a few agencies, mainly through health boards, but I think there is a very good case to be made for expanding the numbers of agencies involved in adoption for the reason that you mentioned, because the current agencies, I think, don't have .... they have a credibility factor.

Deputy McGennis: That's right.

Ms O'Brien: If I might just comment quickly on that, I think there might be a slight degree of unfairness in the perception because the practice has changed so much. I would feel that we are actually to the forefront of good practice now.

Professor Casey: Now, yes.

Ms O'Brien: In a sense, the people who are presently engaged in it are paying for what people did in the 1950s and 1960s.

Professor Casey: Exactly, yes.

Ms O'Brien: I think it would be unfair to penalise people who have pioneered in a sense a more modern approach, a more open approach, by saying that they couldn't be subsequently involved in adoption. It's just a comment.

Deputy McGennis: Yes, I understand exactly what you're saying but, unfortunately, the good practice which exists now is not, you know, the one that's getting attention. Mind you, there was very good practice in the 1940s and 1950s and thousands and thousands and thousands of couples had children placed with them and, you know, children were delighted to have been in that circumstance. It worked out very well, but it is the unfortunate cases, obviously, that get the attention.

Just on the kind of adoption situation that we have at the moment, you mentioned the Law Reform Commission report. I was involved with that with a number of groups. You can put on the record that the Adoptive Parents Association felt that they were actually misrepresented in the final report because they did not say that they would place a veto on contact registers. They did not suggest a passive contact register. I told them to ensure that that appears in the final report because that is not their position and it is not the way they would want themselves represented.

Professor Casey: I spoke with them last night in fact.

Deputy McGennis: Yes. They are very angry about it. On the counselling issue, I can understand why you're saying that it's probably .... I think what the Eastern Health Board did, to be fair to them, was an absolute knee jerk reaction to something which was very wrong, should never have happened and, because somebody feels passionately in one area or another does not in any way, you know, condone or accept that they should have been doing what they were doing. It was just wrong, but I think maybe we need to make the case that there are different types of counselling. I mean I have an involvement with Parent Line and if you were to apply those criteria, then Parent Line would find themselves totally devoid of counsellors. We need to ....

Professor Casey: The Samaritans would go with that line.

Deputy McGennis: Exactly, but I think we have to ensure that whatever it is, it certainly isn't, it doesn't result in what happened in the most recent cases.

On the relationships and sexuality education, I think you could nearly subtitle that, then you're maybe promoting a positive image of teenage boys and girls because I think the image of boys and girls, of teenagers particularly, is very skewed. I say that as a parent of two – they're gone beyond teenage, but one that is – but with a lot of involvement, as I'm sure all the public representatives have here, with very young women who find themselves in maybe not crisis pregnancies, but find themselves as unmarried mothers. I don't know what their image of themselves is and I would find myself asking the most, you know, well, probably out of .... the way, unacceptable questions of these young women who have had maybe a second child. It's not the questions that they're expecting to be asked. It is younger we're seeing, although the statistics are saying it's moving a wee bit back.

I understand what you're saying about delaying sexuality. Can I put that in the context of the issue we were talking about a moment ago in relation to adoption? There was certainly a delaying of sexual activity in the 1940s and 1950s on pain of ex-communication, the fires of hell and just absolute fear, but we still had a huge number of unplanned pregnancies. They didn't always end up as unmarried mothers because I think the book which you have there suggests that there was the phenomenon of shotgun weddings. So, while we had that .... okay, fear may have been the motivation but whether it's self-esteem or if it's empowering people to make decisions now, it amounts to the same thing. We still had very high numbers of women ending up in, you know, crisis pregnancies which saw them either going to England to have their babies there and adopted or coming to Dublin or the Magdalene Laundries. I don't know that, you know, that argument in itself is going to stand up because certainly what you faced as a result of becoming active sexually in the 1940s and 1950s in Ireland would not have, you know, in any way encouraged anyone, a woman, to become pregnant. It happened and it happened in large numbers, so I'm just a wee bit concerned.

I'm not saying that it's not something you should do but I would say again that as a mother I know that saying to my three children, you must not do that and do not do that, would be absolutely counter-productive. I would try to do both and say listen, you know, certainly, what you're saying, don't end up in a situation where being involved in a sexual relationship means nothing but if you are, then you want to make sure and I think that, you know, if you are going to have a baby that it's when you're ready to support it. I'm not sure about the American model of this. It may be very focused on a particular area.

I thank you very much for the statistics you gave about the Netherlands because I thought we were heading to the Netherlands to be educated. You learn something every week. The fact that you've said that, in fact, abortions are not categorised as abortions up to eight weeks and that it's ....

Ms O'Brien: In doctors' surgeries.

Deputy McGennis: .... that puts a whole different slant on the statistics for that country. But I would say, just to back up the last point, I think what we probably do see there is a greater involvement by parents in discussions. I don't know what your children would feel if you went into the local community school tomorrow to be a peer educator. I think they would die on the spot. You know, with one of them, I'm not allowed to even mention the word. You are certainly very much more open. But it is something that is very delicate.

Certainly, in the book on crisis pregnancies again you see both ends of the spectrum. People where, you know, a family were totally anti-abortion and because of fear of being found out or discussing the issue you found somebody going to have an abortion, which seems to be the worst thing in the world. Again, because it was an issue that was never discussed at home and, you know, you just didn't talk about it. The same ignorance, you know, at both ends of the spectrum leads to that. But, I think, maybe as parents we need to be taught, you know, when to hold back but how to approach the subject. Some kids are not happy at all or comfortable with their parents doing it. As I say, I thank them, Chairperson, for the presentation.

Senator O'Dowd: I welcome your contribution here this morning. I found it very useful and very helpful. Just a couple of things that concern me basically and I very much laud your conference for producing the abortion leaflet providing real alternatives. One of the issues I face as a public representative, a lot of young mothers under 18 coming to me looking for advice. It goes back to your counselling and so on. An awful lot of mothers who choose to be single mums and to have their babies are left that they have no proper counselling services after they've

had the child. I've been very critical of health boards that when you refer them to social workers they're actually too busy dealing with sexual abuse cases or whatever. I don't know have you or do you intend to do any research into that area into increasing and getting better support services for mothers who have decided to keep their children and are living alone?

The other issue that I feel and it's part of what Marian was saying there that with the breakdown in family life and the old traditional family or community, as we know it. I find an increasing number of young people and, indeed, their parents don't know what to do or don't know how to deal with those issues. They're completely at a loss. When they come to public representatives, we're not skilled but we have contacts and we can help them as much as we can. One of the biggest things we do is actually listen to them. There is nobody listening to these people out there. I don't know if you've any views on that.

Finally, what I want to say is that where people make the choice when they are pregnant to have their child, you know, I think that's what we all want and we reduce abortion that way. But there's a significant amount of support needed for single mothers out there when they have one and, indeed, often when they have their second child, they come up against an awful lot of criticism, an awful lot of prejudice. I think that everybody needs to put a lot more effort into that. I'd be happy to have your views on those issues.

Ms O'Brien: I agree completely with you in what you're saying. But can I make a point which I think is very important? An elected representative actually challenged me very severely on what I was saying about, you know, images of motherhood and said what we really need to do is to go back a step further into the circumstances which makes it appear that in a sense your best option is having a small baby when you're not much more than a child yourself. The significant thing that I think has emerged from the study is that having a future is actually a great disincentive, having educational prospects, job prospects and so on. It's actually a slightly different question to the abortion question because in the cohort that we're talking about abortion is not really an option but it's a huge question. I don't think you could tackle these two things independently of each other.

That's again why intervention at an early age, as some of it is happening very positively from the Department of Education in terms of early start education and so on. But you actually need to go back a step further and to say why does, and this is again research – I think Professor Casey will agree with me – why does somebody in a sense choose, because we have to face up to the fact that sometimes 14 year olds choose to get pregnant? Why would that seem to them to be in a sense a career option and why would that seem to convey a sense of self-esteem and a sense of worth and what can we do to intervene at an earlier stage? I think that would get across some of the difficulties that Deputy McGennis referred to there in relation to people saying you're glamourising lone parenthood. I would be very conscious that we should not do that.

We do not want to increase, inadvertently by trying to reduce the numbers of those seeking abortion, the numbers of lone parents because, unfortunately, the reality is that it's an indicator of poverty, it's an indicator for long-term dysfunction. So there's a very delicate balancing act here but I think it's one that could be tackled. We have the resources, we have the research and the people capable of doing it. What you need is an integrated policy, something similar to the poverty proofing that things have to go through. You have to look at the impact on family structure, on things like teen pregnancy and older age pregnancy, of everything that we do, you know, and particularly everything that legislators do.

Professor Casey: Another related point in relation to, you know, resources and helping single mothers, some people say that we should stop welfare payments. In fact, they have stopped welfare payments in the United States. I want to put it on the record that we do not support that. We do not believe in penalising women who become pregnant and choose to continue the pregnancy and have their babies. We do not support that measure. I know it's happening in the United States. I understand it's being considered in Britain but we would consider that cruel. Instead, we have to, at an educational level, and the research demonstrates the effect of it, talk to young teenagers about the future, offer them prospects, educational prospects, career prospects, and that combined with the educational package seems to be one of the components of an effective sex education programme.

Ms O'Brien: I suppose in a sense, and I don't intend at all to be flippant about this, the answer to crisis pregnancy is that people do not get pregnant and that we should be working towards that, I think, as a solution and that as a society we would work together to try and do everything. In a sense it's something that needs to be attacked on all fronts at once. Also, as legislators, you're very used to hearing there's greater co-ordination between Departments. You know, that territories would not be quite so jealously guarded perhaps.

Senator O'Donovan: I will be brief, just a couple of questions. First, I welcome you. I've been listening to your interesting submissions and comments. On the question of adoption, is it not the fact – maybe I'll address this to Professor Casey – that what happened basically in around the late 1970s and early 1980s I'd say the whole, if you want to put this, I'm not saying this in any way derogatory, raw material dried up? In other words, there came to a stage that there were little or no babies for adoption and that has actually broadened for a number of reasons, particularly, I suppose, there was a seismic shift whereby pregnant women were prepared to have their baby and rear their babies which, maybe in the early 1960s, there was a stigma attached to that and that we've shifted in that direction. It's a shift I welcome and I welcome your comments also with regard to … I couldn't see this State denying such people their social welfare benefits, you know. But isn't it a case that the raw material, so to speak, dried up?

I want to further my point in that there is a huge demand, in my view, out there by couples throughout this country for children for adoption. I had some experience of this myself. Furthermore, certain people waiting for ten, 12 or 15 years are frustrated because basically you have as good a chance of winning the lottery

as getting a baby. That is a thing I've come across. Furthermore, there was age restriction, etc., brought in. As against that, to show the huge demand and desire I think approximately 400 couples went to Romania and adopted children – it may be more or less. I was out there myself and I saw the orphanages, etc. In what way now can we promote adoption when we've a sort of a shift of emphasis on the way young girls think? There is also, obviously, very few available even now.

Deputy McGennis: In reference to what Professor Casey said, we need to de-stigmatise adoption. Adoption is now considered to be an absolutely horrific handing away of a baby.

Professor Casey: Girls who contemplate adoption are made to seem abnormal. They are made to seem the mavericks.

Deputy McGennis: And will be for the rest of their lives.

Professor Casey: Women who come to me who have had abortions, and who have been traumatised by the abortions, will say to me 'I could never have given up my baby for adoption, it was easier to kill my baby'. They use that very dramatic language. I think we have to begin to de-stigmatise adoption.

There have been a number of television programmes and radio programmes devoted to it, but we need an advertising campaign, as I said earlier, similar to the citizen traveller one, that would perhaps focus partly on the general population but, more specifically, on the population who might be considering adoption, i.e. women who are pregnant with unplanned pregnancies. A leafleting and advertising campaign, similar to the positive images of motherhood one, would go very well. A combination of the positive images of motherhood and the adoption type advertisements could work very well on national television and independent television channels, and then using leaflets, posters and billboards as well. There is a huge job of work to do.

I am not suggesting for one moment that adoption will solve the problem totally because it will not – it will only be suitable for a number of women. But it could be very useful for a much greater number of women than it now is.

Ms O'Brien: One of the valuable things in the RSE resource material is that they actually discuss the issue of adoption very sensitively and well. But it would be wonderful if people like, say, the adoptive parents association, who are quite willing to go into schools and are quite willing to talk about it .... I have had the very sad experience of a girl actually being afraid to admit she was adopted because of the negative reaction she got from her peers. They said, 'Oh, that's terrible, your mother abandoned you', instead of seeing it as 'your mother loved you so much that she was willing to part with you because she felt …'. I think it can be done, though.

Senator O'Donovan: In regard to educational research, I made the point to one of the expert speakers that we are seen in this country as having, if not the best, one of the best educated young populations in the Western world. Is it the case that, whereas we are maybe leaps and bounds ahead of other countries or, at least, abreast of them in many ways, we are miles behind in regard to sex education, both in schools and at home?

Ms O'Brien: It is funny – I do not actually think we are. I think perhaps we under estimate ourselves. I do not have the research to hand, but I remember a study which showed that 67% of parents – which is quite a significant number of parents – were actually instigating sex education with their children themselves.

Perhaps we have a sort of national inferiority complex in many ways about many aspects. It is extraordinarily common to hear we have the highest abortion rate in Europe, which is simply not true at all. But it is so common to hear the idea that we are very poorly equipped in relation to sex education.

The RSE programme only came in a number of years ago. However, in the school in which I work, and in many other schools of which I am aware, relationships and sexuality education would have been part and parcel and responses would have been given to what young people were asking at a particular time.

There is always something to learn. Perhaps, what we need to learn from the Netherlands, if we are going to learn anything, is the strong family emphasis. We tend to think of the Netherlands in terms of Amsterdam, the coffee shops, the free availability of drugs and so on. There is actually still an extraordinarily strong Calvinist element to the Netherlands, which nobody is looking at, at all. Family structure and family loyalty are considered to be very important. That is not looked at as a factor. It is a very strong factor. I spoke to a researcher in Britain two days ago who is very much of the 'Well, they are all going to be doing it so we better get them using condoms' mentality. She said she has been to five different conferences where they have been looking at the Netherlands. She said what has emerged out of all of them is the importance of family and the importance of looking at all the structures and all of this working together.

Senator O'Donovan: Speaking as a lay person, I feel, coming from a very rural part of Ireland ....

Ms O'Brien: As I do.

Senator O'Donovan: .... that not enough is being done in the schools. I know parents have to play a role, and I am a parent myself. However, I feel that sex education is a bit like civics, in that it is the class you can go to sleep in or doss. I honestly believe ....

Ms O'Brien: Nobody goes to sleep in sex education. I can guarantee that.

Senator O'Donovan: Fair enough, but the point I am trying to make is that it is not at the top of the agenda.

Ms O'Brien: Sure.

Senator O'Donovan: I still reckon we are lagging far behind. Maybe some of the other schools are not. However, I do not think we are doing enough in the schools.

Ms O'Brien: If I could make a quick point – it would not be appropriate for me, as a teacher, to be here and not to carp a little bit. When you mentioned civic, social and political education, they were introduced along with RSE as mandatory. There was supposed to be room found in the timetable for them, in a timetable that was already bursting at the seams. That is part of the difficulty. Also, one class a week – the ideal thing is a cross-curricular approach that is dealt with in science. Actually, some of the most frightening sex education happens in science, when they study things like sexually transmitted diseases. The young people come out weak at the knees after it. It happens in science, it happens in home education, it happens in religion, according to the ethos of the school. It happens in social, personal and health education, it happens in English class, in a sense. It is across the board. But it is very difficult to do that in a timetable which is bursting. Schools are being asked to do more and more to make up for the deficiencies of society, and there is only so much that can be done.

Deputy McGennis: I would be tempted to say teachers should be working longer hours.

Ms O'Brien: Perhaps we should scratch that from the record.

Chairman: I do not think we should ask the schools to solve all our problems. One view I got from you very clearly this morning is that our images of motherhood, adoption, pregnancy and sexual activity are very important. All of us, as legislators, parents and communicators, have a responsibility to see that appropriate messages go out in that area. To some extent, there are a lot of confused images today of these matters, and that does not help.

I will leave it at that, unless anybody has any questions. Thank you very much for your assistance.

Ms O'Brien: Thank you very much for listening.

THE JOINT COMMITTEE ADJOURNED AT 1.08 PM UNTIL 9.00 AM ON WEDNESDAY, 24 MAY 2000.

WEDNESDAY, 24 MAY 2000, 9.00 AM.
MEMBERS PRESENT:
DEPUTY B. DALY, S. KIRK, M. McGENNIS, L. McMANUS, J. O'KEEFFE, SENATOR D. O'DONOVAN, K. O'MEARA.

DEPUTY B. LENIHAN IN THE CHAIR

Mr Tony O'Brien, Ms Sherie de Burgh, Catherine Forde, Dr Niall O'Leary

Chairman: We are now in public session and I welcome to this meeting of the Joint Committee on the Constitution the following representatives of the Irish Family Planning Association: Mr Tony O'Brien, chief executive; Ms Sherie de Burgh, director of counselling; Catherine Forde, honorary legal counsel; and Dr Niall O'Leary, special adviser and general practitioner. We have received your presentation which has been circulated to members and tabled in the Houses of the Oireachtas. The format of this meeting is that you may, if you wish, elaborate on your submission. That will be followed by a question and answer session with the members. Your attention is drawn to the fact that while members of the committee have absolute privilege, the same privilege does not apply to you. I take it that you propose to elaborate on the submission, Mr O'Brien?

Mr T. O'Brien: Thank you, Chairman. By way of a slightly enhanced introduction, I would emphasise that the pregnancy counselling service the IFPA provides, which my colleague Sherie de Burgh directs, counselled 2,080 women in 1999, of which 1,169 asked for abortion information within the meaning of the 1995 Act. Some 305 women had first contact with us post-abortion. Our service also provides training to a wide range of other service providers, including general practitioners and the organisation Cherish. That is by way of background.

Your hearings so far, Chairman, have been very much concerned, as we read them, with what are generally called the hard cases. We have also noted some negative and somewhat dismissive references to other types of abortion, which have been characterised here as social abortions. We think this dichotomy is false. For those involved, every abortion is a hard case. Our aim today is, if we can, to help turn your attention to the everyday realities of Irish abortion for thousands of women and couples. We would say that any discussion which invests its concern only in the so-called hard cases would be irrelevant to the daily reality of Irish abortion and the needs of the women and men and their families who experience it. On reviewing the extensive medical evidence which you have heard, it does not appear to us, in the main, to have been from persons actually involved in dealing with women experiencing everyday crisis pregnancy. This year we expect that more than 6,500 women will give an Irish address when in an English abortion clinic, while countless other Irish women will use convenience addresses and very few of that total will be reflected in the hard cases that you've been discussing.

At this very moment, there are very certainly 20 to 30 Irish women in English abortion clinics and some of them will be in a clinic which is no more than 120 miles from the room we're in this morning. We would very much doubt that more than one or two of them at the very most

would fit the working definition which we've heard here – hard cases – or, on their journey, would have come next or near many of your previous witnesses.

We would also argue that the long running and delayed debate has been not so much about abortion as about geography and perhaps about abortion law and also that the protracted nature of the debate prior to the publication of the Green Paper, which we very much welcome, has also been part of the problem. Given that we're in a country which may very well now be contemplating a fifth referendum on the abortion issues in under 18 years, it is perhaps shocking to note that no Government to date has ever published a quantified target for the reduction of the number of teenage pregnancies, a quantified target for adoption in unplanned pregnancy in general, a quantified target for reduction in sexually transmitted infections or, indeed, a quantified target for the reduction in the incidence of Irish abortion. Any commitment to minimise the incidence of Irish abortion or, indeed, to improve sexual health more generally will require far more than the overdue scrapping of some bizarre laws. It requires concerted action, targeted resources and clear policy and we are sorry to say that to date we've seen evidence of none of those.

We hope that the committee can come to share a vision which we have of a society in which we are all committed to meaningful action to reduce the causes of abortion rather than simply trying to wish it away in the midst of what we would characterise as a moralistic haze and the vision of a society in which we treat all women with equal respect and care whatever their decision.

We've also been disappointed to hear the phrase 'opening the floodgates' cropping up here in recent weeks. We're at a loss to know what the precise nature of these alleged floodgates is. If your committee, as part of this process, wished to hear evidence from the Irish women who have had abortions in the past two decades and assuming you could persuade them to come and talk, no room at your disposal would suffice. You'd really need to hire Croke Park over several days in order to accommodate them all. So we really don't understand this reference to floodgates.

While many different factors are considered by those experiencing a crisis pregnancy, it is our experience that the current state of the law in Ireland is not one of them. So the reality is that more than one in ten Irish conceptions ends in abortion. The reality is that those abortions occur later in pregnancy than would be the case if those abortions were available here. Hitherto, as a society, we haven't really done anything about that. We strongly contend that this society can and must do much better. Thank you, Chairman. That concludes our opening statement.

Senator O'Donovan: First, I'd like to welcome you here. I've just one question. I've listened with interest to what you've said. I was interested in what the Irish Medical Council said, in its submission, which I felt was rather conservative. It has a particular stance on existing practice in this country and maybe I was one of the people who mentioned the question of opening the floodgates. The views I got from some of these consultants … you might argue, and correctly so, that they may not have first hand experience of women who become pregnant and seek help, advice and counselling … they're obviously at the coalface … they also admitted, I think, that it's only when they get into the maternity units that they're faced with this situation. I got the distinct impression from the Irish Medical Council, which is an umbrella organisation covering obstetricians and gynaecologists, and I think all doctors are affiliated, that, in a scenario like in England where abortion has been legalised on whatever terms, in this country if we had a more flexible attitude, leaving aside the social grounds, most of its members, if not all, would be of the view that they wouldn't deal with most of the situations we referred to.

You might argue that we're exporting our problems. I don't honestly know, I don't have all the answers. I'm just wondering what would your stance be, given that the Irish Medical Council in its recent submission felt that if, say, we legislate here to bring in abortion even in very limited circumstances, there could be difficulties practically, maybe on moral grounds or ethical grounds, under its guidelines in effecting such changes.

Mr O'Brien: Well naturally the current ethical guidelines of the Irish Medical Council are a direct reflection of the current state of law and we wouldn't expect that to be otherwise. We would take the view that if the legislators or whatever other process you might adopt were to change that law, that would have a profound effect both on attitudes and medical practice. In other countries where similar changes have been contemplated, we have also seen changes in practice following those things, but fundamentally, the fact that doctors under the current situation do not see that it is possible to provide abortion should not provide an argument for changing the legal framework.

Senator O'Donovan: Well, I don't want to pursue this but one if not two of the experts I listened to in the debate so far clearly made the point that let's say euthanasia was legalised in this country, on moral ethical grounds he – I think there was somebody else said that – wouldn't take part in such action. I think purely changing the law may not change the ethical guidelines. I got the distinct impression from some of those experts from the gynaecologist-obstetrician field that even if the law was changed on their strict ethical guidelines, they would have a different parameter.

Dr N. O'Leary: If I could just interject there. Ultimately, I suppose it's up to an individual doctor to … ultimately a doctor, I suppose, always has the right to opt out of a particular clinic situation should he or she have a moral difficulty with it. I think our view here would be that if the law makes certain changes, then the doctors – all doctors, in fact, to clarify that – are bound by the Medical Council. If an individual acted legally but acted in a way that was outside the parameters of the current guidelines from the Medical Council, there would be a conflict there and certainly the doctor could be brought before the Medical Council. The Medical Council doesn't strike a doctor off, of course, it simply recommends to the courts, the High Court, I think, that this individual be struck off and, ultimately, it would then be for the courts to decide. I think a doctor would certainly fight it in the circumstance where he was pursuing a particular line which was legal but which was not necessarily within the parameters of the Medical Council.

I would reiterate that the council should respond to the current situation, and that's how I would see it, and review its own stance based on current thinking, based on what the law is. I think the onus would be on the Medical Council to review its own situation. I think doctors would … if the law changed, I think it would free up those doctors who felt they could pursue a certain line to continue with that and then doctors who had a moral dilemma could have the option of opting out just as is the situation now. I don't know if that answers your question.

Senator O'Donovan: Yes, I think. I accept what you are saying but it's just that there's been so many different opinions offered to us. I am purely a lay person in this argument and we're faced with a mammoth task of trying to resolve the situation. Some people will say that a referendum is the solution, more people say legislation, others say a mixture of both. When I questioned some people from the Medical Council I was seeking guidelines on what it would like to see from an ethical practical point of view on a day to day basis, I found it almost impossible to get answers from them. I also got the impression that even if the law was changed maybe the vast majority of them wouldn't operate the system.

Dr O'Leary: I'm not sure it would be the vast majority. I think within the Medical Council you get quite a broad range of opinion which is reflected in the medical profession as a whole. I certainly wouldn't see a situation that if the law were changed that there would be inevitably a conflict between the Medical Council and the legislators. It would simply mean that it would move the thing a little forward on and rekindle debate within the Medical Council, but I certainly don't see the vast majority of those within the Medical Council recommending that the *status quo* be maintained, particularly if changes were to occur in the legislation.

Deputy McManus: Just a couple of brief questions. First, the point is well made that we're not hearing from the women themselves and, in a sense, people have to be agents on behalf of the women. One point that has come up from some service providers is this idea that somehow abortion is very traumatic, that women are damaged by it and that the common complaint is had they known what they were letting themselves in for they would not have done what they did. I noticed that a small number of people come back to you post-abortion and maybe you could explain a little what your experience is in terms of the post-abortion experience, whether that is an adequate description.

You concentrate on minors having access to court. Perhaps you could talk a bit about that. I am not clear, your primary recommendation is the deletion of Article 40.3.3o, but what are you suggesting would be put in its place? I do not mean put in its place in the Constitution, but are you saying that legislation should be introduced or should it just be a matter between a woman and her doctor? I am not clear. What is your primary or ideal proposal?

Mr O'Brien: I will ask Sherie de Burgh to respond to your first question.

Ms S. de Burgh: The thing about women traumatised by abortion, I would have to say in my experience the first thing is that no woman ever wants to have an abortion or would ever have one if she felt that there was another option. That would certainly be my experience. But given that the average fertile woman has about 35 child bearing years during which she could technically be pregnant every year, many, many women have unplanned pregnancies right across the board, going from approximately 13 to 50 plus.

For each woman her unplanned or unwanted pregnancy is a crisis and I think that counselling services … my own feeling that the provision of non-directive counselling and support services makes an enormous difference to women who decide to travel for termination or who have crisis pregnancies and are looking at the options or who have even decided themselves that termination might be their best option. The reason I think that is simple. Any crisis that occurs in any of our lives, of any sort, any major decision that we have to make, the time that we can take to look at the options, to look at our feelings, to separate from the initial reaction of how it is going to affect everybody else and come back to how we ourselves feel, to get a sense of choice, even if the choices are not good.

In a crisis pregnancy a woman will have two basic choices, to continue or not, both of which she would feel are rotten choices to have to take, but she is going to have to choose one of them. I think that counselling services can help, non-directive counselling services can help enormously in that. That kind of procedure in decision making reduces enormously the issues that arise afterwards. For instance, very often in post-abortion work, either one-to-one counselling or the support group that I facilitate, women will – it is not that they regret the decision in the sense that when they go through the situation they were in at the time they took the decision they will very often realise the reasons why they took that, in other words they thought and felt that it was the best decision for them and for their immediate people at the time. But, because they had not the opportunity, perhaps, to work through that at the time it comes up for them over and over again.

Very often, in post-abortion work, the woman will finally resolve the situation around her initial crisis pregnancy or, in many cases, look at the whole of her life in which that crisis pregnancy occurred. Does that help answer it?

Mr O'Brien: I will ask Catherine Forde to respond to the second part.

Ms C. Forde: With regard to access of minors to the courts, I would refer you perhaps to our initial document or initial submission, Facing up to Reality. On page 11 of that there is a discussion as to why minors should have access to the courts. A lot of those difficulties were actually highlighted by the C case, where in fact if the child in the C case had not been suicidal then the court would have refused the health board permission to take her outside the jurisdiction for an abortion and in those circumstances that child would have been required to take that pregnancy to its – to have the child. Parents can be in conflict as to what the child wants and unless the child has actually direct access to the courts then they may be in difficulty

in exercising their own rights to travel because of their, what you might call, legal incapacity. Those are the main reasons we would be of the view that minors should have access to the courts.

With regard to the deletion of Article 43.3.3o, I think I would refer you – it is also referred at the back of the Green Paper on Abortion, to the situation which operates in Canada, where there is no legal or constitutional restriction on access to abortion in Canada. They legalised abortion in 1969 and in 1988 the law which permitted abortion was actually struck down as an interference with the right to security of the person and the right to liberty and to freedom of conscience. Since that time that Government has not succeeded in bringing in any legislation which restricts access to abortion, hence abortion has now become an issue between a woman and her doctor.

If you look at the statistics in Canada, you will see that in 1969 there was an increase in the abortion rate when it became legal. Prior to that there had been an abortion rate, a back street abortion rate, but not a legal abortion rate. The abortion rate increased. It then increased again slightly in 1988 and since that time in fact it has been decreasing and the things that affect the abortion rate in Canada are things like recession, increases in the poverty rates and, in particular, cutbacks in Government reproductive health programmes. Those are the things that affect abortion, not the fact that it is free and easily acceptable. Laws do not create abortion, it is the situations that create pregnancy crises that do.

Deputy J. O'Keeffe: I missed the early part of your presentation. I have been reading your opening statement and I have been comparing it with the evidence we had yesterday from Professor Casey and Ms Breda O'Brien, especially your comments about minimising the abortion rate. Is there a big difference between the approach you are suggesting from that point of view in the economic context of your views on adoption, counselling, education and promoting positive images of motherhood? You obviously were not here yesterday, but if you are talking about establishing a quantified target for the reduction of teenage pregnancy and about meaningful action to reduce the causes of abortion rather than simply trying to wish it away, is there common ground with the witnesses we had yesterday on the areas I have mentioned?

Mr O'Brien: Not having heard their evidence yesterday it is difficult to say, so I would be aware in general terms of things they might be likely to say, but very much the emphasis of our recommendations would be on the provision of very accessible high quality reproductive and sexual health services, supplemented in many ways by things which they recommend which we do not have a problem with. But we are concerned that in the last ten years, as I said in the presentation, we have seen some fairly negative laws swept away, but we have not seen particularly good programmes put in place. We have not seen the establishment of targets or the provision of funds to match those targets, so we would probably say, I think in fact we would say, that we do not take at all seriously the issue of limiting the number of teenage pregnancies or unplanned pregnancies in general, so we would very much put the emphasis on directing resources and programmes at affecting early sexual behaviour, affecting attitudes to the risk of pregnancy and affecting practice in terms of use of contraception or avoidance of first onset of sexual intercourse.

Deputy J. O'Keeffe: Without in any way presuming on the view that will emerge from this committee, we certainly have had an amount of evidence in relation to the lack of resources in dealing with the question of crisis pregnancies and in reducing and minimising, in particular, teenage pregnancies. As I said, without anticipating on the basis that there will very probably be a strong recommendation in that regard from the point of view of making available the necessary resources, it is then a question of resources for what. If we are agreed that it is to achieve something like reducing the incidence of teenage pregnancy, we are agreed. There may then be agreement on resources and there may be agreement on the objective, but then it becomes a question of what is the best means of using those resources to achieve that objective. That is perhaps where we would like to tease it out a bit more.

In relation to two issues, perhaps you might give me a further view. One is in relation to the kind of educational approach that should be adopted. What are your views on the current RSE? What changes should be made in this regard? Second, what are your views in relation to the availability of, and access to, contraception for the young?

Mr O'Brien: We are very positive supporters of the content of the framework RSE programme, as published by the Department. Our concern would be that it is being regarded as something of an *à la carte* menu and that it is being cherry-picked in an inappropriate way in some schools, that the latest figures which we have seen indicate that there are still a significant number of schools not adequately providing the RSE programme. So we would be concerned to see intervention on the part of the Department of Education and Science to ensure greater access on the part of school students to the RSE programme.

The second point is we would think that the most important single measure that could be taken is the introduction of a universal free family planning service for all persons in the country, but as a first measure targeted at all persons under the age of 25, which would include an absolute right to choose the point of contact so that they would have the right to choose either their own family's doctor, particularly if they are a GMS cardholder, or another doctor or a right to transport that benefit to a specialist family planning or Well Woman health clinic. We would also like to see that supplemented by the establishment of a substantial network of centres specifically targeted and catering for the needs of young people, designed with the input of young people, open at the times that are appropriate to them and sited in locations that are accessible to them.

Deputy J. O'Keeffe: What would you feel about programmes which would be designed to discourage sexual activity on the part of the young?

Mr O'Brien: Any programme would have to include appropriate content which would point out the benefits of deferring first sexual experience. There is also … It is important I should say that there is no evidence anywhere

that the provision of a contraceptive service directly affects the level of sexual activity in the sense that if there is no contraceptive service, sexual activity will still take place and if there is a contraceptive service, that level of sexual activity will not be increased. One of the key issues is to create a context in which young people will feel that they have the right to access appropriate personnel who can discuss with them their wishes, their views and their needs, talk to them about whether they are being put under peer pressure to become sexually active before they are ready and make sure that they have the appropriate information; and to include within that information that makes it clear to them that they have the right to defer sexual experience, that there is no prize for being the first in the class to be sexually active, that in fact the notion that everybody is doing it is not correct at all – there is a lot of myth out there – and to include in that empowerment information so that people feel that they have both a right and some benefits to deferring first sexual experience until later, until they are ready.

Deputy J. O'Keeffe: Do I take it then you do not see a necessary dichotomy or difficulty in achieving a balance in terms of a programme that would involve encouraging a delay in sexual activity on the part of the young and at the same time highlighting the availability of contraceptives?

Mr O'Brien: Certainly not, as long as it is done from the standpoint of empowerment of the young person rather than a censorious or directive approach.

Deputy J. O'Keeffe: Thank you.

Chairman: Just returning to your report, you have recommended to us that the present constitutional provision inserted in 1983 should be repealed in its entirety and that the Constitution should be amended to provide that any right to life in the Constitution only refers to persons who are born, so that would require a referendum, that particular recommendation, isn't that right?

Mr O'Brien: That is correct, yes.

Chairman: Under our present constitutional arrangements.

Mr O'Brien: Yes.

Chairman: Do you really see that as a political starter?

Mr O'Brien: It depends on the extent of leadership that is shown in framing the question. I think that much of the evidence that you have had hitherto – we have read it very carefully – tends, if anything, to support the view that Article 40.3.3° was a mistake and that a good starting point would be to remove it, but clearly there would be many views and any process which is begun which could lead to that outcome would be, I am sure, a very interesting and detailed discussion. This is one reason we have included within our proposals the notion of a preferendum because we think that the history of black and white, yes or no, referendums has proved very unhelpful in the context of this issue, regardless of your viewpoint on abortion but from the point of view of having good public policy and a clear outcome.

Chairman: Your proposal is that any right to life in the Constitution only refers to persons who are born. That is a proposal for a referendum, isn't it? There is no choice on that.

Mr O'Brien: Any single proposition can be put with other single propositions into a preferendum so that does include choice.

Chairman: You are opening for debate the preferendum option essentially. Is that a fair comment on your submission?

Mr O'Brien: Yes, although I believe you have also had some evidence from the de Borda Institute, which has put forward the de Borda preferendum principle. We agree with the principles that it talks about but we have suggested removing one or two of the options which your hearings have already shown to be impractical and contrary to the interests of women's health.

Chairman: Yes, your first point is that the absolute ban option should not be recommended by us and I am ....

Mr O'Brien: That's right.

Chairman: Moving to your next proposal, the committee should recommend that sections 58 and 59 of the 1986 Act should be repealed, that is the present criminal prohibition on abortion.

Mr O'Brien: That's right.

Chairman: Have you any proposals to put anything in their place?

Mr O'Brien: I think perhaps while you were out of the room earlier we covered the situation in Canada.

Chairman: No, I was in the room and I heard that.

Mr O'Brien: We see the situation in Canada as being a good example to work from, and perhaps Catherine would like to say another word.

Ms Forde: I will just say that one of the difficulties that there is with the legislation, the Offences Against the Person Act, is that that continues to cause difficulties in the North of Ireland and there have been reports that state that that is probably in conflict with European conventions so I think that we would be looking for the repeal of that Act in any event.

The other difficulty there is – you will see from our submission – that we define the word 'unborn' as a foetus which has arrived at the state of viability and, therefore, if rights are to be conferred, they are not to be conferred until that particular time is arrived at. This is because of the conflict that arises between the woman and her foetus, and I think the as yet unforeseen difficulties in legal terms that we will have, both with Article 43 and also with retaining a general right to life of the unborn, as has been

stated by the courts. Therefore, I think our view is that we would want to see the rights being similar to those that are conferred by the Universal Declaration of Human Rights, which only confers rights on those who are born or at least capable of sustaining a proper separate existence themselves.

Chairman: The question I asked was, assume, first of all, you do not want constitutional rights conferred on persons other than persons who are born – that is clear from the earlier submission. The next one is that we should recommend that the Offences Against the Person Act should be repealed, or the relevant sections. My question was, is there any provision you would put in their place?

Ms Forde: I do not see any need to put anything in place and that would be similar to the situation in Canada. I think that the only fallback that would have to be necessary then would be to ensure that any delivery or induced delivery of a foetus, once it has reached viability, would be conducted in a proper fashion. In other words, that would be overcoming the problems with regard to very late abortions after viability. Do you understand what I'm getting at?

Chairman: I don't really, no.

Ms Forde: No, our view is that the unborn should … that the situation with regard to abortion is it's a matter between a woman and her doctor. The foetus will then arrive at a stage when it is viable so if there is any need for criminal sanctions it would be to safeguard and protect any viable foetus, but prior to that there is no need for any criminal legislation. That is the case in Canada. It's not a frightening or intimidating situation. Canada is a very conservative country. Their abortion rate is not excessive and has not increased since the total and absolute decriminalisation of abortion. As I've said before, it is not laws which stop abortion. Article 43 has been for all intents and purposes absolutely useless with regard to reducing the abortion rate in this country.

Chairman: I just wanted to clarify the position then. So you wouldn't have any criminal statutory provision in relation to the protection of unborn life?

Ms Forde: No, there would be no need.

Chairman: Or life before birth. I prefer that expression.

Ms Forde: Yes, life before viability. There would be no need for that.

Chairman: Or life before viability, you say. Excuse me.

Ms Forde: Yes.

Chairman: Medicine is pushing back the time of viability all the time.

Ms Forde: Yes, but I would perhaps point out to you that in Canada where there is no regulation, 88% of women have their terminations before 12 weeks so that when you have an environment where abortion is an ordinary medical procedure the fear and intimidation is taken out of it and people have access at a much earlier stage. As medicine improves this will not be done by surgical methods, it will be done by such things as RU486 and other matters will be dealt with earlier which is much, much more healthy for the woman involved. Any termination at that stage is of less medical risk to the woman than carrying a pregnancy throughout its full period.

Chairman: Various witnesses from the Irish medical profession suggested to us it would be a seismic shift for them to participate in the introduction of terminations on that type of scale in this country.

Ms Forde: I think that if you again get back to a situation where terminations are done very early on by medical procedure as opposed to surgical procedure you are probably doing no different than giving the morning after pill, which can be done by any general medical practitioner. I do not think that there's a general difficulty or problem with the administration of the morning after pill and with the increase and, hopefully, the fact the women would have their terminations much earlier, there would be no difficulty with the administration of such medication as RU486.

Chairman: Yet we didn't hear much evidence of that. Certainly we got very strong submissions in relation to post-coital contraception and the importance of maintaining a clear legal provision there that put the whole question beyond any doubt or question, but I have to say the medical profession in Ireland expressed strong reservations to us about participating in the introduction of abortion here. That was a certain message that was conveyed to us.

Ms Forde: I think that that probably gets back to the aesthetics of abortion and also the later the abortions take place and the manner in which they take place but one would hope that where we take a responsible attitude and women avail of access much earlier that that would overcome ....

Chairman: In England an increasing number of junior doctors refuse to carry out abortions in hospitals.

Ms Forde: I think that's something perhaps Tom will deal with.

Chairman: They exercise their conscientious right under the 1967 Act.

Mr O'Brien: That's right, Chairman. All doctors have that right. It's also the case that with the development of what's called early medical abortion, the type of thing which is associated with the drug RU486, there is a trend in a number of European countries away from a central role of obstetricians and gynaecologists towards physicians. One of the difficulties which Irish women have is that because the use of such a procedure at less than nine weeks of gestation would require an extended stay in England, most Irish women are not getting access to that type of abortion. Where they are having abortions they're tending to have the more conventional form of abortion

which has, although the overall risks are still low, a greater risk associated with it than early medical abortion.

Chairman: Thank you very much for your contribution today. I now ask the representatives of Abortion Reform to take their place before the committee.

Mr O'Brien: Thank you, Chairman.

SITTING SUSPENDED AT 9.46 AM AND RESUMED AT 9.48 AM

Ivana Bacik, Anne Marlborough, Damian O'Broin and Monica O'Connor

Chairman: We are now in public session. I would like to welcome the following representatives of Abortion Reform to this meeting of the Joint Committee on the Constitution. The representatives are Ivana Bacik, Anne Marlborough, Damian O'Broin and Monica O'Connor. I take it that's the sequence in which you are sitting, is it?

A Witness: No.

Chairman: Then it's Ivana Bacik, Monica O'Connor, Damian O'Broin and Anne Marlborough. We received a presentation from you, which has been circulated to the members. We also received a submission from Lawyers for Choice which, I understand, is a group which is subsumed into your group or affiliated to it. Is that correct?

Ms I. Bacik: That's correct, yes.

Chairman: That also has been circulated to the members and both submissions have been tabled before the Houses. The format of this meeting is that one of you may make a brief statement elaborating on your submission and that will be followed by a question and answer session with the members. I want to draw your attention to the fact that while members of the committee have absolute privilege, that same privilege does not apply to you.

Ms Bacik: We welcome the opportunity to make an opening statement. I can make that on behalf of the group.

Chairman: Yes.

Ms Bacik: I think there's just three issues that we'd like to address in an opening statement to you all and we have copies of a brief opening statement if any committee members would like to see them. So there are three issues we'd like to address, themes which derive from our larger submission to the committee. The first issue is the reality of women's experience which we would describe as a double crisis for Irish women and I think this is the first and foremost point we wish to raise. We want to address the reality of Irish women's experiences. For too long we've had a myth that we do not have abortion in Ireland, we clearly do. We can estimate although we don't know the full extent of Irish abortion figures that over 100,000 women have had abortions since 1983, since the constitutional amendment was passed. There is, therefore, an Irish abortion rate. It runs currently at about 6,000 women per year, yet as the IFPA already said this morning, the voices of those women are never heard in this debate. We all know those women. All of us know women who have had abortions in Ireland but those women are silenced under the present legal regime. They are women who face a double crisis. On top of the crisis pregnancy which has given rise to the need for an abortion for them, they also face the added crisis involved in the difficulties in making the journey to England and in the legal and social stigma still attaching.

We say that the needs of these women offer a strong practical reason for legalising abortion in Ireland but it is also important to remember the broader context and, as we said in our submission, control of fertility is increasingly being seen as a human right which is essential to women's control over their lives, to their existence as autonomous members of society and their ability to participate fully in the economic, political, social and indeed cultural life of their country. Our present law makes us deny Irish women full participation in our society. In this context, we should be particularly concerned about inequality of access to abortion. Irish women who are disadvantaged economically or socially face added significant difficulties in seeking abortion in what is already a crisis situation for them. We should not forget the situations of young women, women in remote and rural areas, women in care, asylum seekers, women with learning disabilities – any legal solution must offer a solution that meets their needs.

Abortion Reform, as you know from our submission, is a broad-based pro-choice organisation. We have a number of support groups, among whom we number Lawyers for Choice. We also number Women's Aid – our colleague, Monica O'Connor is here from Women's Aid. We number also Catholics for Free Choice. We number an abortion support group which assists Irish women in London who seek abortions. The Dublin Abortion Rights Group and the Irish Family Planning Association are also affiliates of ours.

Many of the individuals and groups who have signed up as affiliates to our organisation have long experience of working with women in crisis pregnancy. They know very well the real meaning of this phrase ' a double crisis'. They know its effect on the lives of real women and they know especially the effect on those women who are facing added disadvantage. The experience of those women's real needs informs our campaign. The question for us and clearly for you is how do we address the needs of those women in our law?

There are two other points. First, we believe the legal change that is necessary must move from a penal regime to a practical solution. We say no more penal law, instead we must move to a practical legislative framework for the regulation of abortion. We favour the decriminalisation of abortion, as we said in our submission, we favour the

removal of abortion from the Constitution. This is what is ultimately required, we say, to meet the real needs of Irish women. We do believe that it is possible to find a practical, political solution that will meet the needs of Irish women.

One proposal, as we have said, is clearly not practical. That is the proposal contained in option one of the Green Paper, that of an absolute constitutional ban on abortion. We say that any roll-back of the eighth amendment would seriously endanger the lives of Irish women. It would necessitate a removal of the present situation where the life of a woman is seen as equal to that of the foetus in the Constitution. We have seen from the medical submissions and the evidence of doctors before this committee that there is some disagreement among the medical profession as to when terminations of pregnancy are necessary in order to save pregnant women's lives. But it is also clear, as the Green Paper has said, that the idea of an absolute ban relies on an understanding of a distinction between what has been described as direct and indirect abortion and that this understanding is itself controversial and it would be unsafe to rely upon it in any legal framework. We believe that it not only would be unsafe, it would compromise current medical practice and endanger the lives of Irish women.

We believe, therefore, that a practical approach must recognise the need for legalisation of abortion. and we believe that this outcome itself is more important than the process by which it is achieved. However, as our third point we do think we can address you on practical processes for legal change whereby a legalisation of abortion could be achieved. We say there are essentially two processes by which practical legislative compromise would be achieved. First, it could be done without the need for a constitutional amendment. In 1992, legislation was promised in order to implement the X case judgment upon the defeat of the 12th amendment to the Constitution.

Such legislation could be introduced permitting doctors to carry out abortions where the continuation of a pregnancy posed a real and substantial risk to the life of a pregnant woman, the test proposed by the Supreme Court in the X case. Such legislation would safeguard current medical practice, prevent the occurrence of future X and C cases and be in line with the existing constitutional position. In our policy document, which you should also have received a copy of, we have set out the issues which would need to be covered in any such legislation and indeed the Constitutional Review Group has also considered the matters that would have to be dealt with in such legislation, without the need for a constitutional amendment.

If, however, the committee were to decide that the Constitution should be amended, and indeed ultimately we believe it should be, then a practical political solution again presents itself. We believe a preferendum type vote could be held in order to prevent polarisation of the issue and in order to present the people with a broader range of choices. We believe that a number of options for reform could be put to the people, perhaps mirroring some of the options presented in the Green Paper. In such a preferendum, our position would be to call for the repeal and deletion of Article 43.3 and its replacement by a legislative regulatory framework for abortion.

The advantage of this type of vote would be that it would enable a better reflection of the broad spectrum of views which currently exists on the issue of abortion among the Irish people. This type of vote would be better able to engender a consensus as to some sort of compromise on an issue that has always been seen as politically divisive. The option ultimately chosen in a preferendum would represent the approach acceptable to most people, a compromise that all could live with and, we say, a move from coercion to compassion in the law.

We have spoken, therefore, of the double crisis facing Irish women, the reality of their experiences of abortion at present, of the need to move from a penal regime to a practical solution and of the processes whereby this could be achieved, and we hope our submission is of some help to the committee.

Deputy J. O'Keeffe Thank you for coming along and presenting your views with such clarity. We have had the opportunity of reading your earlier submission. Basically, as I see it, you want to remove the issue from the Constitution and you want legislation regulating abortion in Ireland. Can you give us any idea as to whether you think there is much support in the country for such an approach? Do you think from a practical point of view there is any significant view in Ireland behind the approach you are now advocating?

Ms Bacik: Yes we believe there is and we have made reference in our submission to an opinion poll conducted in 1997 which showed that, I think, 77% of those polled believed in some form of limited abortion. Again, as I have said, we believe there is a broad spectrum of views and I think that is the right position but when people are confronted with a real situation, as they were in 1992 with the X case and again more recently with the C case, I think that the views of people tend to become less fixed and less absolute. What we are proposing is a move from the polarised positions often taken in this debate and a move towards trying to find a solution that is acceptable to most people.

Deputy J. O'Keeffe: Now that you have raised the issue of that poll, perhaps we might just explore the findings. You mentioned the 77%, but in fact in that poll 35% were supportive of an abortion where a woman's life was at risk, but, indeed there was a residual 18% who would not even consider that as being the case for permitting an abortion in Ireland, who would not accept an abortion under any circumstances. Does that not indicate a very hard core view against abortion under any circumstances, even when the mother's life is at risk?

Ms Bacik: Obviously we do not want to rely too heavily on any poll because a poll is questions in the abstract. I think the outpouring of public sympathy for the girl at the centre of the X case and for her family demonstrated that when confronted with a real situation most people do move somewhat from a very fixed position.

Deputy J. O'Keeffe: Do you understand the relevance of the feelings of the people because if you are talking about any constitutional change, obviously the first practical issue one has to consider is whether any such constitutional change will be approved by the people?

Ms Bacik: Yes, and I think that is one of the reasons we have put forward the idea of a preferendum which my colleague, Damian, can expand on.

Mr D. O'Broin: Given that there is such a wide divergence of opinion on abortion, and clearly it is not a black and white issue, there are many shades of opinion on it, a preferendum is one mechanism which will allow that opinion to be expressed by the people and give voice to those opinions and those differences and, hopefully, reach a workable and practical solution which the greatest number of people can actually live with as a political solution to the issue of abortion in Ireland.

Deputy J. O'Keeffe: Moving on to the question of legislation, do you think that there should be any criminal sanction in relation to abortion at any time?

Ms Bacik: Well, we have called for the repeal of sections 58 and 59 of the Offences Against the Person Act because we believe – I think there would be wide support for this view – that it's inappropriate that women in crisis pregnancies should be faced with criminal sanction. Indeed, the law hasn't been used for a very lengthy period of time to criminalise women who have had abortions. We do believe, however, that a legislative framework should be introduced regulating the process whereby abortion is performed in Ireland. Clearly there would have to be some form of sanction for those medical practitioners who didn't abide by the regulations set down, for those who were breaching the law, but other than that, no, we don't believe in criminal sanctions. We don't believe they're appropriate for women in crisis.

Deputy J. O'Keeffe: Do I take it that you would see no criminal sanction against an expectant mother for any abortion at any time during the term or for any reason, that she would be exempt from any criminal sanction, but that you would envisage some form of regulatory framework for the medical profession? Could you just briefly indicate what you think such a regulatory framework might be?

Ms Bacik: Well, we'd be happy to provide the committee with the heads of the Bill, if required. We welcome that opportunity to do so. I think that, again as I've said, the Constitution Review Group and we in our own submission have made clear the issues that would have to be addressed in a regulatory framework, and they would include matters such as the definition of abortion, the provision for opt out by medical practitioners who wish it. I think that's been raised previously before your committee. We'd also have to deal with issues about term: when within pregnancy, up to what stage, could abortions be performed and so on. So, there are a range of issues which would have to be defined and regulated through legislation.

Deputy J. O'Keeffe: Finally, on that point, what would your view be on term?

Ms Bacik: Well, none of us here is a doctor. I think we would leave that to expert medical opinion to decide upon. I think we can look at examples in other countries to see at what point … there's generally a consensus in other countries as to what term within pregnancy abortions can be performed until.

Deputy McManus: Thank you very much indeed for coming here. I think you have certainly clarified the points as regards the position and, again, there is this difficulty the committee has that we can't access the women directly and that it is important that the points that I think some of them might raise are raised here as best we can.

I just wanted to focus for a minute on this idea of a preferendum. I have a difficulty about getting my head around this. The argument as I understand it is that you're saying this matter should not be in the Constitution. If that is the case, presumably the idea of a preferendum would open up options that would have this issue dealt with within the Constitution, even though that is not the position that you would hold as being desirable or helpful. Is that right?

Second, in regard to a preferendum, my understanding is that a preferendum is simply an opinion poll. It doesn't have a statutory basis or constitutional basis that would render a decision made by way of preferendum to be binding.

Mr O'Broin: Well, just on the first point, obviously we would advocate, in a preferendum situation, if there were a number of options placed before the people, the removal of Article 40.3.3° and its replacement by legislation providing a regulatory framework for abortion. Other people wouldn't hold that view and would obviously advocate other positions and other people believe that abortion should remain in the Constitution. What a preferendum will do, it will allow people to advocate their own particular view and, hopefully, allow Irish people to come to some consensus or compromise on the issue. We may not win. We don't claim that that will be the outcome.

On the second point, I don't think there's anything to preclude a preferendum taking place in the Constitution and I'm not a constitutional expert, but I do know that Gerard Hogan has suggested that the issue be kept under review in the Constitutional Review Group. I believe the de Borda Institute has suggested that maybe a constitutional amendment should be introduced to enable a preferendum specifically as a means of resolving disputes of this nature.

Deputy McManus: So you're not suggesting a preferendum on a preferendum?

Mr O'Broin: That may not be possible.

Deputy McManus: Okay, so what you're saying is that, if there were a preferendum, if the choice was at the end of the day that there would be something included in the Constitution, there would then have to be a referendum, unless there was a constitutional referendum in order to allow for a preferendum.

Mr O'Broin: Well, possibly, but again I understand from the de Borda Institute submission that they feel that a preferendum could be used under the current constitutional framework. Now, I don't know the detail of the argument there, but I think the safest option would be to

implement, to facilitate a preferendum by changing the Constitution and then allowing ....

Deputy McManus: Are you absolutely certain that if there was a preferendum choice made which subsequently went to a referendum, people would decide the same way?

Mr O'Broin: Well, I understand the experience has been that it tends to be that case but, again, nothing can be certain.

Deputy McManus: Okay. Thanks very much.

Senator O'Donovan: Just two brief questions. One, the previous group, the Irish Family Planning Association, mentioned, I think, that it used the term with regard to abortion that it would be sort of okay up to viability, which is I understand 22, 23 weeks approximately. It's coming down. I think in Great Britain – there's been a lot of criticism of the English legislation on abortion – the limit, and I stand to be corrected, is about 12 weeks, maybe 14. The big worry I would have in that, if we were to go down that road, whether we like it, I feel Ireland is still very conservative and I would put the question to you, surely is it not essential, seeing that we would be making, if that was the way the people decided, a seismic shift, so to speak, surely there would be initially very stringent restrictions on the timescale for abortion. Again, I'm a lay person. I understand that, you know, it's known in a matter of four or five weeks whether one is pregnant and certainly within possibly two months. Surely there would be a very stringent restriction on this issue, if that were to be the case. If you want to answer that first, I've just one other question.

Ms Bacik: Well, I think that this sort of discussion shows clearly the need for legislation, that this isn't the sort of issue that can be dealt with through the Constitution, that the idea of term and the idea of when viability comes about in pregnancy … as you say there is some change in medical view on that. I think we can gain from experience of other jurisdictions and some jurisdictions have different time limits depending on the reason for the abortion. That might be a model we could look at.

I think we might want to just reconsider the notion of seismic shift given the numbers of Irish women who have had abortions and given the reality of their experiences which some of my colleagues, particularly Monica here, would have had personal experience of women who've been through the reality of abortion. Those women number many thousands. I think that there isn't the shift, there wouldn't be the need for the seismic shift that you describe. I think that there is a view that most people have that abortion is in Ireland, it is an Irish phenomenon. It happens abroad, it happens 120 miles away, but it is an Irish problem that we have at the present time that we have to address. I don't think it would require a seismic shift to change the law to recognise that reality.

Chairman: It would require the seismic shift of a referendum, though, wouldn't it?

Ms Bacik: We put forward two alternative processes, one which wouldn't require a referendum, which would require simply legislation to implement the X case test.

Senator O'Donovan: Just one final question. We heard from the three masters of the biggest hospitals in Dublin – maternity hospitals – and from many other experts in that field – I'm mainly talking about gynaecologists, obstetricians – and also from the Irish Medical Council. The view I got from the questions answered by this committee was that they were extremely conservative and wished to, I think, align closely to the existing medical practices that take place in Ireland. If the change that you suggest were to take place, I get the distinct impression – again, that's just the vibes I'm getting – that the vast majority of the Irish Medical Council and the people we questioned would not operate that type of system and that one way or another, whether we like it or not – I am not saying we do not have a problem and I am not denying that 6,000 women go abroad each year – if the law or the Constitution were to change, you would still have a major problem with people going abroad. I get the distinct impression – and I may be wrong but I am putting the question to you – that currently the Irish Medical Council's ethical code and that of the majority of senior gynaecologists and obstetricians would not result in the operation of any type of liberal system.

Ms M. O'Connor: One thing I would say is that doctors have a duty of care and I would challenge the idea that it is ethical to force women to carry through pregnancies as a result of rape, for example. I have worked with women for many years who have, in fact, had later abortions than they would have wanted because of the inability to travel, the lack of resources or the control by violent partners. It is assumed that women can travel to have abortions. Women can't always travel and are often forced to carry through pregnancies they don't want.

Many women are in situations where they have no control over sexual practice and no control over whether they are pregnant or can use contraception in the first place. I would say it is unacceptable for the medical profession to claim ethics and not cover duty of care to women who are in situations of what is, in fact, compulsory motherhood. There is a lot discussed about the trauma of abortion but the trauma of women having to carry through with something they do not want is rarely discussed. Thousands of Irish women find themselves in that situation every week. We know that one in four women in Ireland have experienced abuse and violence in intimate relationships, including marriage.

A lot of the time we are ignoring the very reality that, in fact, doctors have a duty of care to all women in this country. I understand that there will be an opt-out for doctors and I would accept that but I don't accept that this is not an issue doctors should be challenged on. There needs to be some leadership among medics and politicians about hiding behind ethical guidelines as if they cover the reality of the situations of women who travel every day or the women I work with who do not have the capacity to travel. I would just add that increasingly, vast numbers of women in this country are marginalised economically, for example, asylum seekers who will not be able to leave this country, who are going to be in situation where we do not have any facility at all, regardless of the context in which they become pregnant. I want to leave that as a challenge to the medical profession.

Senator O'Donovan: The reason I mention that is that according to their fifth edition in 1998, two years ago – and I raised this question with the Medical Council which was slow, I suppose, in giving us guidelines – are you saying so that the ethical guidelines of the Irish Medical Council, which is an umbrella organisation of all medical practitioners in the State, are not in touch with reality?

Ms O'Connor: Yes, I am challenging that there are a number of women to whom they are failing in their duty of care.

Deputy J. O'Keeffe: To touch on the specific proposals you make … you made one from a legislative point of view and one from a constitutional point of view. I dealt with the difficulties of any constitutional amendment earlier. As I see it, your proposal from the legislative point of view is to actually implement the Supreme Court decision in the X case and permit doctors to carry out abortions where the continuation of a pregnancy poses a real and substantial risk to the life of a pregnant woman. Apart from the issue of suicide, which is difficult territory but which is not the main focus of my question, would it make any difference whatsoever if such legislation were introduced? We have had evidence from the medical profession that where there is a real and substantial risk to the life of the pregnant woman, they use whatever procedures are necessary, including termination, to save the woman's life. What would be the practical effect of introducing such legislation? I do see the point at a theoretical level that public policy should make law covering what is actually happening. Would such legislation affect current medical practice one iota, would it change anything?

Ms A. Marlborough: I think it would surely put the practice of doctors on firmer footing. Having read the transcripts, several of the doctors expressed concerns about this direct-indirect distinction and whether they are providing medical treatment or abortion. We need clarity in the law in that area. How practical a difference that might make I am not sure but some of the doctors did say they would not feel fully secure that they had proper adequate legal cover for carrying out certain terminations unless law was introduced providing for termination in the case of a risk to life. I think for legal certainty and protection for doctors that would be necessary.

One of the main reasons I know is problematic is that this is uncertain. It is a very basic legal requirement that there must be certainty, that you must know what the law is and what you can and cannot do. At the moment, in relation to risk to the life of the mother, the X case interpretation says there is an entitlement to an abortion in those circumstances but the circumstances are not spelt out and, clearly, regulation is needed there at the very minimum. I would say that having such legislation would make a practical difference for doctors and that it would also make a symbolic difference, of course, on a public policy level.

Deputy J. O'Keeffe: I take the point about the symbolic resonance but at a practical level, at the end of the day, the decision as to whether there is a real and substantial risk to the life of the mother will be the decision of the attending gynaecologist or medical personnel. How would one change that? If there were such legislation, would we not have to provide that, at the end of the day, it would be a matter for medical decision? Would we be going any further than the present situation of it being accepted that if such medical decision is made, it is never questioned by the law and, even in relation to the direct and indirect effects, are we then trying to cover the thought processes of the medical specialists, some of whom even have difficulty with saying that what they are doing is an abortion? Some say it is a termination, some say it is killing the baby because it is necessary, some make it quite clear that they would not do it, others that it is a medical procedure to save the life of the mother which, in effect, brings us back to where we started and, therefore, as far as they are concerned, is an indirect effect of that medical treatment. What will be the benefit of actually introducing legislation or a regulation to cover a situation which is already working?

Ms A. Marlborough: I would consider it a bit dishonest and dishonourable to have a situation which is running and seems to be working perfectly but, if a problem occurs, it goes to court. We already saw that in the X and C cases. The threat to life in those cases happened to be from suicide but if there were a different type of a threat to the mother's life and there was a divergence of medical opinion, there would have to be resort to court because there are no legal guidelines for doctors. From the transcripts, doctors did attest that in cases of uncertainty, they would proceed with the termination and then deal with the legal consequences afterwards. They should not have to find themselves in the position of wondering whether they might be breaking the law in a particular case by intervening where there is a threat to the life of the mother.

Deputy McManus: Can I just ask, to follow on from that, in view of what Monica said – you are talking about particular women you are dealing with – do you think that the idea of deciding, if we were to decide, that legislation was not an option, leaving it to the courts is a serious option for the women with whom you are dealing?

Ms O'Connor: No, very simply. I would come back to what Ann said that there is a political responsibility to take a decision about legalising abortion which should not be left to individuals who are already in a state of crisis. I think this is a totally unacceptable way to leave it. In a way it is an avoidance of reality. When you asked me about doctors and duty of care, they are certainly failing the women who are leaving the country. They are also failing the women if, in a sense, they are expecting individuals who are already in crisis – which is how we have dealt with it up to now – to be the test case, to be the woman who is at the centre of a controversy as in the X or C case. It is totally unacceptable to leave it to another case each time. This is at a time of extreme trauma already for both of these young girls and their parents. I do not think this is an option. It is not enough to say that it is going on and let us leave it. That is an Irish solution, as usual, until there is another tragedy for some woman to have to deal with that directly in the courts.

Deputy J. O'Keeffe: One of the guidelines is that refusal

by the doctor to treat a woman with a serious illness because she is pregnant would be grounds for complaint and could be considered to be professional misconduct. The guidelines themselves make it clear that there is an obligation on the doctor, whatever his or her conscientious position is, to give whatever treatment is necessary for the woman if there is a real and substantial risk to her life. Would you not accept that?

Ms Marlborough: It depends on how one would define treatment. One doctor might say that includes termination, it is indirect, it is treating her illness, but some of the other doctors might not agree that abortion comes within the definition of treatment. I think it requires legislative clarification. The ethical guidelines anyway are only a professional body of rules. They are not drawn up in relation to the public. They are not drawn up by elected representatives. It is the professional code for a body of practitioners and they can draw up to an extent what suits the operation of their profession in Ireland today. Legislation needs to have wider concerns.

Deputy Daly: I would like to thank the delegation for the information and clarification they have provided. They put a lot of emphasis on the double crisis, that is the situation where women have to travel to the United Kingdom. If the reforms you are suggesting were put in place, what effect would that have on the numbers travelling abroad and how much of that is related to the social stigma rather than to availability? On the reform organisations, how representative are you? Have you had discussions with some of the other organisations, the vast majority of whom have views totally opposed to yours? Have you had any discussions or dialogue with them to find some formula to advance this issue?

Ms Bacik: I will leave it to Ms O'Connor to answer the first part of your question and I will deal with the second part of the question in relation to the organisations. We gave a large number of organisations affiliated to us. I think you received a list of those. We would all have experience of working with organisations which do not necessarily reflect our views. We have participated in debates and discussions with groups from what would be seen as the other side of the political spectrum in terms of their stance on abortion. What we are trying to do is prevent the debate from becoming as polarised as it was certainly in 1983. We are trying to approach what might be seen as some sort of consensus. Obviously we will never achieve representation of everybody's views but we are trying to find a solution which will best achieve a compromise that everyone can live with. That is the aim of this group and that is why we formed in the way we are as a coalition or umbrella of other groups.

Ms O'Connor: I agree with you that the social stigma must be removed and that legalising and providing for facilities here is not enough. I think there is a social stigma and it is our responsibility to ensure women do not experience that on top of all the other crises they are facing.

In relation to women's organisations and service providers, Women's Aid is 25 years old today and has for 25 years provided, with much difficulty, for thousands and thousands of women who have experienced abuse. However, it is extremely difficult for service providers to both speak out on this issue and to reflect the reality for those women of crisis pregnancy in situations of abuse. We would work with any organisation that has the interests of women and children at heart, and we are very clear about that. The reality is that it has been quite a difficult area in which to work. We fully support the abortion reform campaign and have always supported a pro-choice position, particularly the concerns of the women we represent. I am very sorry that women don't feel they can speak for themselves. What Liz has said is so true. We have had survivors speak out on so many other issues in this country and it is still a deafening silence for the thousands and thousands of women who have had abortion. Maybe that in itself highlights the existing social stigma that was talked about, that it's left to women's organisations like ourselves to represent the women who we know and work with everyday who have had abortions. I think it is very sad that it is still not possible for women to actually say they had an abortion and give the reasons, and that it is representatives instead who are trying to represent those women.

Deputy M. McGennis: I welcome the group. You are quite clear about your position. I have listened to various speakers on the radio say this is what we would actually like to see happen, but we are realistic, and if we can achieve … particularly you mentioned the legislation implementing the X case test. If you leave aside what we hope will continue to be current medical practices … what is happening in our hospitals which some define as non-abortion and being a medical procedure and other medical practitioners who came before us stated quite clearly that they were terminations or abortions. Would you see … if we were to bring forward legislation, would you see it just to recognise the substantial risk to life of a pregnant woman as being suicide … the suicide test … or would you see it recognising a lot of other instances, which we would bring forward by way of legislation? Also, would you support the concept of a referendum, similar to the divorce referendum, by which we would bring forward legislation to the people showing them precisely what we intended to enact if the referendum were passed?

Ms Bacik: Certainly we would see suicide as having to be encompassed in the risk to the life of the pregnant woman, because that was accepted in both the X and C cases. Indeed, the people voted against a proposed amendment in 1992 that would have restricted risk to life of the woman and would have ruled out suicide as a possible risk. So any legislation implementing the X case would, of necessity, have to include regulation of the risk of suicide. I know the committee has heard evidence as to risk of suicide and the fact that suicide risk in pregnant women used to be a lot higher than it was perhaps before the availability of legal abortion in other jurisdictions. Therefore, the suicide risk would have to be encompassed in legislation.

Deputy M. McGennis: Would there be other issues or other risks that you would actually define in legislation? You mentioned bringing forward heads of a Bill.

Ms Bacik: We would welcome the opportunity to offer you heads of a Bill. We have given some detailed consideration to what would have to be in a Bill. I don't think any Bill could spell out situations or enumerate the list of medical conditions which would give rise to risk. Indeed from the evidence that the committee has heard, there seems to be a range of different conditions which may, in certain circumstances, give rise to a need for termination. The second question about putting legislation to the people similar to the divorce referendum, again this is something we have canvassed in our submission. This is something we would support. We would support any outcome that involved legislation which legalised abortion in some form. We do not see the process as being quite as important. Clearly the process is important politically and it is for this committee obviously to decide on the process. We think the example of the divorce referendum is a good example because people were very clear about what they were voting on. The committee might like to consider that issue.

Chairman: Can I come back to the 1993 referendum. You said people rejected certain matters but, of course, a large proportion of the people rejected even the right to travel overseas and the right to provide information. Clearly they were part of the 'No' vote on the substantive question in 1992. Is that correct?

Ms Bacik: Well, I think it's a particular euphemism to describe it as a substantive issue and we've tried to get away from that.

Chairman: It was called a substantive question because there were three issues put before the people, or submitted to the people, in that referendum. It's not a euphemism. The question of travel and information, at the time, to explain the matter to the people, was described as a substantive question. I agree with you, it's not perhaps helpful to go on discussing it in that context but that, I presume, was the reason at the time.

Ms Bacik: Yes. I think that the fact that the travel and information referendums were accepted shows what I described earlier as the outpouring of support for the very tragic family at the centre of the X case. I think there was support for their situation and many people felt themselves shift, I think, on what might have been a more absolutist position previously, and certainly supported the right to travel and for information as a result of the X case.

Certainly, on the twelfth amendment, the defeated amendment, there was more confusion – we can say that. There were groups from very different viewpoints who would have campaigned against it but the fact is that it was defeated so the X case test remains the present law and the present constitutional position. What we're proposing as a very minimum solution that we believe would address at least the needs of some Irish women would be legislation to implement the X case test and to provide for the framework, as Anne said, a clear framework within which doctors could operate if the life of a pregnant woman was at risk.

Chairman: Yes, but the reason I put the question about the twelfth amendment in 1992 was that if you take the preferendum approach, which you've advocated, you'd have to assume that proposal would've been carried, or perhaps a more restrictive proposal, if you took the preferendum approach because, on the evidence of opinion poll surveys at the time, a number of people voted against the twelfth amendment because of objections to the amendment which were raised by prominent ecclesiastics. I remember canvassing as an ordinary canvasser at the time in the contemporaneous general election and a very great number of persons said to me they would vote against this proposal because it was an irreligious, ungodly proposal because it raised the question of abortion directly in the Constitution. Naturally, there were those like yourself, I think, who campaigned against it for a different reason to do with the precise criterion on which … or the indication on which medical procedures could take place, the life as distinct from the health and so on.

The point I'm making is that if the preferendum route had been taken in 1992, you might've come out with a result that was rejected by the people. That appears to have been the middle ground in 1992, because you're saying people have to accommodate. If there had been an accommodation in 1992, there would've been a substantial consensus for the proposal that was put to the people.

Mr O'Broin: I think what happened in 1992, where both people who were opposed to the introduction of abortion and those who favoured the introduction of some form of abortion opposed the amendment, shows the problem of a 'yes' or 'no' referendum. I think, in actual fact, the preferendum may have solved that problem to some extent in that it would've allowed people a range of options which were more reflective of their own positions on abortion. It may be the case that if that approach had been taken in 1992, a more restrictive form of words would've been inserted into the Constitution, but, equally, it may have been the case that a more liberal, or a more pro-choice view may have won.

Chairman: Not on the opinion polling at the time. Not on the data that we knew at the time about the matter.

Mr O'Broin: I think, without an actual preferendum, it's hard to know exactly what the result would be but I think the process would allow for more choice in terms of voters expressing their opinions on the issue.

Chairman: The de Borda Institute were talking to us last week about it and one of the difficult matters in the preferendum is that you have to assign a value to each preference the voter exercises. So first of all, you have to catalogue a range of options and then you have to assign a value to the preference vote cast for each option. One of the difficulties with this issue is that for certain people in the philosophical dispute, there is only one option, or at most two, shall we say. Therefore, their votes automatically are worth less.

Mr O'Broin: Well, there are a number of models of a preferendum and I think the constitutional review group has looked at using the single transferable vote system

and Gerard Hogan has put forward that as an option. I think it is important to look at it as a possible route to reach a political solution here. I'm not an expert on the area but I think it does hold out the possibility of, first of all, a less polarised debate, and second of all, a workable solution.

Chairman: The suggestion of a transferable vote approach would not have been supported by de Borda. It's a different idea. Clearly, if we're to have a transferable vote exercise on this particular operation, you would start off with a very substantial number of first preferences in the unequivocal support for the first option in the Green Paper. You would start off with 30% to 40% of the electorate, I would estimate, as a minimum in that position, waiting to collect transfers from options down the line. Therefore, I'm just suggesting to you that the preferendum might not lead to the outcome which you seem to think it will lead to. That's really the point I'm making to you.

Mr O'Broin: I don't know the answer. I think that's something that needs to be teased out further.

Chairman: I appreciate all the de Borda objections to majority voting, but the problem is for the people. Often the clarity of a decision making process is important as well. It's very hard to have a public debate when you've a complicated procedure built in to adjudicate on the question. That's just the point I wanted to leave you with on that.

Ms Bacik: Of course, we would say it's up to the committee, up to the legislature, indeed, to make the determination as to what options are put to the people. We've suggested that some of the options to be put in a preferendum might reflect the Green Paper options but it might, perhaps, not include option one, the absolutist position, and include, rather, a range of more moderate positions to be put to the people, which would alleviate the problem you describe.

Chairman: That begs the whole question … you're prejudging the whole philosophical question once you go down that route.

Ms. Bacik: We are just saying that there are various options.

Ms O'Connor: May I quickly make a point as well to go back to what you said? I think there's a real failure of education around the issue as well. You go back to 1992 and talk about the right to travel. Should the right to travel ever have been put before the population, that they could see that they had the right to stop women leaving the country, and were they going to screen women and have detention centres for forced pregnancy and motherhood? The consequences of putting things before the people, before that happens I think you have to thread through all of the fine lines of that and make people face the consequences of decisions they make regarding referenda.

I contend that the people were not educated about what would happen if they voted to deny the right to travel. What were the consequences and how could that be implemented and was that a reasonable option or choice? It is up to the committee to make very strong decisions. If the preferendum idea is to be thought through, I think those consequences or possibilities need to be taken into account. I would agree with you, it needs to be really teased out. The big issue is that there has to be some leadership and courage about the issue as well. There has to be. It is not good enough at this stage for all of us working with women everyday, facing the reality of this issue .... that some lobby groups dominate both the form of education around the issue – that's happening – and have the resources to do that and have the resources to dominate the debate and put forward ideas like the right to stop women travelling, as if that's a realistic option. I would just challenge that. There is still, I think, a failure to engage in the real issue at any level.

Chairman: One of the difficulties in 1992 – I wasn't a legislator then, I was a citizen … I'm a citizen still but then I was a private citizen – was that the travel ban idea was actually accepted by the Supreme Court in the X case. The X case, as well as addressing the question of what procedures were possible in Ireland, decided that in any context outside those, there was no right of travel. That was a difficulty which I presume the Government had to face.

Coming back to a technical question I wanted to ask Ivana Bacik, and that relates to the Offences Against the Person Act, the ban in the Offences Against the Person Act applies to medical practitioners. To what extent does it apply to the woman?

Ms Bacik: Well, section 58 clearly penalises the woman, section 59 penalises anyone who assists her, as I understand it. Neither section has been implemented here for a long time.

Chairman: Well, just taking section 58, does it apply though to a service lawfully carried out in the United Kingdom?

Ms Bacik: No, clearly it doesn't have extra-territorial jurisdiction. The sections have been reviewed.

Chairman: They have been cut down by the adaptation of enactments.

Ms Bacik: Yes.

Chairman: So it is a ban within the State.

Ms Bacik: It is a ban within the State but it has not been utilised. Again, one might ask the question that because the facility of abortion in England has been available, albeit with great difficulty, for women from here there has not been a need to operate these whole sections. We say they should be repealed and I do not see that as being a controversial view to put forward, given that they have not been implemented and given that there would be a widespread view that pregnant women – women in crisis pregnancies – should not be criminalised by the law.

Chairman: May I just distinguish between sections 58 and 59 for the purposes of that argument for the moment?

Would you make the case that it is possible to repeal section 58 within the present constitutional arrangement?

Ms Bacik: Yes, I would, because section 58, in the way it has been interpreted by the courts both in England in the Bourne judgment in 1939 and in Northern Ireland much more recently, demonstrates that the test is rather different to the test used by the Supreme Court in the X case.

Chairman: Section 58 applies to the person who assists, did you say?

Ms Bacik: Section 58 applies to the woman.

Chairman: Yes. That is what I thought.

Ms Bacik: Section 59 applies to the person who assists. It is section 59 that has been the object of the interpretations.

Chairman: That is right, but taking section 58 – leave section 59 for a second – do you say that it is possible to repeal section 58 within the present constitutional dispensation?

Ms Bacik: Yes, I say it is possible to repeal both within the present constitutional regime. I should have made that clear. The Constitution takes a very different approach.

Chairman: But in the case of section 59, does not a different consideration apply? I am trying to draw a distinction between them for the purpose of this argument. In the case of section 59, the ban on a person assisting has to be there as long as you have the constitutional presumption that both lives must be defended and vindicated as far as is practicable. The State could not, with constitutional propriety, dispense the operation of the criminal law entirely in that circumstance.

Ms Bacik: That would be arguable. Clearly they are two very different regimes, the constitutional regime and the criminal regime. There have been suggestions, indeed in the students' case on information, that there might be a possibility of creating a crime through the Constititution but that is a very contentious proposition and it has never been supported by authority. I would see the two regimes as being very different. You are saying the Constitution puts it up to the State to provide criminal sanctions for abortion. I do not think that argument is tenable because the criminal law, as it presently stands, is actually less restrictive than the constitutional prohibition on abortion, such as it is. The Constitution permits abortion, since the X case, where there is a real and substantial risk to the life of the woman. The Bourne judgment and the Northern Ireland cases show us that there is a more flexible interpretation given to risk – physical and mental wreck being the wording used.

Chairman: The Bourne judgment is not law here.

Ms Bacik: But it has been applied, not only in Northern Ireland but in many other jurisdictions.

Chairman: But it is not law here in this State.

Ms Bacik: No, but it would be persuasive authority, given that we do not have an interpretation here.

Chairman: It would have to be considered in the context of the constitutional provisions. And at the time of the 1982-3 debate, one of the arguments used was that the loophole in the Bourne case should be closed off. That was one of the reasons the question was submitted to the people in 1983.

Ms Bacik: But we have never had a judicial decision on it. In which case we would have to look to other jurisdictions. We can look at the cases in Northern Ireland. We review that in the text book and the Green Paper has reviewed them also. They clearly are following Bourne.

Chairman: Without prejudging the merits and demerits of their arguments on the general issue, do the pro-life supporters not have a point when they say that the courts are being used to circumvent the expressed will of the people in a referendum?

Ms Bacik: That is something I wanted to come back to, following from what Monica said about consequences of the vote. In 1983, the wording put to the people and approved by the pro-life campaign, and indeed initiated by them at the time, was a wording that had utterly predictable consequences: that where two rights are set up in conflict, as they were with the woman's right to life and the right to life of the unborn, there would inevitably be a situation where somebody – and it would have to be a constitutional court – would be called upon to intervene and to decide which right took precedence. It was also predictable – and indeed predicted by those who opposed the 1983 amendment – that it could be used in future to block women from travelling and those who were pro the amendment at the time said they would not use it to pursue individuals through the courts and then subsequently turned around and pursued Well Woman Centre, Open Door Counselling and the students' unions.

We have to be clear that the consequences of the 1983 amendment were predictable and were predicted in 1983. Perhaps there is an argument that people were not fully informed about those consequences but that is a fault of those who were pushing the amendment – that they did not see through what was the likely outcome of that referendum. There is an argument now being put forward that the will of the people is not expressed by the Supreme Court judgment. It was predicted in 1983 that a situation would arise in which a court would be called upon to make that judgment.

Chairman: The principle of law in the X case is that a real and substantial threat to the life of the mother would be a ground where the mother's life must prevail. That is clearly left open by the 1983 amendment.

Ms Bacik: Yes.

Chairman: The point at issue in the objections we have received is that the actual grounds, on the facts of the X case, did not match the legal principle found by the Supreme Court.

Ms Marlborough: That is very much a matter of debate and a matter of evidence in the particular case. I certainly think, on the point of principle, the decision in the X case is not objectionable. It is a very minimal … to reflect what the 1983 amendment expressed and I certainly do not think that any arguments are tenable that it is in any way counter-majoritarian. It is not like all of our unspecified, unenumerated rights that were interpreted by the Supreme Court and created over the years. Rather, that was specifically interpreted. The possible consequences could have been predicted, as Ivana said, and the judges interpreted it. I really have no difficulty with it, in that I think people got what they voted for.

To be democratic about it, we should probably go ahead and have new legislation because, on a technical point, the Offences Against the Person Act is very old. It is not a product of this State or of this Legislature. I do not see any technical difficulties at all with repealing it. Probably the solution is new legislation.

Chairman: Thank you very much for your assistance. I suspend the meeting for five minutes until the representatives of the Irish Congress of Trade Unions take their place before the committee.

SITTING SUSPENDED AT 10.47 AM AND RESUMED AT 10.50 AM.

Mr Peter Cassells, Ms Inez McCormack, Patricia O'Donovan and Joan Carmichael

Chairman: I welcome the following representatives from the Irish Congress of Trade Unions, Peter Cassells, General Secretary, Inez McCormack, President, Patricia O'Donovan, Deputy General Secretary and Joan Carmichael who is an Industrial Officer. We have received your presentation which has been circulated to Members – it is at page 433. It is the Congress submission signed by Peter Cassells.

The format of the meeting is that one of you may make a brief opening statement elaborating on the submission, if you wish, which will be followed by a question and answer session with the Members. I draw your attention to the fact that while Members of this committee have absolute privilege this same privilege does not apply to you.

Mr P. Cassells: Thank you, Chairman. Briefly, by way of introduction, we want to elaborate and comment on two areas of the submission we have made. I would ask our President to very briefly set out the context in which we made the submission and are appearing before you. We are a representative body, which is important, and then ask Patricia O'Donovan to elaborate for you, since we are asking that you should give preference to dealing with this area by way of legislation, what we would see as being incorporated in that particular legislation.

Ms I. McCormack: Thank you for giving Congress the opportunity to make an oral presentation to you on the question of abortion. We welcome the opportunity to clarify the Congress position on this complex social, medical and legal issue. We are also happy to provide any further information or clarification which the committee may require on any aspect of our submission which was forwarded to you in October 1999.

Congress is the national trade union centre and represents workers both in Northern Ireland and the Republic of Ireland. Women constitute 40% of our members. In the Republic there are over 217,000 women trade union members and it is the largest single representative organisation of women in this country. We have sought consistently to enhance the status of women not just in the workplace but generally in society. We have a long standing commitment to equality for women in the workplace and in all aspects of economic and social life.

Our commitment to equality and access for women is reflected in the many legislative and other policy initiatives which Congress has pursued to promote equal treatment for women in employment and to enable working parents to combine work and family responsibilities, for example, maternity and adoptive leave, parental leave, carers' leave, family friendly workplaces. The question of women's health and well-being was one of the key areas addressed in our charter adopted in 1985 and, indeed, all the national programmes negotiated since 1987 contained detailed commitments on women's health including the promotion of workplace health and cancer screening programmes, also the question of the provision of quality child care facilities has been a central demand of the Congress equality agenda since the early 1970s. It is deeply regrettable that for many years we were, more or less, a lone voice on this important issue. In recent years the importance of child care has been more widely recognised and Congress will be pressing for practical measures in child care in the forthcoming budget.

I have set down this general background and the trade union movement's commitment to equality for women because I think it is important to situate Congress' views on abortion within the context of our overall commitment to equality and access for women. Women's right to life is fundamental and cannot be dealt with in isolation from women's economic and social rights and the right to be treated as equal citizens. It is Congress' commitment to equality for women in Irish society which motivates our contribution to this discussion. We believe that women must be respected as full and equal citizens, whose right to life is not compromised by constitutional, legal or medical ambiguities.

The Green Paper on abortion refers to the significant number of Irish women every year making a difficult and often lonely decision to have an abortion abroad. The Constitution Review Group stated that there is much private sympathy and concern for the personal, social and moral

anxieties of those facing crisis pregnancies. The importance of access to information to enable women to make informed choices in crisis pregnancy situations is highlighted in the Green Paper and Congress fully supports this. There is a strong statistical probability that many of the estimated 95,000 Irish women who travelled to England and Wales between 1970 and 1998 for abortions were trade union members or were subsequently during their working life. Congress has a responsibility to give public expression to the private sympathy and concern identified by the Constitution Review Group.

Chairperson and members of the committee, we do not underestimate the difficulty of the task before you. However difficult and complex it is, it is absolutely clear that eight years after the Supreme Court decision in the X case which laid down the constitutional parameters for protecting the right to life for pregnant women our elected representatives have a responsibility to introduce legislation to give effect to this decision. Congress fully supports the introduction of such legislation.

Chairman: To clarify one point on your submission, is the covering letter distinct from the submission of the women's committee? Are there two different submissions here in effect?

Mr Cassells: You have effectively two submissions, both of which should be taken together. You have a submission from the ICTU to the joint committee. Earlier when the interdepartmental committee was sitting which led to the Green Paper on abortion our women's committee made a submission to the interdepartmental committee. I am sure that's what you have in your documentation.

Ms P. O'Donovan: Congress policy on the substantive question of abortion is based on the position which we took on the eighth amendment to the Constitution proposed in 1983. Congress opposed that amendment on the grounds that it was unnecessary and that it would be unwise and undesirable to proceed with it. The Congress position was based on three considerations – first, that matters of this kind should be the concern of elected representatives and that statute law is the proper means of dealing with them; second, that the rigidity and inflexibility of constitutional directives on social and moral issues are inappropriate in a democracy; and, third, that the wording of any constitutional amendment must inevitably be vague, uncertain and imprecise. Of course experience since the enactment of the eighth amendment has strongly confirmed this point.

In relation to the series of constitutional amendments proposed in November 1992, Congress supported the amendments on freedom to travel and the right to information. We opposed the amendment on the substantive issue of abortion. Congress opposed this amendment, that is, the twelfth amendment, on the same grounds that it opposed the eighth amendment, that is, a constitutional directive is inappropriate as a means of dealing with complex social, legal and medical issues, but also on the grounds that the twelfth amendment proposed, *inter alia*, to exclude the risk of suicide.

Having regard to the rejection of the twelfth amendment in the 1992 referendum and to the case law which has developed since the enactment of the eighth amendment and, in particular, the tests laid down in the X case in 1992 and subsequently applied in the C case in 1997, as far as Congress is concerned it is clear that legislation is required to give effect to the constitutional legal entitlement to abortion in the circumstances as defined by the Supreme Court. The *status quo* is not acceptable as it requires each situation to be determined on a case by case basis in the courts.

Congress supports the introduction of legislation to give effect to the decision of the Supreme Court in the X case. We believe that such legislation should provide for the following issues – first, that abortion is lawful in this State where it is necessary to avert a real and substantial risk to the life of the mother, including the risk of suicide. We are aware of course that the committee has given time to the consideration of other aspects or other grounds which may be considered in this context and, in particular, questions around rape and incest and congenital malformations. Congress has no position either in favour or against the inclusion of such other grounds and would simply like to indicate that we nevertheless believe that these are issues which must be given full consideration by the committee.

We also believe that the legislation should provide for the repeal of sections 58 and 59 of the Offences Against the Person Act. It should define the medical certification and, where appropriate, the psychiatric certification procedures to be followed. The legislation should also set down the procedures for obtaining and certifying the woman's consent to the termination of her pregnancy. In this context, we would also signal that we would recognise that there may be a need for different procedural requirements, specifically where minors might be involved.

Legislation should define the approved hospital and clinical facilities where termination of pregnancies may be undertaken and it should require the provision by these facilities of relevant information and counselling services, including post-abortion counselling and post-abortion medical check-ups.

Legislation should provide statutory protection for medical personnel who, for conscientious reasons, do not wish to assist with the termination of pregnancies. It should also provide statutory protection for medical practitioners who terminate pregnancies in accordance with the terms of the legislation. It is a matter of deep concern that the guidelines issued by the Medical Council in 1998 could lead to a charge of professional misconduct against a medical practitioner who carries out an abortion in circumstances permitted by the X case, including the risk of suicide. Of course these difficulties are adverted to in the Green Paper itself.

In relation to what should be included in the legislation, Congress believes that the opportunity should be taken to incorporate the Regulation of Information (Services outside the State for Termination of Pregnancies) Act, 1995, into any new legislation.

Legislation in other jurisdictions dealing with abortion normally contains provisions which specify the time limits within which the pregnancy may be terminated. This is clear from the survey of the legislative position in the range of countries reviewed in the Green Paper on abortion. However, if the legislation introduced in Ireland restricts the availability of abortion to circumstances where there is a real and substantial risk to the life of the mother,

to include any time limits in the Irish legislation would appear to be incompatible with the Supreme Court's interpretation of Article 40.3.3 and could, therefore, face constitutional challenge. It could also rule out certain medical procedures which are currently practised. The reality is that life-threatening conditions can develop at any stage during a pregnancy and the introduction of time limits could threaten the life of the mother where such circumstances are outside the specified time limit or limits. In most jurisdictions with legislation providing for the termination of pregnancies a distinction is drawn between life-threatening situations for the mother and terminations on other grounds. In life-threatening situations for the mother time limits normally do not apply.

In our submission to the committee Congress called for increased resources so as to enable more education, information and comprehensive family planning services to be made available to all who require and need them. Congress welcomes the consideration of these matters in the Green Paper on abortion. While these issues are clearly not necessarily a matter for legislation, congress would like to express its full support for the measures discussed in Chapter 6 of the Green Paper and specifically for the proposals contained in paragraphs 6.50, 6.26 and 6. 67 dealing with education, contraception and counselling and information for women with crisis pregnancies.

Chairman: I take it that is the initial statement. Thank you for the succinct character of your submission. You have three very clear recommendations. There is only one question. It is a point of clarification on the middle recommendation in relation to the legislation. Clearly your recommendation is that we should enact legislation to give effect to the X case decision and provide for that. You then say sections 58 and 59 of the Offences Against the Person Act should accordingly be repealed. Do you mean repealed in that context or repealed generally?

Mr Cassells: I think repealed in that context but also, as Patricia has outlined, in terms of any new legislation that would be introduced, a range of issues emerge in that context both in terms of the protection for the medical practitioner in the context of section 59 and then, presumably, the inverse of that in terms of any body acting outside the legislation, various other matters emerge.

Chairman: Thank you very much.

Senator O'Meara: I also thank you for your succinct yet comprehensive submission setting out clearly the issues as you see them. Can I put it to you that your proposal constitutes what many would see to be a pretty liberal approach to the availability of abortion in this country?

Mr Cassells: I would have thought we would be accused of the opposite. This is why I asked our president earlier to set out for you our representative structures in the sense that the views we are expressing are not the views of any of the individuals here or the arguments we would have within our own structures, but the limited democratic view that would have come through from our conferences in the early 1980s when the original referendum came about and then in our conference in the 1990s. So the limited circumstances that that brought up were whether these matters were proper for either legislation or the Constitution, and the view of our conference was that these are matters for legislation and then, because of the complex nature of them, the difficulties in terms of being so uncertain and imprecise and all of that.

The second one related to the narrow grounds that emerged from the Supreme Court in terms of the real and substantial risk to the life of the mother, including suicide. There is a range of other more liberal regimes you could develop, rape and incest, as Patricia said, being two obvious ones. As we have indicated to you, while obviously we believe they are significant and very important issues that the committee should consider, as an organisation which is here in a representative capacity, we do not have a view or any mandate to express a view to you on those issues. I would have thought it was more narrow than liberal in that context.

Senator O'Meara: That is useful. I was anxious to clarify that because some would take the view that including the risk of suicide in fact, to use a phrase one often hears, opens the gates and you are on a slippery slope. In some regimes the inclusion of the risk of suicide has been widely interpreted by doctors, whether general practitioners or psychologists or psychiatrists or whatever. If a woman presented with a crisis pregnancy and presented as traumatic, that could be interpreted in a wide and liberal way. However, you do not see it that way and clearly your members do not see it that way. In other words, your inclusion of the risk of suicide is more that it is consistent with the judgment in the X case.

Mr Cassells: There are two issues that faced us when that referendum arose in relation to the X case. First, we saw it as being consistent with the Supreme Court decision, and certainly since we had argued that these issues must be dealt with by way of legislation and legislation is open to interpretation by the courts, logically our position fell within the ambit of that extension by the Supreme Court.

Second, the information or advice available to us at the time seemed to be that statistically it is very rare in the sense that only about 2% of women of child bearing age who commit suicide are pregnant. That gives you a more limited regime. Obviously in that question, the whole question of time limit issues comes up. We have not expressed a view on that because as individuals, as people or as an organisation we would have thought that that is very much a matter of assessment in terms of both the clinical and mental health issues involved. You have already been dealing with and hearing from psychiatrists and medical people in that context. Our approach of including suicide was very much to keep it consistent within the Supreme Court decision and the fact that the advice to us was that it did not open up the way to easy availability.

Senator O'Meara: There are, that we know of, at least 5,000, and probably nearer to 6,000, Irish women travelling to Britain each year for abortion. Clearly the vast majority of them are not going for medical reasons or because of risk of suicide and so on, although we do know that a small number do travel for medically related reasons. That is a very large figure. Some would argue that we already have a very high rate of abortion in this country. As you

quite rightly point out, it is more than a medical and legal issue. It is a social issue as well. Can I just put to you what is possibly an unfair but very general question? As an organisation which has a very large representation of women, what should we be doing to attempt to reduce that rate? Should we be doing anything to attempt to reduce that rate?

Mr Cassells: In the presentation we made this morning and in our participation – and we did participate actively – in the discussion in the referendum in the early 1980s and again in 1992, we have argued strongly around the whole issue of information, counselling, facilities, back-up support, the whole area in terms of standards of care in these areas, including the whole area from contraception to information and counselling. The one issue that we have not come to a conclusion on within our democratic structures is what to do in the case of whether you can terminate those pregnancies other than on the grounds we have talked about. As our president indicated earlier, we have a very poor record in this country of dealing with questions of women's health, of dealing with child care, that whole broad family support and family planning area. Your committee probably has a very narrow brief in terms of the issue you are dealing with, but we would have felt that the much broader support framework and services that are needed should be put in place.

Senator O'Meara: Including, presumably, not only the provision of child care but also on the issue of counselling.

Mr Cassells: Yes, very much so.

Ms McCormack: That is why we emphasise very much the context.... because the right to information, the right to informed choice, the right to see this issue in the context of the woman's right to health, life and equal treatment would require that broad approach, but in the context of why we are giving evidence today, the legal right to abortion as defined in our submission is also putting it in a context in which they can see themselves as citizens.

Senator O'Meara: Do you think that the wider availability of counselling and information would possibly reduce the rate of Irish women travelling?

Ms McCormack: I think the context of our submission in legislating the X decision set in the provision of the issue of pregnancy and of a woman being pregnant being able to have support resources to inform choice may well help to reduce it. I think, if you like, there's a culture of change required – resource allocation, recognising it's not an issue to be swept under the carpet. That's why I think that giving the legislative expression that we've recommended is, if you like, a very public context to do that but it links me to the culture allocation resources as well. I think those two together – one or other may not.

Deputy McGennis: Thank you for your submission. You have made it clear that your position is as it was in 1983 and that the Constitution was not the place to deal with this issue. You are recommending, as indeed the Supreme Court did, to legislators that legislation is the direction in which we should go. However, there is a further sort of bombshell – maybe it was obvious – if we were to go the legislative route and that is you're saying that if we were to respect the decision in the X case, that abortion was to be allowed in certain circumstances where there is a real and substantial risk to the life of the mother and suicide being recognised as one of those, then we are going to be faced with a huge problem in terms of time limits on that. You mention specifically that if we were to put time limits on it, this could also rule out certain medical procedures currently practised.

Now, leave aside the suicide risk; I'll deal with that later. The medical procedures which the doctors in the main maternity hospitals spoke to us about, I don't feel that they could be challenged constitutionally unless there was an absolute total ban on abortion. But if we were to simply legislate in accordance with the X case, why do you feel that those medical procedures could be challenged as being illegal? Secondly, are you saying to us that if we legislate in accordance with the decision of the X case, if we respect the decision of the X case, if a woman presents at 38 weeks pregnant and says 'I am going to kill myself', that she would then be legally entitled to a termination at that late stage?

Mr Cassells: I will ask Patricia because she has been working on the very question you've asked, as to what would be included in any legislation.

Ms O'Donovan: To deal with the last point of your question first, that is, the question of suicide and if somebody were to present threatening suicide at a late stage of pregnancy, Peter in his comments indicated to you that we could see a situation or we would envisage that there may be a situation where you could have some guidance on time limits in relation to the suicide question. We would see that as being different to other circumstances even though when you push that to the limit it does raise questions. Of course, if there is a professional judgment made that the life of the mother is at risk from a suicide, the question does arise in the context of the judgment of the Supreme Court that the life of the mother must be given precedence in those circumstances. We are simply in our presentation today saying to you that in our understanding of the Supreme Court case, which didn't make any mention of time limits at all, where there is a real and substantial risk to the life of the mother, then the life of the mother must be given precedence.

If you look at the legislation in many jurisdictions, 12 or 14 weeks are the standard time limits. Leaving aside even the suicide question, somebody could present with a serious medical condition outside a 12 week period – let us say 13 or 14 weeks; it doesn't matter once it was outside the time limit period. The first part of your question was about what medical procedures which are currently practised could be excluded if legislation is proposed which contains a specified time period within which these procedures to terminate the pregnancy can take place. Unless there are exceptions to that time limit *vis-à-vis* specified or unspecified medical conditions, then procedures which are currently followed – none of us are medical experts on this side of the table but we've been looking at the medical evidence – for some of the situations arising around high blood pressure, circumstances and so on which can arise at any stage of the pregnancy, the question arises as to whether that would compromise the

position of a pregnant woman who presents outside the time limit with a life threatening condition, including the risk of suicide.

It is a very difficult proposition. In my presentation I pointed out that when you look at the legislation as surveyed in the Green Paper and in other jurisdictions, where there is a real and substantial risk to the life of the mother the normal time limits do not apply. They are exceptions to the time limit requirement. In our presentation today we are pointing that out. That is, we think, a real challenge in the context of addressing this issue.

Deputy McGennis: So you would see that the X case judgment has made matters more difficult than they were before in that to legislate to respect that – I still feel that medical procedures as they were outlined to us by the masters of the main maternity hospitals may not pose that difficulty – we would have to bring forward legislation which would probably permit abortion up to term.

Ms O'Donovan: Where that was the professional medical judgment made, that was necessary to protect the life of the mother. The point is that at a certain point – again, we are not medical experts – or a certain stage of the pregnancy, the child can be delivered; it's viable. So there is a point at which the crossover takes place. But clearly, where the judgment is made that there is, that is, as I understand it, as the medical people have presented it to you..... In the current practice, where they are presented with a condition where the life of the mother is at risk, they will take the necessary measures to protect the life of the mother. I don't believe that they indicated they were operating within any time limits.

Chairman: I think they were anxious to quantify the gravity of the risk and a lot of the discussion turned on that. They emphasised various conditions which did amount to a very serious risk and they wanted to be able to exercise their clinical judgment at any stage in relation to them. I must say also that, notwithstanding the X case, I saw little evidence that suicide could ever constitute a real and substantial risk, in the quantifiable sense, to the life of the particular mother who is expecting a child. In other words, the option of termination of the pregnancy was a solution in the context of that risk. There was little medical evidence to that effect before us and that is one of the difficulties the committee has in assessing the evidence. But clearly a range of other risks were postulated which were very serious and required clinical judgment at any stage. That seemed to be the tenor of what the doctors were saying.

Ms McCormack: I think one view is that time limits would not enable the risk to be quantified because it would actually set the decision.

Chairman: It is in relation to the serious medical risks; there had to be respect for the clinical judgment of the doctor at any stage during the pregnancy.

Ms O'Donovan: If I could just come back to the suicide point, it is a difficult one. Peter has indicated that it may be a situation where you could contemplate setting some kind of time limit realistically. Assessing the risk of suicide in the instance of a pregnant woman I presume poses the same challenges as assessing the risk of suicide in other circumstances. Those judgments are made frequently by the qualified psychiatric consultants and personnel. What congress is saying here today is that we have to accept the view of the Supreme Court, as interpreted under the Constitution. Their view is that suicide is to be included as a ground which may be a risk to the life of the mother. Within that context congress is saying we believe that the suicide risk has to be taken into account.

Chairman: Of course I understand how you formulated your position and you've phrased it very carefully but I hope you appreciate the difficulty we have in relation to this question. Clearly, with the question of suicide, as you rightly say, clinical assessments can be made even on some sort of basis as to whether there is a possibility of it. However, the conclusion then that abortion is the appropriate form of treatment for suicide is a very controversial conclusion in the light of what we have heard from the doctors. Yet, as you say, we have to study the terms of the judgment as well.

Deputy J. O'Keeffe: Apologies for being missing earlier but I was speaking in the Dáil. I have been reading your documentation and you have a very clear approach in relation to the need for legislation. Could I raise just two other issues? A number of witnesses have suggested that we should have provision for abortion here in Ireland following rape or incest. Others have raised the issue, the possibility of having abortion facilities here in Ireland where there's clear evidence of lethal foetal deformities. Could I ask you, you're clear that you want legislation where there is a real and substantial risk to the life of the mother, including the risk of suicide, so you're on all fours there with the X case as I see it. Have you had a look at or have you any views in relation to these two other issues that I have mentioned?

Mr Cassells: As we indicated earlier, Deputy, we are here in a representative capacity in the sense that what we're presenting to you is some of the views through our democratic structure of an organisation representing a fairly wide range of people and, therefore … and the view that emerged through that process was that these are issues that should be dealt with by way of legislation, were not appropriate for a Constitution for the reasons we give in the submission on that. Following the logic of that through then, we sought this morning to set out what would be in that legislation. Obviously, since we're not advocating going back, as it were, in the context of the Constitution, we had to embrace the Supreme Court judgment because it's now with us.

So, if you take the issues of rape, incest and, as you say, serious deformities we don't as an organisation have an actual view on that. Many of us as individuals would, and indeed people like Dr Anthony Clare, you know, made fairly strong persuasive arguments to you in these areas. Therefore, as individuals, we've been trying to follow the evidence in front of you but, as an organisation, we wouldn't have a view on that except to say, as we did in our presentation this morning, that these are serious issues which we believe as a committee you should address, as indeed you are doing now at the moment.

Deputy J. O'Keeffe: Just one other issue, a number of other witnesses have presented a very strong view that there should be a substantial allocation of additional resources from the point of view in particular of ... well, especially from the point of view of encouraging a delay in sexual activity on the part of the young and otherwise dealing with crisis pregnancies. There has been a focus on the issue of promoting positive images of motherhood on the one hand, more money allocated to the adoption area, more counselling and more money allocated there and a very special focus on the need for relationships and sexuality education and also more resources, although there's a certain amount of conflict as to how they might best be applied from the point of view of the availability of and accessibility to contraceptives. Does the Congress or the council of trade unions have a view on that approach?

Mr Cassells: In fact, we would have strong views in relation to that approach in that we have, and again our president outlined this earlier, we have for quite a number of years argued very strongly around the whole area of the provision of counselling, of information, of facilities, of comprehensive family planning. We have supported very much the relationship and sexuality education programme in schools and supported teacher unions and teachers in trying to deal with that programme and develop it. We've also supported very strongly the allocation of increased resources to women's health, as you say, the whole projection and importance of supporting both women's health, both positive and obviously in terms of dealing with problems that emerge, but also dealing with the whole area, as you say, of family planning, relationships, sexuality, all of those issues.

Ms McCormack: As we said earlier, we don't think this is an either-or situation. We think ....

Deputy J. O'Keeffe: Irrespective of any constitutional or legislative changes.

Ms McCormack: Yes, we think this is a context which should be the right for a woman to have equal treatment as a citizen, to recognise these issues and needs and to make it a very public and positive debate.

Deputy Daly: I would like to welcome the president and the delegation and to acknowledge the invaluable work which Congress has done over the years for the promotion and your commitment to equality for women. Certainly, I've seen this in the 27 years that I've been here. Over that length of time you've been to the forefront of many campaigns.

Could I just raise with you how representative of the ordinary rank and file 200,000 women that you have associated with you would the views that you are putting forward be? Perhaps you could respond to a view that's been put forward, that this view which you're putting forward to us represents really a small minority of, maybe, activists within your organisation which doesn't affect the views of the overwhelming membership of your organisation. Even in the 1983 referendum when you recommended a vote against the change, it would be generally accepted, I think, that a substantial number of your members didn't go along with your advice.

Mr Cassells: Of course, as a former Minister for Labour, Deputy, you would have probably a closer understanding of our structures and how we operate than maybe most members of the committee in that we're a democratic organisation which holds an annual conference with over 700 delegates, representing a very obviously wide range of different professionals, different types of work, different groupings. Our position in relation to this particular issue at all stages would have been discussed and debated at that conference and positions taken. As we indicated here today, while we may as individuals have a range of different views on the issues, we are presenting to you the outcome of that democratic process.

Now, on this issue in particular, of course, you're always going to get arguments as to how representative that position is and, obviously, you will always get individuals who say, 'Well, I specifically as an individual was not asked in that context'. We get that argument and, I mean, if you take national programmes which are generally publicly strongly supported, that's normally only supported 60:40 within our organisation. So, there would be divided views on this issue as well and we have sought as an organisation to do two things, first of all, to create the environment that the president has just mentioned, that in terms of maternity leave, child care, relationships and sexuality education, family planning, women's health, to create that supportive environment generally for dealing with these whole areas.

Then, at the end of the day, as a representative organisation, you have to come to some position on these and try and come to them in a way which doesn't create major problems for individuals and also respects their views. That's where we've ended up with the position we have and I would have argued in the context of the range of issues that I have dealt over the years with congress that it is as representative a position as you're going to get, bearing in mind that there will be a significant minority who wouldn't even come this far with us.

Deputy Daly: With your experience, especially in Northern Ireland, would you see much difference between the position women adopt in Northern Ireland and, say, in the Republic on this particular issue? Is there much difference of view?

Ms McCormack: Interestingly, a thing that takes forward Peter's point and your issue around representative democracy and conference is that this issue was discussed at the ICTU women's conferences in both the 1980s and the 1990s at which were present both delegates from Northern Ireland and the Republic of Ireland. Those delegates would represent unions and they would have come to the conferences with positions that would have been discussed first in their own unions. There were also people who were for and against. The decision which we came to was actually based very much on the feeling there had to be respect. It's a very simple word which means, I think, a great deal. Clearly, the consensus arrived at at that conference, and I participated in those debates and women from the North spoke, women from the South spoke, women spoke for and women spoke against, that they felt that this was a position which actually respected the right of women to equal treatment without all the ambiguities. They felt that they could actually unite around

this position and take it forward.

All of us brought our own perspectives to that debate. You know, women from the North did as well and from the South, so the sense in which these discussions took place, it wasn't just something that came through in a statement. It actually was a real serious debate at the women's conferences before it actually went to the annual conference. So it was very broad ranging indeed. Yes, there's different experiences North and South, but the common view of congress, including women North and South, is expressed in our submission to you.

Senator O'Donovan: I, too, would like to welcome you here. I listened very interestingly to your submissions. I'll not go over any of the questions previously raised but I would be concerned, having listened for several weeks now to various experts ... and that is on the definition of abortion. I'm coming from a situation .... Some of the experts referred to it as termination, some say medical intervention to save the life of the mother. There's the phrase indirect abortion, there's the phrase miscarriage, etc. Now if we in this committee – maybe I stand alone in this – are somewhat confused on what, in fact, is abortion or otherwise, then surely the general public in a situation of a referendum would be confused.

Some of the medical experts said that in a life threatening situation where the mother's life is at risk and both mother and baby are likely to die that medical intervention, which I understand is supported by the Irish Medical Council as standard ethical practice up to now, is not, in fact, abortion. Others say it is but just by another name. I'm just wondering on this very basic, fundamental and crucial issue, do you see a need for clarification and, possibly, legal definition on what it is or not? While that myth and theory is there ... because I understand that one of the churches, I think, accepted current medical ethical practice in our hospitals is not, in fact, abortion. Others said well, look, technically speaking, if you want to go into a court ... have it defined ... it is.

That's causing a lot of confusion in my mind. I certainly feel it would cause a lot of confusion abroad in the minds of the public. I'm wondering do you have a viewpoint on this question of lack of clarity, what, in fact, is abortion? One of the medical experts, I think one of the masters of the big hospitals said, look, even a miscarriage is, in fact, a type of abortion. So, like, I feel a lack of clarity and maybe your council would have a view on that.

Ms O'Donovan: I think the main view we would have is that in so far as it's at all possible, and we don't underestimate the difficulties, any legislation which may be brought forward should define as clearly as possible what is meant by the term abortion if that's the term to be used. In fact, my understanding is that in the formal English usage of the word, abortion does include both what we would normally refer to as a miscarriage, which is spontaneous abortion, as well as what might be defined as a deliberate termination. So there is a need, I think, for clarity.

I think it is important that the public do have a clear understanding of what's .... I think there is when in the normal usage of the word abortion in public exchanges, I think people do understand what they're talking about. I can see how the medical and, indeed, even religious authorities might want to look at, kind of, the number of angels on the head of a pin and so on. But the reality is that, I think, we would have the view that it would be extremely important that in the context of legislation that you would arrive at a definition which is clearly understood by the public in terms of what is meant.

I think congress's understanding, and we are not here as either medical experts or religious experts, of the word of abortion would be the common understanding and that is where an act is done to terminate a pregnancy. Now whether the termination is the direct or indirect result of the act, you know, there are finer minds coming before you or have been before you on that issue. But that would be our sense of it and I do think that there will be an expectation that these ambiguities will be cleared up in the legislation. We don't underestimate the difficulty, as you have outlined it, but we certainly would hope that that .... It obviously has been defined in other jurisdictions and in other legislation and clearly we could benefit from looking at that. Thank you.

Chairman: Thank you very much for your help and for the process of consultation which you had with your members and your assistance to us here this morning. I'll suspend the session for a few minutes until 11.50 a.m.

SITTING SUSPENDED AT 11.45 AM AND RESUMED AT 11.50 AM.

Professor Ian Graham, Dr Fergus O'Ferrall and Dr Elaine Kay

Chairman: We are now in public session. I welcome the following representatives of the Adelaide Hospital Society – Professor Ian Graham, chairman, Dr Fergus O'Ferrall, director, and Dr Elaine Kay. I welcome you to this meeting of the Joint Committee on the Constitution. We have received your presentation which has been circulated to the members. You will find it at page 461 of the brief book. It has been tabled before the Houses of the Oireachtas.

The format of this meeting is that one of you may make a brief opening statement, if you wish, which will be followed by a question and answer session with the members. I want to draw your attention to the fact that, while members of this committee have absolute privilege, this same privilege does not apply to you. Have you decided that Professor Graham will make the submission?

Professor I. Graham: Thank you, chairman. I will introduce my colleagues first – Dr Fergus O'Ferrall is the director of the Adelaide Hospital Society and Dr Elaine Kay is a consultant pathologist and a board member of the hospital society. I am a consultant cardiologist at the Adelaide and Meath Hospital, with a chair in epidemiology in the College

of Surgeons and a chair in cardiology in Trinity College. I am chairman of the Adelaide Hospital Society.

We thank you for the invitation for us to meet with the all-party Oireachtas committee. The Adelaide society, in particular, welcomes the kind of detailed scrutiny which the committee is giving to the complex issues involved in abortion. This is in sharp contrast to the insensitive protest outside the Adelaide Hospital in June 1998, after we published our submission to the interdepartmental working party on abortion.

This protest and harassment of the hospital and its staff, which persisted for some time, may be perceived as an attempt to create an atmosphere of fear, where the genuine health care issues involved in the abortion debate are unable to be discussed. We, therefore, welcome very much both the detailed analysis in the Green Paper on abortion and the presentation for the first time in public of the medical evidence of your committee. Both the analysis and medical evidence, we believe, support the approach of the submission which the society made in 1998.

Before I highlight just a few key points from our submission, I would like to say briefly a word about the Adelaide Hospital Society. You may wish to refer to page 469, points one and two, and page 480, points one and two. The society is a voluntary, charitable health care organisation which participates in the governance of the Adelaide and Meath Hospital Dublin, incorporating the National Children's Hospital. The hospital is governed by a charter approved in 1996 by the Oireachtas. The charter provides a unique governance framework for an Irish public voluntary university teaching hospital because it enshrines, as a core value, the confidentiality of the relationship between the doctor and the patient, and the availability to the patient of such medical and surgical procedures as may lawfully be provided within the State. It also fully secures the rights of conscience of all the staff of the hospital, irrespective of background.

It is in this context that the society makes its submission on the complex issues involved in abortion. We believe the issues should be dealt with in the overall context of women's health care, in order to maximise the opportunities to reduce the numbers of unwanted or crisis pregnancies, and to provide the kinds of preventive health care so obviously required. We believe that the Government should legislate to make termination of pregnancies lawful within the framework established by the courts' decisions in the X and C cases.

The Adelaide Hospital Society is a Christian organisation, committed to the sanctity of human life and to the dignity of the person. We believe that there are sometimes tragic choices to be made. As a cardiologist, I can give examples of where termination of pregnancy would be indicated in order to preserve the life of the mother. Such a termination ought to be possible in the Irish health care system, and we ought to have a clear and secure legal framework. The committee will have heard from other specialists examples of medical circumstances where a termination of pregnancy is clearly indicated.

We are also concerned that if our health care system is to provide the best health care for everyone, it will mean that the thousands of women who have to have terminations of pregnancies should be able to obtain sensitive health care. Every citizen, including citizens who have made choices which others believe to be detrimental to their human dignity or to their health, deserve a confidential and best quality health care service. Clearly, Irish women do not have such a service. We believe that Irish society is quite simply failing one of the most vulnerable sectors of our population.

You may also wish to refer to Dr Fergus O'Ferrall's letter of 25 November, which is on page 461, in which he summarises a couple of key points: firstly, the need for positive strategies to reduce crisis pregnancies, secondly, the need for the provision of comprehensive health care for those who will have, or have had, terminations and, finally, whatever legal framework is adopted must be clear and explicit.

The Adelaide Hospital Society believes that it is highly likely that a comprehensive caring and non-directive health care service for Irish women will be more effective than prohibition in reducing the very high rate of abortion in Ireland. This is our ambition: to see far fewer terminations of pregnancy occurring in Ireland; to provide much better health care for Irish women, in particular the many thousands who have had or may have terminations of pregnancy; and to provide a clear legal framework for circumstances where there are medical indications for a termination of pregnancy. That concludes our background submission, Chairman. The summary of our submission and recommendations are, as you know, on page 465 of the document.

Chairman: And you have enclosed the original submission you made to the interdepartmental working group?

Professor Graham: Yes.

Chairman: Thank you very much for your assistance.

Deputy J. O'Keeffe: Thank you very much for coming along and for the very carefully prepared submission which you have made, and which I have read, and indeed for amplifying on that this morning. May I say that I am very concerned to learn of the difficulties that you had at your hospital after you made your written submission. I certainly strongly condemn any efforts to stifle informed debate on this issue, in particular that insensitive effort, as you say, that was made outside your own hospital at the time. I think we can do without that. I would like to put on record my total condemnation of any such effort. What we need is informed debate on this issue. While I might not necessarily agree with all your views I am delighted that you have come along to express them.

The second point I want to make is that people will know that I agree with the views you have expressed in relation to the measures necessary from the point of view of reducing crisis pregnancies and otherwise dealing with the issue at a practical level from the point of view of education, counselling and so on.

Could I just ask you to focus on an issue from the point of view of the Constitution and the law? Do I take that in summary, taking the law first, you believe there should be legislation to deal with the existing constitutional position as laid down by the courts? From that point of view, does that indicate an acceptance on your part of the existing constitutional position, or do you feel there should be some ... what in brief would be your view on the constitutional position?

Dr F. O'Ferrall: Yes, the view of the society would be that we need legislation to take into account the circumstances of the X and C cases because broadly our position is that there should be a legal framework whereby medical indications for termination are clearly secured in a legal framework so that the health care system, and doctors and others who have to care for women, have a very clear situation, which they don't have at the moment. What we have is a constitutional position but we do not have a legal framework.

Deputy J. O'Keeffe: Do you accept that the general medical practice at the moment is that where there is a real and substantial risk to the life of the mother, the medical practice in Ireland is that that is dealt with and if that involves the termination, a termination is provided. And if that is so, why then is it necessary to have further legislation at this stage on the issue?

Professor Graham: I would think that is outside the brief of the Adelaide Hospital Society. The society itself would not have particular knowledge of medical practices.

Deputy J. O'Keeffe: Right, and just one other issue. We have had certain evidence here in relation to the need for abortion facilities in the event of rape or incest, or indeed in the situation of clear evidence of lethal foetal deformities. Has the society any view on that? For instance, Professor Anthony Clare was very forceful in his view in relation to rape and incest, and we had others who indicated ... at least, indicated that we should consider the possibility of abortion facilities where there is clear evidence of lethal deformities. Have you a view on that idea?

Professor Graham: Well, we would have, perhaps, personal opinions about this, but the society felt its competence was to address, particularly, the social issues and the inability of the State to look after a particular sector of our society. It did not feel competent to address the issue of suicide or abnormal foetuses.

Senator O'Meara: Thank you for coming to speak to us here today. May I ask you to elaborate on the issue of legislation for a framework provided to us by the judgment in the X case? You stated that is your preferred option in relation to what we as legislators should do. The X case has put into our framework of law now, thanks to the Supreme Court judgment, that the risk of suicide ... that suicide can constitute a risk to the health or life of the mother. There has been evidence put before us that that would not necessarily be the case. In other words, that the risk of suicide to a pregnant woman is very, very small. In fact, the risk of a pregnant woman committing suicide is, in fact, much lower than in the female non-pregnant population and obviously in the wider population as well. So that the inclusion of suicide as a risk to the life or health of the mother is anomalous to say the least, and potentially broadens the whole grounds for availability of abortion. Indeed, some would argue that it would make abortion easily available. Would you have a view on that?

Professor Graham: It is, unfortunately, outside the competence of the society. We have individual opinions on that but it is really outside the competence of the society to know the actual risks of suicide within pregnancy.

Dr O'Ferrall: Except to say, of course, that it is a medical indication in a sense, on the part of psychiatrists in the health service who would have to take that decision.

Senator O'Meara: Yes.

Dr O'Ferrall: Generally, the position in the society and the philosophy we have always had in hospital care is that we trust our doctors, consultants and staff to deal within their ethical codes and, within the law, in a confidential relationship with patients. We would, I think, broadly favour a situation where we would have some trust in our psychiatrists and in our health care professionals that they would make a judgment based on the medical or psychiatric need of the patient.

Senator O'Meara: Yes.

Dr O'Ferrall: That is why we broadly favour that the law would allow for medical indications of those characters, whether they are psychiatric or other decisions that have to be made.

Chairman: There was no psychiatric evidence in the X case.

Dr O'Ferrall: Well, as Professor Graham says, we are not competent to go into the actual details of that particular case but I am just making the general point that where such psychiatric evidence would be adduced by professional people, it should have the same status as other medial judgments that are made and have to be made.

Chairman: Of course.

Dr O'Ferrall: And even – as Senator O'Meara said, the incidence may be small – if there is only one woman involved, she deserves, as a citizen, the best health care.

Senator O'Meara: Yes.

Dr O'Ferrall: So the size or the numbers of the population really are not that relevant to what the law has to do. The law has to address all the needs of people.

Senator O'Meara: Yes.

Professor Graham: I don't think I will be going much beyond the wording of the submission if I say that I think the philosophy of the society is essentially one of trusting the wisdom of people, and particularly women. Within our hospital we do not, for example, have an ethics committee. We assume that our medical staff will behave ethically and it's a matter of trust. We feel, I think – and again this is perhaps the philosophy rather than the words – that excessively restrictive legislation may cause some difficulties and that there has to be the allowance for wisdom and trust of people.

Senator O'Meara: It's a second issue, and I must say that I very much welcome your very strong emphasis in your submission on the wider social issue, in other words, that we as a society do face a major problem with regard to the level of abortion that we effectively have. The rate of

Irish abortion, which you quite rightly point out … while Irish women are travelling to England for abortions, we actually do have a very high rate of abortion. We clearly do have a major problem concerning crisis pregnancy. You are not the first group who has come before us and suggested greater resources and, indeed, a far more structured approach to the availability of counselling and the availability, particularly, of information. And, of course, that is not either a medical or a legal issue and, as you quite rightly point out, we can recommend those issues – we can make recommendations on those issues without looking at the medical or legal issues or constitutional issues, indeed, at all. But do you think in your experience and in your judgment, would the wider availability, the easy availability shall we say, and the very kind of proactive and positive approach to the availability of counselling, in particular, and information of a non-directive and in non-judgmental form, would it act to break down what I would consider to be an atmosphere of secrecy, a culture of fear, and, you know, an inability to discuss the matter in our broader society? You know, should we be looking at ways of dealing with that negative culture and negativity around the whole issue?

Dr O'Farrell: Yes, I think we would. We actually made our submission prior to the Trinity study ....

Senator O'Meara: The Conlon, Mahon, Dillon one.

Dr O'Farrell: Yes, which bore out, I think, in a much more scientific way what you are saying about the need for contraceptives, because they traced the pathways to crisis pregnancies and so on and it bore out the need for what we had broadly indicated in our submission. Also the Green Paper, I think, has advanced that discussion because that had a good section in it on the need for education and support and I suspect the Department of Education's programmes have actually advanced since even 1998 when we made our submission.

So, I think, a lot of the evidence that you've heard would support that as well. So, I think, one of the things we could do, and as we say in our submission, regardless of the legal options, what we can do as a Government or as a society, is to address some of those broader issues and that means that we've got to change some of our attitudes, as Professor Graham says, towards women and regard women as equal citizens and make sure that they have access to the services that they require in their terms and try to prevent in that way ... and bring down the very high level of unwanted pregnancies and extraordinarily high abortion rates we have in Ireland.

Senator O'Meara: Thank you.

Senator O'Donovan: Just a couple of very brief questions. I presume you're affiliated to the Irish Medical Council, individually or ....

Professor Graham: The position is that surgeons in hospitals would be bound, of course, by the Medical Council because that's the registration body.

Senator O'Donovan: I'm just wondering do your society subscribe to their medical ethical code or are you totally independent?

Professor Graham: Completely independent because they're governing the medical profession and our society is predominantly lay people.

Senator O'Donovan: Just one final question. Do you feel maybe somewhat shackled or restrained by the existing law, as it stands, on this overall issue and maybe the constitutional provisions? In other words, do you feel curtailed as a society ... that as the constitutional position and the legal position stemming from the old 1861 Act, as it currently stands, do you feel shackled, constrained in the workings of your society and your philosophy?

Professor Graham: Bear in mind the society does not provide health care; it is an electoral body to the board of management of the hospital so, although it might have opinion on that, you can't particularly feel shackled. Now, but it does, I think, believe that the present legal situation is unclear and makes it hard for physicians who are actually providing health care to know what to do.

Senator O'Donovan: You mentioned that one of your prime objectives was the ... I think you put it, as being the common sense of the woman and what the woman wishes, etc. Isn't there following on that something radically wrong with our society that we have such a huge amount of unwanted pregnancies, where there are say 6,000 estimated going abroad every year? There's probably no simple solution but, obviously, the common sense .... Having regard to the education and contraceptive facilities available to young Irish people, I personally feel that there's a wide range available, you know, throughout the country. Is there a lack of common sense or where does that break down in general society? I cannot put it down ... I would be very slow to say pure ignorance but is it lack of education or where does it come from? Do we need a sort of ... maybe a television or an educational campaign to say look well if you're involved at a young age in sex, you're likely to get pregnant and so on?

Professor Graham: In a way, I suppose, traditionally there has been almost a conspiracy of silence and the recommendations start by talking about – page 466 – the need for a comprehensive schools programme. It goes on to talk about contraceptive provision, the counselling services, health education and contraception programmes and many others. So, it addresses nearly all the issues you have covered and, yes, it needs a very, very, comprehensive approach in our view really at every level.

It is interesting with the freedom of termination in the Netherlands that their abortion rates went down rather than up, but they have an enormously comprehensive programme starting in the schools and throughout society where there is no particular stigma, no particular fear and everything can be openly addressed and there is complete freedom of information.

Dr E. Kay: I would agree with your summary that it is that broad and comprehensive education that will help bring down those figures which have ....

Deputy Kirk: Thanks Chairman. I join with you in welcoming the group today. The question I'm going to ask may well have been dealt with earlier, and I apologise if

it has been. If you might briefly talk us through the question of the standing and status of the mother and the unborn in a pregnancy situation as your society sees it.

Professor Graham: The submission didn't address the standing and the status specifically, so I need to be careful not to stray beyond it. I think implicit in it though is the lack of trust given to a young woman or a pregnant woman and the lack of realisation that people do not make decisions about abortion lightly, with very few exceptions. There is a slight unease in the society at the presumption that, for example, a lot of middle aged men presuming to know the answers to these very complex issues. So we do feel, I think, by and large, young women are both patronised and not given sufficient support.

Chairman: I would like to thank you for assisting us here today and I will suspend the session for five minutes.

SITTING SUSPENDED AT 12.17 PM AND RESUMED AND 12.22 PM.

Ms Alison Begas and Dr Shirley McQuade

Chairman: We have resumed our public session and I would like to welcome the following representatives from the Well Woman Centre: Ms Alison Begas, the chief executive and Dr Shirley McQuade, the medical director, to this meeting of the Oireachtas Joint Committee on the Constitution. We have received your presentation, which has been circulated to the members and laid before the Houses of the Oireachtas. The presentation can be found at page 431 of the first interim report, containing the briefing documents.

The format of this meeting is that one of you may make a brief statement elaborating on the submission, if you wish, and that will be followed by a question and answer session with the members. I have to draw your attention to the fact that while members of this committee have absolute privilege, the same privilege does not apply to you. Which of you will begin?

Ms A. Begas: I intend to make a short opening statement, but before that I would like to just introduce my colleague, Shirley McQuade, who has worked as a doctor with Well Woman for four years and has been group medical director for the last three, and in such capacity is not only responsible for seeing clients in a clinical situation, but also for the operation of policy within the group – medical policy. I myself joined Well Woman as chief executive some 18 months ago having come from the rather different situation of the Chambers of Commerce of Ireland, so I am a relative newcomer.

I think you will be aware of the history of Well Woman, which was founded in 1978 with the aim of giving women access to decision making over their own reproductive well being and family planning options. It seems hard to remember, but this was at a time when contraception was illegal in the country. The crusading zeal of Well Woman has often placed the organisation in some divisive and rather draining campaigns. This was perhaps most notable in the 1980s when the Society for the Protection of the Unborn Child took an injunction restraining Well Woman from giving information to women seeking access to information on termination, and you will be aware of cases to the Supreme Court and Well Woman's ultimate successful case under the European Convention on Human Rights, which challenged that injunction.

Since then, and with the publication of the regulation of information Act in 1995, we have continued to offer non-directive pregnancy counselling within the parameters of that Act. We are proud of the professionalism, the compassion and the integrity with which that service is offered and just to give you a sense of context on this, in 1999 we saw 1,351 women for pregnancy counselling. That is within an overall picture of 55,000 clients coming to us.

To address the issues raised by the Green Paper, we would indicate that our experience over the last 20 years makes it clear that no constitutional ban or legal sanction can effectively restrain Irish women who choose to seek a termination. With that in mind, we are opposed to the insertion of clauses in the Constitution which tend, or have the intention of criminalising those women who are faced with the need to seek termination. We would like to see the removal of the stigma of criminality from abortion and would ask that the all-party committee give consideration to recommending the deletion of sections 58 and 59 of the Offences Against the Person Act. It is the experience of our counsellors that many women feel that difficult as the decision already is for them, it becomes even more difficult when they are aware of doing something that may be classed as criminally wrong, as they are already very tough on themselves in the counselling session and this exacerbates the problem.

Well Woman is committed to the belief that abortion is a personal, moral, ethical and social issue which has no place in the Constitution. Therefore, we are also opposed to the holding of another referendum. Referenda held to date have only succeeded in muddying the waters and have not resulted in clear conditions.

We emphasise our position as being pro-choices for women, and I must emphasise the plural there. Our commitment is to giving women access to all options and facilitating decision-making themselves, based on knowledge of all options available to them. We reiterate that indications since the X case in 1992 have confirmed that there are ambiguities in the present legal situation and having stated our opposition to further constitutional amendment, we call on the all-party committee to recommend that legislation is passed to address the anomaly between the X case and Article 40.3.3°. No less a person than Ronan Keane, our recently appointed Chief Justice, has used the expression 'legislative inertia', and I think that is a very telling statement and an indication that legislation is required.

One approach here would be to legislate to bring the X case judgment into expression on the Statute Books – option (v) of the Green Paper. In stating this we are mindful of the immense difficulties involved in defining parameters for such legislation. We acknowledge the view that the risk of suicide by a pregnant woman is extremely small but it is nonetheless a risk which must be considered, and it was interesting to note that Anthony Clare, when he addressed this committee, specifically made the point that for a psychiatrist to assess the likelihood of a woman committing suicide or not – a pregnant woman – is extremely difficult, so whereas it is small, it is still a risk.

We also acknowledge and are proud of the high standard of medical care available in Ireland and indicate that there are few medical circumstances in which the life of a pregnant mother might be endangered and that would justify directly the availability of abortion. However, those circumstances do exist and applying an absolute constitutional ban where there are even small circumstances to justify it, we think, would not be wise.

We are aware that it is almost impossible to define medical criteria which would not in time lead *de facto* to a liberal abortion regime to which we would be opposed and we would indicate that some other jurisdictions have found the only practical way was to define a term limit or a time limit at which abortion should be permitted, and this was a model to point to.

We also are concerned that Irish women who travel particularly to the UK for terminations do so at later stages of the pregnancy than their UK counterparts. Medical thinking would advocate that abortion in the first trimester is preferable as far as the impact on a woman's health and well-being is concerned, and we can only conclude that the availability of services within the State would make pre-abortion health care and post-termination health care more readily available. My colleague, Shirley, can speak a little of her clinical experience in women who come to us for post-termination check-ups, and you will remember I used the figure of 1,350 women coming for counselling. Last year between 300 and 400 women came to us for a post-termination check-up so it is probably the more self-aware ones, the ones who are more aware of their own health needs, who come back; many do not, and that is alarming.

In summing up we would reiterate that abortion is a very complex issue. It is no instant solution. Again our experience in seeing women and men for post-termination counselling underlines that it is a decision that lingers, that it has impact on people, that it is a decision that changes women's lives. Our submission has referred to the need for education and greater access to contraception to reduce what is an alarmingly high number of abortions so I won't go into those issues, but again we can speak from our experience in dealing with women and reiterate that there is ignorance out there as to family planning and women's choices.

Finally, I would reiterate our commitment to the need to continue with freedom to travel and freedom to give information, and I would urgently ask that this committee, as one of its recommendations, back the need for regulation of pregnancy counselling. I think I will conclude on that note, Chairman.

Chairman: Thank you very much.

Ms Begas: Thank you for your patience.

Chairman: Thank you. Not at all. There was no patience – you elaborated on your submission. Did your colleague, the medical director, wish to elaborate because there were one or two points?

Dr S. McQuade: No.

Chairman: No?

Dr McQuade: I am willing to take questions.

Chairman: You would prefer to deal with the questions. Deputy O'Keeffe.

Deputy J. O'Keeffe: If I might take the constitutional situation first, do I take it that your view is that we should not have a further referendum on the Constitution?

Ms Begas: Yes.

Deputy J. O'Keeffe: Well do you .... Does that then imply that you accept the present constitutional provision ....

Ms Begas: We ....

Deputy J. O'Keeffe: .... which cannot obviously be changed other than by way of another ... you would need a referendum if you wanted to change it.

Ms Begas: We are very wary of tinkering with the Constitution from the prospective that medical treatment and medical knowledge changes, and the Constitution is to a certain extent an inflexible medium; it can only be changed by the people, as is right. We would like legislation passed to bring into effect the Supreme Court's judgment as given in the X case.

Deputy J. O'Keeffe: I might come to that. If you want to leave the Constitution as it is, are you ... are we then in a situation that you want legislation, and your legislation or your legislative request, as it were, is to have in legislation the constitutional interpretation of the Supreme Court in the X case? You want legislative regulation covering that.

Ms Begas: Yes.

Deputy J. O'Keeffe: So in that .... That would mean that ....

Ms Begas: But with the proviso that definition of the medical circumstances and the decision-making process is very clearly specified.

Deputy J. O'Keeffe: But that is all then under the umbrella, the constitutional umbrella of real and substantial risk to the life of the mother. That would be the constitutional framework within which any legislation would be framed. Is that really what you want?

Ms Begas: Can you ....

Deputy J. O'Keeffe: Well, the Constitution at the moment

provides – in brief now – that where there is a real and substantial risk to the life of the mother, whatever medical attention she needs or whatever medical procedures she needs will be given, and that then was interpreted by the Supreme Court as including the situation where there's a risk of suicide. Okay? That is the constitutional framework at the moment.

Ms Begas: Yes.

Deputy J. O'Keeffe: I am merely trying to tease out your position on the .... Is it within that constitutional framework then that you feel that legislation is necessary, or did I gather from your other remarks that you felt that other options should be available to the pregnant mother and should be provided for in legislation?

Ms Begas: First we are not legislators.

Deputy J. O'Keeffe: Yes.

Ms Begas: I think certainly within that framework, yes, but what we're anxious to avoid is further X cases, further C cases. We do not wish to see, as an organisation, individuals forced to go to court to justify, to test the Constitution on a personal decision. So I think legislation is needed to clarify the Supreme Court's judgment within that context, yes.

Deputy J. O'Keeffe: But you'll appreciate that if it is merely to clarify the Supreme Court judgment, it is within the context of the existing constitutional framework.

Ms Begas: Yes.

Deputy J. O'Keeffe: And I suppose you also accept that it's a matter for the Supreme .... I'm not making any comment on Justice Keane's reference to legislative inertia but it's a job of the Supreme Court to interpret the law and in particular the Constitution.

Ms Begas: Absolutely.

Deputy J. O'Keeffe: There's one other issue, well two issues. One is could I just tease out a bit further when you refer to all options being available to the pregnant woman? What exactly do you mean by that?

Ms Begas: Within the context of a pregnancy counselling session in Well Woman?

Deputy J. O'Keeffe: Yes.

Ms Begas: When a woman comes to us .... Would it help the committee if I talked a little bit about what happens when we do a pregnancy counselling appointment?

Deputy J. O'Keeffe: Indeed.

Ms Begas: Some 50% of those women who come to us for pregnancy counselling have already in their own minds gone through their options and have reached a decision that a termination is what is required, is what they need. The other 50% are open to discussion or have not yet reached a decision. When we counsel them we talk them through all options. Those would be continuing with the pregnancy – and we do discuss the range of social welfare supports available – fostering, adoption and termination. Even if they begin the session by saying 'I want information on a termination', we point out that legally we are obliged to discuss all options with them. It does occasionally happen that women starting a session by saying 'I need a termination' will go away and think things through and then maybe come back for another session, then decide to have their baby.

But our counselling is non-directive. We do not try to steer a woman in either way. Sometimes women will look to us for validation of their decision if they decide to have a termination which we do not give. That would be against the parameters of a non-directive counselling session, but we find that they come from a very isolated position. Sometimes when they come to us they have not had the opportunity to discuss their crisis pregnancy with anyone. They're frightened. They need a lot of reassurance that we don't come from any one particular agenda and, especially in the light of the private adoption case that came to light last summer, they want information that we will discuss all options with them. They also are given, if they ask, information on the process that will occur should they decide for a termination. So we will discuss the process with them after care. We will stress the need for a post-termination medical check-up, for post-termination counselling and we encourage them to come back for a second appointment or even a third appointment if they wish and many of them do.

So when we say all options it's not a case of us handing an information pack saying this is where you go in Birmingham. We go through a user booklet produced by Treoir, the organisation here for single parents, which does address all those alternatives.

Deputy J. O'Keeffe: Do I take it from that then that you are very happy with the legal requirement that all options be covered ....

Ms Begas: We are, yes. We don't have a problem with that at all.

Deputy J. O'Keeffe: I see. You did make a comment about the need for regulation of pregnancy counselling. Could you amplify on that a small bit? Were you referring to a particular instance we read about some time ago on ....

Ms Begas: I was. I was referring to the case that came to light last August/September of a counselling agency using what could be described as 'coercive and highly emotive counselling tactics', which should not be part of ethical, professional counselling. We would be funded by the Eastern Health Board, as are five or six other agencies. Some of them have a more pro-life stance, some of them have a more pro-choice stance but all of those agencies funded would engage in very, very supportive, professional, compassionate counselling. There would be none of the secrecy and none of the coercion involved. It's hard sometimes for women, again coming from a very isolated position, to know which agencies are going to empower to make their own decisions and which agencies are going to try to coerce them.

Deputy J. O'Keeffe: And the regulatory framework that you'd recommend in the circumstances?

Ms Begas: We would like to see strict parameters. We would like to see some sort of accreditation system.

Deputy J. O'Keeffe: From the health boards or the Department?

Ms Begas: From the health boards as the funding agency. Things have moved on since last August in that the Eastern Health Board or the Eastern Regional Health Authority now advertises those six agencies it funds in the yellow pages, so there is some highlighting of the agencies it endorses as being professional in their operation. That's very important. It's a very good move and it is to be welcomed.

Deputy J. O'Keeffe: Okay, thank you.

Deputy Kirk: Just to welcome the group in – a few short questions. The Well Woman centres. How many clinics have you around the country?

Ms Begas: We are purely a Dublin-based organisation now. We have three clinics, one in Coolock in the Northside Shopping Centre, one on Pembroke Road and one on Liffey Street. At one stage we had clinics in Athlone and Bray as well but those have now closed.

Deputy Kirk: Yes, you referred to funding being available from the health board. Is there any fee charged to callers?

Ms Begas: For the pregnancy counselling, no. It's free of charge, as is post-termination counselling.

Deputy Kirk: Yes, the monitoring of callers or patients subsequently. Do you monitor each caller subsequently? For instance, what percentage of callers would subsequent to a visit on a counselling session have an abortion of that total number that would call?

Ms Begas: We never know that. When a woman comes to us the undertaking is that .... We would never initiate contact, for example, after a session with a woman. We frequently don't even have a last name. Some women will just give us their first name when they come to us. So unless a woman comes to us for post-termination counselling or for a medical check-up we have no way of knowing what decision they make after they leave a pregnancy counselling session. Sometimes at the end of a session ....

Deputy Kirk: Do you operate a filing system from ....

Ms Begas: Our counsellors will keep their own notes of sessions but even within that context it may not be clear what decision a woman has made. Sometimes they'll be very clear and they say, 'Yes, I still wish to go ahead with the termination' and sometimes they won't indicate, sometimes they will go away and think things through.

Deputy Kirk: Yes, medical ethics. Is there any benchmark at all which your group operate in relation to that? Do they have regard to the code of ethics which GPs or obstetricians would have? What's your group's position?

Dr McQuade: If we're talking in relation to counselling, counselling is a separate issue from general practice, for instance. General practitioners would access counsellors as well so that they are two separate groups.

Deputy Kirk: Yes, but will you have regard to the code of ethics in the process of counselling?

Dr McQuade: Our counsellors do have regard to the code of ethics because they're all registered counsellors and that is part of what we're calling ....

Deputy Kirk: But there is a code of ethics?

Dr McQuade: The counsellors have their own body. It's a separate body from medical practitioners.

Ms Begas: It's the IACT. It's the Irish Association of Counselling and Therapy.

Deputy Kirk: Yes, thanks for that. What qualifications have the counsellors got?

Dr McQuade: Counsellors have a range of qualifications and that's one of the difficulties with regulation of counselling at the moment because, as far as I'm aware, almost anyone can set up a plaque and say 'counsellor' underneath and they can set up in practice as counsellors. Those that are associated with the Irish Association of Counselling and Therapy have gone through training. As I'm not a counsellor, I can't tell you exactly which things. They have several different training bodies that help with counselling. Certainly all our counsellors and any that are regulated will also go through regular updates and they also have their own counsellors.

Deputy Kirk: Do you operate a panel of counsellors or do you simply call up a counsellor when you need them? What are the logistics of that?

Ms Begas: We have three counsellors who are employed by Well Woman and they not only provide pregnancy counselling, they also see clients for other issues.

Deputy Kirk: They are actually in the employment of Well Woman.

Ms Begas: They are actually in the employ of Well Woman, yes and they are the ones who provide the pregnancy counselling service. I think it is important to stress, in addition to being IACT accredited, in addition to the fact that we strictly monitor the way the service is operated and ensure that it remains within the parameters of the 1995 legislation, we also have our own internal protocol defining its operation. I would have no doubt that it is offered with a great deal of integrity and professionalism.

Deputy Kirk: Do you feel there is a deficiency in the whole range of advice being provided – the fact that you do not keep a record of what subsequently happens to callers or patients?

Ms Begas: Short of contacting people a month later, two months later, we cannot know what decision they make.

Now we can assume that many of them do go on to have a termination.

Deputy Kirk: Do a percentage of them return for post-abortion counselling?

Ms Begas: Yes, approximately 10% come back for counselling and last year we saw about ....

Deputy Kirk: Yes, I know, but 10% of what?

Ms Begas: Last year, if you bear in mind we saw 1,351 women for pregnancy counselling, 135 women came for post-termination counselling. That is almost exactly 10%. Sometimes they do not come back immediately. Sometimes it could be six months on and it is often not the termination that triggers their need for a counselling appointment – it can be something else. That is a relatively small figure who come back for post-termination counselling. Some 300 to 400 come back for medical check-ups post-termination.

Deputy Kirk: The status and standing of the mother and the unborn in a pregnancy situation ... the Well Woman Centre ... what is their actual position in relation to that?

Ms Begas: In what sense?

Deputy Kirk: In a pregnancy situation ... the mother and the unborn child ... the standing and the status.

Ms Begas: In terms of medical treatment?

Deputy Kirk: Yes.

Ms Begas: Well, as primary health care providers, it would not be within our ambit to be having to make decisions.

Dr McQuade: Our position on the status of women is that women should be allowed to have choice in their decisions on all kinds of lifestyle choices, including during pregnancy.

Deputy Kirk: Do you feel that the present constitutional and legislative position, that there are inhibitions to that choice?

Dr McQuade: There are several issues involved in choice with women. Women should be able to have a choice as to whether or not they engage in sexual activity, they should have choices as to whether or not they use contraception and they should have information on the kind of contraception they can use. They should also have choices in relation to their fertility – should they get pregnant – as well.

Senator O'Meara: I would like to welcome you here today and to say how informative your comments have been. Can I ask you, in relation to referral, under the law you do not refer clients for abortion. Did you in the past?

Ms Begas: No, we would not.

Senator O'Meara: You say that 50%, generally, of women who present for counselling, who come to you for counselling, will have generally made up their minds that they are going to have a termination so clearly they are looking for information.

Ms Begas: Yes.

Senator O'Meara: Do you think you should be ... you should have the choice of referring. Would you prefer to have a situation, particularly from a medical point of view, of being able to refer a client to a particular clinic, to a particular doctor, in order to ensure good medical procedure, we'll say, that you could refer somebody to a clinic where you know the procedure will be properly carried out?

Dr McQuade: Yes, I think from a medical point of view, we cannot regulate the services that are provided for women who go to Britain or indeed France and Holland – I have seen people go there as well. We cannot guarantee the quality of service outside the State, so, therefore, we are giving women information on services outside the State without being able to say to them, 'This is a reasonable place to go to or this is not'. I think from a medical point of view, that is difficult.

Senator O'Meara: But you can give a woman on a clinic ... where a clinic is ....

Ms Begas: Yes, we can and sometimes the women who come to us will want a lot of reassurance that the information we give does not pertain to a 'backstreet clinic', so we do point out the clinics we list and it is an important distinction between listing and referring. The clinics we list are all UK Government regulated and have all been opened since the 1967 legislation in the UK.

Senator O'Meara: Of the women who return for post-termination visits or terminations, would any or any significant number be coming back with medical problems associated with the abortion?

Dr McQuade: It would be a very small number of women who come back with medical problems. A post-termination medical check-up would be for several reasons – firstly to ensure that they are not still pregnant which occasionally can happen, particularly in early termination. A very small number may have an infection. Those women .... Some of the clinics in Britain will provide antibiotic cover during the termination, others do not. We have no way of way of knowing which ones do and which ones do not, which is a problem. There is also the issue of future contraception and that is a very important one. Again, some of the clinics in Britain will discuss that with the woman before she leaves, others do not.

Senator O'Meara: Have you ever come across or would it happen at all that you would meet a woman or a woman would come to you who would be suicidal as a result of pregnancy.

Ms Begas: No.

Dr McQuade: I have never seen someone like that. Having

said that our clinics would not be the place for someone to appear like that, it would be much more likely that they would access casualty, a more crisis situation.

Senator O'Meara: Of the 50% of those who have more or less made up their minds that they will have a termination, what affect would counselling have on that figure. In other words, if I put it a different way – would there be any significant reduction, do you think, in the numbers having terminations arising out of counselling? By broadening out the range of options, by discussing the range of options as you are required to do and as you do, do you think that that is reducing the number making a decision to have a termination?

Ms Begas: Certainly, I think it is true in some circumstances women go away and do decide to continue with their pregnancy. I think a lot of women come to us to reassure themselves that they have options, they have choices and having gone through those choices with one of our counsellors, some I am sure, do decide to have their baby.

Senator O'Meara: But of course you have no way of knowing really.

Ms Begas: No, we do not.

Senator O'Meara: Thank you very much.

Chairman: Just one matter – in your submission you say, 'It is the experience of our counsellors that many women feel that difficult as the decision already is for them, it becomes more difficult as they are aware of doing something that may be classed as criminally wrong'.

Ms Begas: That was in relation to the terms in the Offences against the Person Act.

Chairman: Yes, indeed. That is part of the general social stigma because we heard legal opinion earlier this morning that section 58 does not apply to an abortion carried in England as it is a service lawfully available there. I just wanted to clarify what was your point on that.

Ms Begas: I appreciate the distinction you are making between our jurisdiction and the UK. I think for the women, they are aware of ... well there is a number of emotions that they feel that come out in the counselling session. For some of them, a termination is the only logical decision based on their circumstances at that time. Some are aware of a religious dimension to their thinking, some feel incredibly guilty, some are very, very hard on themselves, they feel what they are doing is a very, very difficult thing but, again, the only decision they can make. So, yes, I would say that in relation to the stigma and the isolation and the climate in Ireland, whereby there is not an open debate and open discussion on abortion, they do feel that guilt.

Chairman: I am trying to relate it to specific legal provisions in so far as it's coming out of the Houses of the Oireachtas, if you like. One question I raised earlier with Ivana Bacik was this question of sections 58 and 59. You see, section 58 is the prohibition on the woman herself having an abortion, whereas section 59 is the prohibition on the person giving assistance. It seems to me, if you have a constitutional ban on abortion, you have to back it up with some form of statutory ban on persons who carry out abortions. The question then arises, there's not been a prosecution for a very long time of a woman herself attempting to have an abortion. I just pose that question this morning because I see you've called for the repeal of both sections and, I suppose, I'm expressing – only personally and not speaking for the committee in any way – a doubt as to whether you could delete section 59 with the present constitutional arrangement. There might be an open question on section 58. I'm just interested in your views on how people's perceptions and counselling were coloured by legal arrangements. That is really what I was getting at here.

Ms Begas: The point is well made of muddy waters and people not being aware. It comes back, I think, to the fact that we don't have a calm, open, healthy, in the broadest sense of that word, debate on abortion.

Chairman: Does any country in the world?

Ms Begas: Probably not. No.

Chairman: Thank you very much for your help and for the insight you gave us deriving from your experiences. I thank you for your contribution. I'm adjourning the meeting until Tuesday, 30 May.

THE JOINT COMMITTEE ADJOURNED AT 1.02 PM.

TUESDAY, 30 MAY 2000, 11.30 AM.
MEMBERS PRESENT:
DEPUTY S. KIRK, L. McMANUS, J. O'KEEFFE,
SENATOR J. DARDIS, D. O'DONOVAN

DEPUTY B. LENIHAN IN THE CHAIR

Dr Geraldine Moane and Professor Hannah McGee

Chairman: We have a quorum and are in public session.

Before commencing today's hearings there is one matter which I wish to deal with. A verbatim transcript of our hearings of 17 May 2000 with Dr T. K Whitaker and the De Borda Institute has been produced. Is it agreed that we print and publish this verbatim transcript as provided for under Standing Orders? Agreed.

Deputy J.O'Keeffe: Do we have to do that for every report – the report of each day's hearings?

Chairman: We are continuing in public session and I would like to welcome the following representatives of Psychologists for Freedom of Information, Dr Geraldine Moane, department of psychology, University College Dublin, and Professor Hannah McGee, department of health services research, Royal College of Surgeons, to this meeting of the Joint Committee on the Constitution in connection with consideration of the abortion issue. We have received your submission, which has been circulated to Members. We intend to table it before the Houses at a subsequent meeting.

The format of this meeting is that one or both of you may make a brief opening statement elaborating on your submission if you wish, which will be followed by a question and answer session with the members. I want to draw your attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you.

Just one matter. I think you made a submission to the Department of Health and Children when the Green Paper was being prepared. Do you have a copy of that submission? Could you hand it in to us?

Dr G. Moane: Certainly, yes.

Chairman: The submission you prepared that we circulated is the submission that was prepared for our committee. Is that the position?

Dr Moane: Yes.

Chairman: I wonder would you like to elaborate on it.

Dr Moane: Right. First of all to briefly say that the Psychologists for Freedom of Information is a group of research psychologists and psychologists in practice and we formed around the issue of information, believing that informed decisions are always better. We are also committed to ensuring that best practice applies in counselling and decision making about abortion. Today, Professor McGee will discuss some of the research literature on suicide and pregnancy and will then on go to look at clinical aspects of suicide and decision making in relation to suicide and then some other points, time permitting, arising from the submission.

Professor H. McGee: My area of expertise is in the evaluation and conduct of research on social and psychological factors in health, illness and health care settings and it is in that context that I am here today as part of Psychologists for Freedom of Information. I want to elaborate on some of the evidence the committee has heard to date. We have had the opportunity to look at previous representations so, in the short time we have, I want to further some of the evidence you've heard in relation to suicide in pregnancy.

You have heard mainly about completed suicide during pregnancy but you haven't heard, to our knowledge, about attempts of suicide during pregnancy. Our evidence would concur with the general thrust of the findings that have been presented to you that completed suicide during pregnancy is significantly reduced over and above levels in non-pregnant women of similar ages. However, the protective factor may not be as powerful as the one in 20 you've heard from the Appleby study in the early 1990s in the UK. This was based on death certification. A more recent and detailed analysis in the US in 1999 by Marsoc – we have copies if people are interested – where they were able to have completed autopsy or forensic examination in all cases shows that the risk of suicide in pregnant *versus* non-pregnant women reduces by about a third. So pregnant women have about a one in three chance of non-pregnant women of similar ages of committing suicide. Importantly, however, although the percentages in all of these studies are low, they represent real individuals. In the New York study, there were six women in four years and in the UK, there were 14 women in 12 years. This is more than one completed suicide per year in both systems where abortion is widely available.

With regard to attempted suicide during pregnancy, there were a number of international studies. There is, for example, a nine year study in Hungary of all persons admitted for self-poisoning to a World Health Organisation collaborating centre there with expertise on self-poisoning. They found in almost 23,000 cases of poisoning by women of childbearing age that 559 of these were pregnant at the time. That is 2.4% but it is 559 women in a nine year period. Most of those women – 61% – had attempted suicide in the first two months of their pregnancy, at the time, they also concluded, where there was an early recognition of an unwanted pregnancy.

A second study looking quite differently at injuries requiring hospitalisation in women of childbearing years in the state of Maryland in the US over a 12 year period by Greenblatt et al. in '97 showed that poisoning was the most common cause of hospitalised injury for pregnant women and that 16.9% of hospitalisations in those 12 years, in other words 369 hospitalisations, were for poisoning in pregnant women. That's an average of 30 attempted suicides by poisoning per year by pregnant women in one US state.

There is a small study in the UK, which may be closer to home, of a five partner general practice in Wales. They looked at their records for women aged 15 to 34 in 1994 and found that 12% of those women had GP records of terminations and 3.5% had records of overdoses and, if you combine them, 1.1% or 15 women in one practice had evidence of both. Most of those women were under the age of 24. There was a significant association between the likelihood of overdose and the likelihood of termination but, with a small number, it is difficult to say what the order was. If anything, the evidence suggested that the overdoses predated the terminations. For us, this combined evidence on completed and attempted suicide in different countries indicates that there are many real life settings, however small they may be in epidemiological terms, in which health and social service professionals have to work to support individual women who are at risk of attempting or completing suicide. In the Irish setting, as has been confirmed to you by the masters of the major maternity hospitals, women and adolescent girls in crisis pregnancies do not currently consult with obstetricians and gynaecologists in these centres to make choices which include termination. There is unlikely, therefore, to be evidence from these sources of suicide risk or loss of life

if it usually occurs in early pregnancy.

Suicide or attempted suicide statistics are not routinely collated by pregnancy status so we have no evidence from which to assume that these events do not happen in this country. We have every indication that such events will be presented to individual professionals in the future. The X and C cases are evidence of this in the past. The argument that such events are rare has no bearing on the responsibility of the State to manage them, rare or otherwise. It would be our contention that the State should legislate to support and protect professionals in doing their work in this particular area. I'll hand over to Dr Moane who will talk about the assessment of suicide and suicide risk.

Dr Moane: I want to move to the clinical level and deal with a situation where you actually have an individual case who is presenting. In the course of their work, clinical psychologists routinely deal with patients who are suicidal and those settings include psychiatric, community, prison and private practice contacts. They are trained in assessment, decision making and intervention in suicide and the training involves a three year professional training. There are well developed assessment instruments and guidelines for suicide assessment and intervention which were recently published in the Harvard Medical School *Guides to Suicide Assessment and Intervention*. Furthermore, they would be involved in decision making and one of those decisions would be whether to admit a patient to hospital and, if the patient does not wish to be admitted, whether to be involved in committing a patient and then, obviously, discharge is another area of decisions making.

Decision making is first based on knowledge of the research literature related to risk factors, second, on objective assessment using well established measures and third, on clinical interview with the patient and related parties. Risk factors would include race, ethnicity, poverty, age – demographic factors where you can say, for example, that a young person is more at risk than an older person. Child sex abuse is a high risk factor so its presence would be taken on board. Other factors which emerge in the literature are a positive HIV status, homelessness, family history of suicide, stressors in the family, alcohol and drug abuse history. So if you have a particular case, for example, a teenager with a child abuse history, that would also be higher risk than somebody in her twenties who did not have that history. You take on board these risk factors. You then do an assessment using standardised instruments which would assess depression, anxiety, coping skills and various other psychological areas and also suicide-specific assessment such as suicide ideation using checklists and rating scales which would give you a sense of where a person's condition lies in relation to the norms available for the scale.

The clinical interview would be based on interview with the patient looking at, for example, previous suicide attempts, recent changes in alcohol or drug use, high risk behaviour, taking risks; suicidal ideation – how often the person has thought about it, how frequently, how much, how intensely, how much elaboration; and self-harming behaviour such as cutting, hair pulling, scratching – various indicators that this is not just a mental state of depression or disorder but actually one which is seriously presenting a possibility of actual suicide.

The actual suicidal intention, as in the belief that this person may in fact commit suicide if there is not an immediate intervention, would be assessed by actually examining the likelihood in terms of method, for example. Has the person identified a method, thought about it and obtained the means? The methods include shooting and hanging which are obviously well known but not that common in women, overdoses, jumping from a height, drowning, poisoning, self-asphyxiation – these are the kind of methods which, if a patient presenting said she had actually thought about and was planning out a particular example, would be a seriously high risk.

Further evidence of intention would be withdrawal. People who are serious about committing suicide will isolate themselves, withdraw and hide the evidence they are about to do it because part of what they want is to actually succeed in the act. Isolation, withdrawal, covering up and other efforts to make sure they are not caught or found out or that somebody does not intervene beforehand would be another very high risk indicator in a clinical interview. Giving away possessions would be another indicator of serious intent.

On the basis of the clinical interview information, a clinician would form a judgment that a case was very high risk and required immediate attention, either hospitalisation or 24 hour monitoring, without which there would be a serious likelihood of attempted or completed suicide. Intervention would occur in lower risk situations, for example a suicide contract, where other forms of therapy and counselling are designed to reduce the actual immediate state.

My point is that there are clearly established procedures for assessing the risk of suicide and for making decisions on foot of that which are carried out and implemented in practice on a regular basis which lead to decisions which involve the Mental Health Act in cases of committal. In the instance of abortion, we propose that it would be possible to make a judgment about the risk to life posed by the threat of suicide and to make a decision based on that judgment. These are two major areas of presentation.

Deputy McManus: I thank the delegation for their presentation. We very much appreciate it. It is an area in which there has not been a huge amount of clarity in terms of the issue of suicide so far. I think it's probably true to say that, because of the lack of research in this country and the fact that the research to which you alluded refers to different systems where there is abortion, it's probably hard to be absolutely definitive about the extent of the problem. Would that be fair?

Professor McGee: Yes, absolutely.

Deputy McManus: But you are saying clearly that the issue of suicide among pregnant women is not something that we can discount?

Professor McGee: Yes, I think our point is that epidemiologically, even if we take the parallel with countries where the percentages may be small but the numbers are real cases, that real health professionals are going to have to manage.

Deputy McManus: Dr Whitaker made the point that, while

he accepted that was the case, he believed that in cases of rape and incest, the proportion would probably be higher because of how the pregnancy came about. I think you mentioned child abuse as being a factor in suicide.

Dr Moane: Child sex abuse is a high risk factor, in other words, there are high rates of suicide among patients who have a history of child sex abuse compared with patients who don't. That would be a recurring theme in the clinical literature of child sex abuse as a risk factor. Then there are also studies .... a couple that I found of college students, for example – Stepacauph 98, Bryant 97, Petrak 99 – all looking at rape victims, which is another area, where, for example, a survey of 393 college students showed that one in four of rape victims reported suicidal acts in the previous year. That's quite an alarming figure. Suicidal acts obviously aren't completed suicides but it certainly shows rape as trauma and a suicide issue in relation to rape and also child sex abuse. The research is there.

Deputy McManus: In relation to the one option that we can pursue which is the question of legislating in accordance with the current constitutional position, including the X case, again Dr Whitaker suggested that in relation to the issue of suicide, the best way was to provide the kind of safeguards that wouldn't be abused as an option of two psychiatrists giving an opinion on a particular individual. Do you think that's a reasonable approach?

Professor McGee: I think the psychiatrist is the head of a clinical team, from which there is the multi-disciplinary perspective, including social work and psychology, for example. The psychiatrist representing the views of a clinical team... I think we would be happy with the notion of a collaboration by a second independent psychiatrist. I think our view would be that we have to trust the people who make these decisions already in the case of the Mental Health Act. Clearly it's a very difficult decision to make, but it's one where this State is willing to withdraw the freedom of its individual citizens on the basis of their own safety, in the case of the Mental Health Act, in terms of involuntary committal. We already have that system and we trust the professionals to take this very serious responsibility. I think our view would be that we would be happy with Dr Whitaker's suggestion that this be made and collaborated by an independent grouping.

Dr Moane: Yes, and that the role of the psychologist there would be according to the assessment. A particular expertise of psychologists is the use of assessment instruments and they would then inform the decision perhaps with their assessment.

Deputy McManus: One option is to simply do nothing, to allow the *status quo* to prevail and the courts ultimately would make decisions where there are difficulties. I have to say I have a concern with that because I think it's leaving it up to women in very distressed states very often to go to court. Do you think it would have a bearing on the psychological health of somebody in a crisis pregnancy to have to go to court for whatever reason?

Dr Moane: Absolutely, there could be no doubt about that. An example of that would be the new research on rape and the impact of a rape victim having to be present in a court case. That is an area that's well researched where it's quite clear that the necessity to do a court presentation adds to trauma. So drawing from that example you could assume certainly even more so an instance of crisis pregnancy in a suicidal state would find that extremely traumatic.

Professor McGee: We would also like to add that I think there were two sets of people in that situation. The other set were the professionals. I think it's unfair on professionals to have to act in a vacuum. We would be concerned, since we represent psychologists for freedom of information. For example, Dr Keane, Master, National Maternity Hospitals, in his evidence on 3 May, made some comments which were unclear, which certainly suggested that there was a reticence about presenting information to women where there was ultra sound about abnormalities inconsistent with life outside the womb. I think it's very regrettable if people feel that they're unable in the current climate to present the range of information that's desirable in a democratic health system about all of the options, even if they're not available in this State. We would be equivalently concerned about the role of health professionals being protected in the conduct of their day to day duties in this area.

Dr Moane: – and legislation enabling them to provide best care in any situation.

Deputy J. O'Keeffe: I thank the delegation for coming. Their evidence is fascinating. The statistics are very compelling but I'm trying to stand back from it in looking at the suicide situation. Do I get the impression correctly that your evidence is somewhat different to the earlier evidence we had in relation to suicide? If I can first talk about the overall picture. It seemed to me from the earlier evidence we had in relation to suicides that the broad thrust was that essentially because of pregnancy itself, this leads to a lower risk of suicide. Do you accept that is the situation?

Professor McGee: We accept that is the case. I suppose the debate is about how low the risk is. As I said, the paper we can enter in today was published last year in the US looking at the lower risk of suicide. The risk is reduced by one-third, it is not as low as the data from England and Wales, published in 1991, which suggested that the risks were one in 20. Our major point is not to have a debate about how … I think we all accept the risk appears to be lower … the issue is not about how low it is. Our point would be there is still a risk. In every clinical situation where you're sitting in front of a patient, it doesn't matter if this is an extremely rare condition, one in a million, in a medical legal sense, you have to be act in the best interest of that patient. It doesn't matter how rare the person is.

Deputy J. O'Keeffe: You accept it's low but it's there?

Professor McGee: It's there.

Deputy J. O'Keeffe: Do you reckon we have to confront the fact, despite the fact it's rare?

Professor McGee: We have to enable professionals to act.

Deputy J. O'Keeffe: On that question, do we have any statistics in Ireland – unfortunately, we have a high rate of suicide, an increasing rate – from recent years as to how many suicides relate to pregnant women?

Professor McGee: No, not to my knowledge. In the published statistics the breakdowns are quite broad. They're in terms of gender, age and socio-economic status.

Deputy J. O'Keeffe: Mostly young men?

Professor McGee: Mostly young men. There is also an increase in suicides among people working in more isolated settings. So young men and older men at the two ends of the spectrum are the highest. We don't have a breakdown by disease or by pregnancy status.

Deputy J. O'Keeffe: Or whether there are any or how many pregnant women is unknown?

Professor McGee: It is unknown.

Deputy J. O'Keeffe: We should have better statistics in that regard.

Professor McGee: It's also unknown how many attempted suicides through poisoning or otherwise would present themselves in hospital set-ups.

Deputy J. O'Keeffe: I had a different impression before you spoke about the ability to have an accurate clinical assessment of the risk. I did get the impression from earlier evidence that it was, if not impossible, very, very difficult to be accurate in that. You would take the view that it is possible to give a reasonably accurate assessment?

Dr Moane: Yes. What they were saying is that it's impossible to predict with accuracy where the person will complete a suicide; in other words you predict the death, to be morbid about it. That actually is impossible because there are so many issues involved in whether a risk of suicide will result in a completed suicide.

Deputy J. O'Keeffe: So you accept that starting point?

Dr Moane: Yes. You would not, with a degree of certainty people wouldn't be willing to make that prediction, that this will definitely happen. What they have to do, therefore, is make decisions based on the information that they have. That's the point we're making – that those decisions are made not every day but on a regular basis in clinical contact. An assessment is made of how high this risk is and what decision will I make on foot of that assessment to admit or not to admit and so forth.

Deputy J. O'Keeffe: In relation to such decisions, there was one reference to such decisions being 97% wrong. Do you accept that?

Professor McGee: Certainly, they're 97% wrong. Clearly when somebody makes an assessment of suicide intent as a professional, they then act on it. So in many ways you change the context immediately by action. But, it's very difficult to predict suicide. This 97 out of 100 cases you're incorrect is partly because of how difficult it is. It's partly because there is immediately some kind of intervention to try to reduce the risk.

Deputy J. O'Keeffe: Is there any breakdown on that? I accept the point that if there is an intervention, the idea is to change the intent. To what extent is the 97% made up as a consequence of the immediate intervention? Is it impossible to say that?

Professor McGee: I think it is impossible to say that. I think what it is possible to say is that every day in this country actions are taken by mental health professionals about suicide risk. Although we know the predictability is very low, people are managed in various ways, including confinement against their will, because of an intention, a high risk of suicide.

Deputy J. O'Keeffe: If we accept that there is a 97% error rate, how then will it be possible for us to have a legal system which would be based on such clinical assessments which you say yourselves are, for one reason or another, so wrong?

Professor McGee: We currently have a legal system under the mental treatment Act which allows psychiatrists to detain people against their will for up to six months on the basis of an assessment of high risk of suicide. So we already have that system in place and that decision is taken regardless of whether somebody is pregnant or is the victim of child abuse or whatever the background circumstances are. The system that currently operates is a system which will *in extremis* take away somebody's liberty because while there isn't high predictability we are sufficiently concerned as a State to mandate health professionals, i.e. psychiatrists, to do that on our behalf in the interests of the safety of the individual. So that's already done. Although for other suicide risk, apart from that in pregnancy, we know that the predictability is very low, we still act in the interests of the safety of the individual.

Dr Moane: That figure, to say that it's actually wrong I don't think is quite a right interpretation. What you're asking somebody to say is, given a case in front of me and accumulated over a number of cases, if I make a judgment that person will commit suicide then, as Professor McGee points out, there will be an intervention there. So, in actual fact, it's impossible to come up with a statement.

Deputy J. O'Keeffe: I accept, of course, you can't say it's wrong. Even the word 'error' that I used is incorrect.

Dr Moane: The only way you could judge it is to look at predictions where the clinician says this person won't commit suicide and then the person goes off and commits suicide. That, fortunately, as Professor McGee points out, is a very rare occurrence.

Deputy J. O'Keeffe: There is just one other question or issue. Your view is that abortion should be permitted here

where there is a threat to the mental health of the mother posed by the traumatic impact of rape or incest. Taking the view that late abortions are dangerous to the health of the mother, you're talking about early abortion. Is it possible to have clear – proof is the wrong word – convincing evidence that, in fact, the pregnancy is as a result of rape or incest at that stage? How would you propose that that would be dealt with? Do you see that if there were such a provision that it could lead to a situation where many pregnancies that weren't welcome might, in fact, then be classified as such or attempts might be made thereat? How would you cover that?

Dr Moane: Again, we're assuming that this decision would be made in a clinical context where somebody is presenting with a traumatic pregnancy which is based on rape. So the assessment would be based on the assessment of trauma. The actual event of the rape itself would be only part of that assessment. So the assessment of the trauma would be based on the kinds of assessment procedures I outlined earlier – measures, clinical interview and so forth. To ascertain the fact of rape would be based on clinical questionings about the event itself and so forth. Within that context we think that a clinician would be competent to make a judgment about whether rape had actually occurred. We haven't agreed, we don't agree on the idea or there needn't be a legal conviction or a kind of legal argument.

Deputy J. O'Keeffe: Who would certify? The clinical psychologist would then certify it. Would that be what you have in mind?

Dr Moane: That's a possibility, but as I say our idea is based on the idea of the trauma rather than the actual rape. So perhaps if it were a legal requirement that there be a certification that a rape had occurred, that's something that would have to be worked out as to who, in fact, would do that. But we wouldn't actually see that as necessary.

Deputy J. O'Keeffe: You wouldn't be certifying then that the pregnancy was the consequence of rape. You would be certifying that there was such extreme trauma as a consequence of the pregnancy ....

Dr Moane: Which is assumed to ....

Deputy J. O'Keeffe: .... which is alleged to have been related to rape or incest that you would then provide the necessary certification and you think that would be sufficient to allow an abortion to be carried out?

Dr Moane: That's our position, yes.

Deputy J. O'Keeffe: Thank you.

Deputy Kirk: I am sorry for being late and some of the questions I ask might have already been dealt with. With regard to the assessment of individual cases purely on a professional basis – I'm divorcing it from the moral consideration where specific recommendations might be made from your point of view – do you find that an acceptable way of dealing with cases which might come before you?

Dr Moane: It is the procedure for dealing with cases currently. All we can say is that in the profession the assessment of suicide is an area that has been advancing for decades. It's a very large area of research involving psychiatrists, psychologists and other areas of research where there is well researched understanding of risk factors, there are well established assessment instruments and there are trained clinicians asking the kinds of questions that need to be asked. So, I would certainly say, yes, psychologists are competent to make an assessment and, as I say, make a decision on that basis. As we said earlier, they do that all the time in the context of hospitalisation and ....

Deputy Kirk: Regardless of the moral consideration?

Dr Moane: A psychologist would certainly be competent to make an assessment as to whether somebody who is suicidal, the degree to which there is a threat to life in the case of somebody who is suicidal, I would say definitely yes.

Senator Dardis: Thank you for your presentation. I wish to return to a point raised by Deputy O'Keeffe and approach it from a slightly different angle. If we assume that suicide is grounds for an abortion, the difficulty arises in the definitions, as you can appreciate. Coming at it from the angle where somebody presents themselves as being suicidal, is it possible or with what degree of accuracy is it possible to say that this person is not suicidal? In other words, by virtue of the fact that they would present themselves as suicidal, that could lead to a situation, as you can appreciate, whereby it would be used as grounds.

Professor McGee: Yes, indeed. We would certainly see that somebody who presents themselves as suicidal would be observed over a period of time. Without specifying what period of time, certainly it wouldn't be an instant consultation with a decision at the end of the consultation. As is the case in other assessment of suicide, it would be a case of observing somebody in a confined situation, probably in a hospital or clinic situation, over a period of hours or days to assess the seriousness of the intent and also, clearly we would want to put this on record, clearly to do something about the suicide intent as a first strategy towards managing the situation rather than seeing suicide intent as automatically leading to a request for termination.

Senator Dardis: There was another area which Deputy O'Keeffe explored and I would like a little bit more clarification on it. It's to do with the evidence on the clinical and statistical side regarding rape and the traumatic effect of rape. You're suggesting that there's a fair body of evidence with regard to that but there's a much lesser body of evidence with regard to the effects of pregnancy on the propensity to suicide and so on. To what degree is there clinical-statistical evidence in these areas?

Professor McGee: Do you mean in the context of rape?

Senator Dardis: No, leaving rape aside, in the context of pregnancy, *per se*, or even in the context of, well, you can extend into crisis pregnancy, obviously beyond that, but there seems to be, in your presentation there's much less

clarity in my view with regard to the degree to which pregnancy would lead someone away from suicide, so to speak.

Professor McGee: Our view is that all of the evidence suggests that there is a protective effect during pregnancy. For what reasons, it's not clear. Our point simply was that the major study that's cited to date has been a study in England and Wales, published in 1991 by Appleby, showing a one in 20 risk of suicide for women who are pregnant compared to eight at a maximum who are not pregnant. In a more recent study in the US, that rate was one in three. The argument of those authors published in the American Journal of Psychiatry in 1997, their argument was that their statistics were probably more accurate because they had access to full autopsy information on most of the cases.

We are really making the point here that we accept that there is a lower risk, but in all of these cases there is some risk. So, we were concerned that there was a notion that pregnancy provided a blanket protection against suicide and that that was not the case. So that for small numbers of individuals, smaller than outside of the pregnant state, there would still be a risk to suicide. It is indeed, for those small numbers of cases, that we're trying to work out a system of wording so that all people are equally protected.

Senator Dardis: But I'm correct in assuming that there's a much lesser body of evidence with regard to the effect of pregnancy on suicide relative to the evidence that relates to traumatic pregnancy, rape, and so on. Am I correct in that assumption? What I'm getting at is that, rather than the .... I accept what you're saying to me, but it appears to me that there is a high number of clinical and statistical studies regarding rape and its traumatic effect and a much lesser body of evidence relating to the other issue.

Professor McGee: Yes, but there is also a much lesser body of evidence combining rape and pregnancy following rape and the psychological consequences there. So there's three, in a way. There's a lot of evidence on rape and the psychological aftermath. There's an intermediate amount on the risk of suicide during general pregnancy, and there's very little on the risk of suicide in pregnancy following rape. In fact, we have not been able to find any. There's evidence on people's preferences for terminations or not, but not on the risk of suicide in that particular group.

Senator Dardis: Thank you. You've answered the question.

Dr Moane: Actually, there is also a lot of evidence on trauma following crisis pregnancy, not specifically suicidal, but trauma generally, so that would be another well researched area in psychiatry and psychology.

Chairman: Thank you very much. You've put a lot of difficult issues for us in focus on this subject. Professor McGee, you're an expert in the area of health services research. Is that correct?

Professor McGee: Yes.

Chairman: What type of research are you engaged in there?

Professor McGee: We look at quality of life in various health conditions and under various treatments and I also look at how people experience the health system. So, I do a lot of work in relation to patient satisfaction, for example, currently, how older people evaluate the services they experience in different health boards in the country. We have started a study which looks at the prevalence of sexual abuse in the community and what are perceived as barriers to effective treatment and care by those who have experienced abuse and by the public at large. So they are the kinds of studies that we are involved in.

Chairman: Have you clinical experience in the care of pregnant women?

Professor McGee: No, I have been involved in research studies looking at the psychological consequences of spontaneous abortion in the first trimester.

Chairman: So to that extent you do, in fact, on the research basis?

Professor McGee: Yes.

Chairman: Yes, you've answered my question indirectly. On the general submission, there was a submission to the interdepartmental working group which contained some papers outlining the position of the Psychological Society of Ireland both on abortion and suicide. Isn't that right?

Professor McGee: Yes, that's right.

Chairman: And then you've supplemented that with this note, which is interesting because it comments on the evidence we've heard and, in a sense, you've responded to the evidence we've heard.

On the question of rape and incest, and this in a way is one of the most difficult issues we have to face, I see you recommend that abortion should be permitted where there is a threat to the mental health of the mother posed by the traumatic impact of the rape or incest. I'm not putting it to you because it was a matter of law, but that would require an amendment to the Constitution. That would require a referendum on the interpretation placed on the current provision in the X case. Isn't that right?

Professor McGee: Yes, it would. That would go over and above the current provision of the X case. We would believe that, in terms of option seven, that we would support, where there is a serious risk to the mental health of a woman pregnant as a result of rape or incest, that there be access to abortion in that context.

Chairman: I don't want to put words in your mouth but, in a way, would your position be that that is a more compelling case, in a sense, than the suicide-based case, given what you've said about the research?

Professor McGee: There's less evidence of the extent of serious ... mental health in pregnancy in women who are raped because the numbers are smaller than there is in relation to suicide. I wouldn't like to make one person's traumatic situation have a greater priority than another's.

Chairman: That's fine. It's just to elicit your position. There was just one other point. Coming back to suicide, of course, psychologists can attempt to assess the risk. In the Irish clinical setting, the obstetricians who spoke to us did not see abortion or termination of pregnancy or induced abortion as a valid clinical response in the context of a suicide threat. How do you treat a suicide threat? Suppose you assess a suicide threat, you assess there's a risk there, how do you treat it normally? Perhaps Dr Moane would like to take that issue.

Dr Moane: As I said, if it's a serious suicide risk, that situation would nearly always be in a situation of psychiatric conditions such as serious depression, mood disorder or whatever. So that's the originating source of the threat of suicide. In that instance, hospitalisation, 24 hour monitoring and psycho-active medication would be immediate options and then therapy of various kinds and more specific suicide contracts. You have there a psychiatric case, and that isn't necessarily going to be typical, although it will occur, obviously, in the case of a pregnancy with the threat of suicide. You might not have that psychiatric condition. You may have it, but you may not have it. In that case, it's not clear that the treatment is going to ... the intervention can be directed at a psychiatric condition. In fact, if a threat of suicide is firmly of will based on the need for abortion as in, 'I cannot live with this option', it seems to me that there would be no other option, that other options would obviously be against the will of the client, of the patient.

Chairman: Dr Moane, you're an expert in clinical psychology and you've conducted clinics, presumably, with pregnant women and advised them on these options.

Dr Moane: No I haven't had the experience of conducting clinics with pregnant women. My training is in the assessment area. I don't conduct a clinical practice with pregnant women.

Chairman: No, but you conduct risk assessment clinics, so you assess the risk.

Dr Moane: No, I'm personally not involved in the assessment of suicide risk.

Chairman: But you've done research on the assessment of risk, so you're an expert on the assessment of risk.

Dr Moane: Yes.

Chairman: And you've made the point to us this morning there always has to be a risk of suicide. That's what I'm taking from what you're saying. The difficulty I have is that, I don't see in the evidence before us so far how abortion is seen as a clinical option in the context of a suicide threat. I don't see the link there.

Dr Moane: Well you're assuming there that the threat of suicide is directly linked to the crisis pregnancy through the fact that the individual feels that their life will not be worth living should they have to continue with this unwanted pregnancy and that in their mind the choice is between abortion and their own life, and that is how they are perceiving the situation. So, that it is slightly different from a psychiatric which is the more usual clinical example of abortion. There is a more wilful element in that situation.

Chairman: But in effect then what you are saying is that if someone threatened to commit suicide because they cannot have an abortion, the law must provide for abortion in that instance.

Dr Moane: I do not know what the law ....

Chairman: I do not want to be unfair on you. I appreciate that the person concerned is under terrible pressure.

Dr Moane: I do not know what the law is actually saying. But what I am saying is that in that instance the option of abortion is one that would presumably remove the threat of suicide. Is that not what you are asking?

Professor McGee: The threat needs to be evaluated professionally as a serious or real intent to commit suicide. I think in that sense, in relation to the question about the obstetrician in that setting, the advice would be coming from that person's colleague, probably the consultant psychiatrist, that this context posed a real threat to the life of this woman in the same way as a cardiologist would give evidence that a particular context would pose a real threat to the life of the woman.

Chairman: Deputy McManus, do feel free to ask questions. I want to resume asking a few questions.

Deputy McManus: It does take a leap of imagination for one to put oneself in the position of somebody who is so affected by a pregnancy that they feel suicidal. It is not possible to do it any other way except to use our imagination. But really, as I take what you are saying, there is the issue of the individual case of the patient ....

Professor McGee: Yes.

Deputy McManus: .... who has been professionally assessed. With the mental treatment Act we have an example of a precedent where we are empowering the professionals to make certain pinnacle decisions and to act accordingly. What you are saying is, there is one issue relating to the patient but there is also an issue relating to the professional which does require our attention. Is that correct?

Professor McGee: We have seen cases through the courts, and obviously as far as the Supreme Court, where there has been a professional agreement that there was a real intent to commit suicide. I think it was Dr McKenna who gave evidence at this hearing that he had personally seen a case of serious suicidal intent in his hospital in the previous year. Is that correct?

Dr Moane: Yes.

Professor McGee: There is evidence that this does happen and that professionals in the situation are clear that there are cases where women are simply not saying something in order to procure an abortion which they do not actually mean.

Chairman: Dr Clare spoke to us about this. He said:

> If I were to summarise, I would say that the only real reason that I am here, I think, and that you will find psychiatrists involved in this is, in a way, because, I suppose we have been drawn in to try and get people off the hook over this issue of a danger to the health and life of a woman who is pregnant and wishes to terminate the pregnancy, so who better than to get the psychiatrist to tell you that if this is refused, this woman will kill herself. Well, no such statement can be made with any great safety, whether the person making it is a psychologist, psychiatrist or a general practitioner.

That was the view expressed by Dr Anthony Clare. I am just putting that to you so that you can deal with it.

Professor McGee: I do not want to paraphrase Dr Clare. I would imagine, going back to Deputy O'Keeffe's comments, and the point that Dr Clare is making is that it is difficult to make that statement with any great predictive power. Of course those statements are made all of the time by consultant psychiatrists about whether somebody is of serious risk of committing suicide and actions are taken under the mental treatment Act in that regard. So, I am not sure if the word 'safety' is the most useful word in this context. I think he is probably talking about the predictive validity of those statements. It does not mean that actions are not taken on the basis of the information.

Dr Moane: A psychiatrist would, for example, be making a decision that if I do not admit this patient this patient will commit suicide. That would be a similar kind of a decision-making process.

Chairman: The context in which he made that statement was the position that obtained before the 1967 Act in the United Kingdom. Before the 1967 Act, under a more liberal interpretation of the Bourne case, it was possible that psychological grounds could justify a termination in England before the 1967 Act broadened the law. That ground still exists in the 1967 Act. The point Dr Clare made to us was that he did not accept the scientific validity of what was happening under the legislation and that in his view the issue was abortion on request or a rather restrictive arrangement. This is the difficulty that we have as a committee, when you introduce a category such as this in effect you open the availability of abortion in general terms but the category itself becomes very wide.

Later we will hear evidence from Northern Ireland. I look forward to that because this question arose and does arise in Northern Ireland as it stands. There has been a number of court cases in the North, a far greater number than have been heard here, where evidence from psychiatrists and psychologists has been admitted on this issue. It seems that when looking at it on a comparative basis from an international point of view that that stage prefigures the final introduction of abortion on request, which is a big ethical issue which convulses our country and has convulsed other countries as you know.

I still have a difficulty with this particular question. In the clinical literature, is the termination of pregnancy viewed as an appropriate treatment for a suicide threat?

Dr Moane: I do not think the word 'treatment' is quite the right word that should be used. What you would have is a clinical setting – there are lots of cases described in the clinical literature of this nature – of a pregnant woman who is suicidal and is threatening suicide. But of course this is in the context of the US or Great Britain where there would be non-directive counselling and options would be explored. If the client then at that point chooses to have an abortion then that is what will happen. You would not call the abortion a treatment in that instance, you would call it a decision that the client has made on foot of her condition that she has made herself in the context of counselling. The clinical context would be one where the counselling is provided.

Professor McGee: I would add that the clinician in that situation, if there is legislation, is not making the decision that this woman should have an abortion. The clinician is making the decision that this woman has a serious or real threat of suicide. It is then the legislation which permits the action that the woman herself decides to take. The psychiatrist or whoever it is in that setting is not prescribing abortion for a woman, they are simply outlining their clinical judgment of the mental state of that individual. It is the Legislature in that context which permits certain actions on foot of that. The psychiatrist is not prescribing.

Chairman: I appreciate that. They are making an assessment.

Senator Dardis: Surely the outcome is based on the assessment? The judgment ....

Professor McGee: One of the possible outcomes is based on the assessment. Clearly one of the other obvious outcomes is treatment for that suicide intent.

Chairman: Did you refer to the page where Dr McKenna's evidence can be found?

Professor McGee: I think it is page 50 something. I do not know if I noted it. The point I simply wanted to make was that he did make reference to having seen a woman who was suicidal in the previous year in his hospital setting.

Chairman: Yes, of course.

Deputy McManus: A fear has been expressed about the idea of suicide being accepted as grounds for an abortion or legislated for – it is already in the Constitution in terms of the Supreme Court decision. Do you feel that it would become an open door in terms of people being able to access abortion willy-nilly or do you think that Irish psychiatrists would use their clinical judgment in a way that would ensure there was a genuine effort to focus it on suicide and not to be used as an excuse?

Dr Moane: You would write up your case and judgment. You would present, in that case, on the basis of your assessment what you based your judgment on, which was obviously to some degree objective in the sense of risk factors, scoring on assessment instruments which are objective and then the actual content of the clinical interview, if there was high risk behaviour, changes or what-

ever. You would actually document the basis of your decision. My personal view is that it would be a very highly contained grounds for abortion if you're going to have a situation where a patient has to be assessed on these bases and documented and a team of some kind has to make a judgment about it and that's in the public domain and can be monitored. It could clearly be monitored.

Professor McGee: As professionals, we're in an era where we're slightly not quite such a small country any longer and I think there is increasing evidence that professionals are willing to challenge the actions of other professionals if they think they contravene the law of the land or ethical codes in their disciplines. I think there would be quite a strong policing by fellow professionals of the management of any kind of restricted legislation that was in place and I think anybody acting in that environment, as indeed some of the people who spoke already have said, in the current environment, people are very careful about acting within the law.

Chairman: I'd like to thank Dr Moane and Professor McGee for their contributions and I'll suspend the session for five minutes until Dr Lamki takes his place before the committee. Thank you very much.

Dr Moane: Thank you. Actually, do you wish to have these documents presented to you?

Chairman: The document that was submitted to the interdepartmental committee?

Dr Moane: Yes, and some leaflet literature and research papers.

Chairman: I have them and I'll table them before the Houses together with any papers you want to present. Thank you very much.

Professor McGee: These are just the ones that we thought were additional to what you've already heard about from other submissions so I've just left two copies of them.

SITTING SUSPENDED AT 12.32 PM AND RESUMED AT 12.35 PM.

Dr Harith Lamki

Chairman: We are now in public session and I'd like to thank Dr Harith Lamki of the Royal Maternity Hospital in Belfast to this meeting of the Joint Committee on the Constitution. I have to draw your attention to the fact that while members of this committee have absolute privilege, the same privilege does not apply to you. Before I ask you to talk to us, I think I'll take you through your qualifications if I may. You're Harith Lamki, you're a consultant obstetrician and gynaecologist in the Royal Victoria Hospital, in the Royal Maternity Hospital in Belfast, is that correct?

Dr H. Lamki: That's correct.

Chairman: Is that one institution or two?

Dr Lamki: It's two hospitals but one institution.

Chairman: Yes, two hospitals and one institution. And you're an honorary consultant at Belfast City Hospital, is that correct?

Dr Lamki: Yes.

Chairman: And you're an honorary lecturer in obstetrics and gynaecology at the Queen's University of Belfast.

Dr Lamki: Senior lecturer, honorary senior lecturer.

Chairman: And you're a past chairman of the Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland.

Dr Lamki: Correct, sir.

Chairman: You graduated from the Royal College of Surgeons in June 1961, you've a diploma of the Royal College of Obstetricians and Gynaecologists in London, March 1965, you're a member of the Royal College of Obstetricians and Gynaecologists in London in January 1967, you're a fellow of the Royal College of Obstetricians and Gynaecologists in London in June 1980.

Dr Lamki: Correct, sir.

Chairman: I take it you have substantial knowledge and experience of the practices that obtain in maternity hospitals in Northern Ireland.

Dr Lamki: I am, yes.

Chairman: Yes. That's why the committee asked to see you. I wonder could you make an outline to us what are the practices in relation to the termination of pregnancies before term in Northern Ireland.

Dr Lamki: Thank you very much. I've been listening and reading some of the pamphlets that I have received regarding the hearing. Certain terminologies have not been used in the way that I would use them, for example, when you talk about termination of pregnancy, it is a terminology that can be used to mean anything at all. If we are dealing with the matured, viable foetus, you talk about induction of labour, rather than termination of pregnancy because, at that stage, you are hoping that you'll get a foetus that's going to survive. If you're dealing with abortions, which are pregnancies prior to viability, then, of course, you talk about termination in the proper sense of the word.

Now, termination of pregnancies should be divided, or abortions should be divided into the ones that occur early, in the first three months of pregnancy, and the ones

that occur later on, which is the second three months of pregnancy, or after 23 to 24 weeks.

It is the practice in Northern Ireland that any problem cases are referred from the peripheral hospital to the Royal Maternity Hospital. Any patient who is suffering from very severe heart disease or very severe high blood pressure, they are once again referred to the Royal Maternity Hospital. In addition, in the Royal Maternity Hospital we have got the foetal medicine department, staffed by two colleagues, who deal with problems of the foetuses. Also, we have the regional neonatal unit the Royal Maternity Hospital with five neonatologists.

Most of the problem cases are referred from the periphery to us. The type of cases that you will get, as I mentioned, are those of medical disorders. Indeed, I was responsible for looking after cardiac women with a cardiologist, Denis Boyle, who is now retired. I've moved out of that field now myself, but during that period of time we had published in 1998 in *the British Journal of Obstetricians and Gynaecologists* 519 cardiac cases and we had the highest maternal mortality of any other cause, three women died out of those 519.

We don't have too many cases nowadays referred to us with severe medical conditions of the mothers which require termination, that is very rare indeed. In the Royal Maternity Hospital now we would terminate somewhere in the region of around 30 or so women a year. The abortion Act does not apply to Northern Ireland, as you're aware, it is for England, Scotland and Wales. We are still working the case law. So far we have not been prosecuted and, partly due to the fact that if a woman needs a termination for whatever legitimate reason, it takes two consultants to sign – we have to sign that we agree that this is a case.

I've been listening to the ladies before I came in talking about depression and so forth. It is a very rare condition for us to be asked to terminate a pregnancy because of depression. Most of the abortions in Northern Ireland are performed now because of foetal abnormalities.

Now, some of us who are practising obstetricians and gynaecologists do agree and some do not agree with abortions for various reasons. However, whatever our personal feelings, we do not allow them to interfere with the women's choices. I am not a Christian, I am a Muslim and therefore termination is not allowed among Muslims, except in the first four lunar months of pregnancy because Muslims believe that the soul enters the body at that stage and beyond that you are not allowed to terminate pregnancy. If I am confronted with a woman who wants a termination because of foetal abnormalities which I disagree with, except anencephaly, because to me a Down's syndrome is not a ground for termination, but still I do refer the patient to my colleagues and if the case warrants termination it is carried out.

I think it is important to realise that the majority of the people in Northern Ireland – consultant obstetricians and gynaecologists, and there are 55 of us – we do not take it lightly. When a patient is referred, she is referred with very good grounds. If a GP sends a patient to us – to me or anybody else – because he or she feels that this woman is going to commit suicide, we do not just accept it. We have to talk to the patient, we have to refer to a psychiatrist or even two psychiatrists and then we take cognisance of what they say and then we decide ourselves whether there is enough grounds or not. Practice in Northern Ireland is probably... it is a good practice for women in Northern Ireland. Termination is not carried out on social grounds. On that side, in the Royal Maternity Hospital we run a very big morning-after pill clinic, which means we have a big reduction in the number of unwanted pregnancies at present. The number of women taking the trip to England, where we used to send them for social termination, is a great deal less than what it used to be.

Chairman: Before the Members, I would like to ask a few questions. Did you give a lot of publicity to your morning-after pill clinic?

Dr Lamki: It has been, by the Family Planning Association, yes. We run it and it is mostly very popular on Fridays and Saturdays.

Chairman: And widely advertised?

Dr Lamki: Oh, yes. Quite a lot of women – young people – come in.

Chairman: And your impression is that that has reduced the rate of abortion in Northern Ireland.

Dr Lamki: It has reduced unwanted pregnancies. I must add here, in my own obstetric practice in the Royal Maternity, nearly 70% of the women I would book for delivery are unmarried. But that is their own choice. Marriage is something of the past in a lot of younger people. They talk of partners, not husbands and wives.

Chairman: As you said, the 1967 Act does not apply to Northern Ireland so you are still operating, as we are, under the Offences Against the Person Act, 1861. I take it all the complicated cases in Northern Ireland go to the one maternity hospital, or the one institution with two maternity hospitals.

Dr Lamki: No, one maternity hospital. The other is a gynie and general hospital, the Royal Victoria.

Chairman: I see, but all to one hospital.

Dr Lamki: Correct.

Chairman: So it is within that clinical setting that the understandings and interpretations of the 1861 Act have been arrived at.

Dr Lamki: That is correct.

Chairman: From my reading on the subject there seem to be three grounds in Northern Ireland. There are, first of all, the medical grounds which were outlined by the masters to us here as well, such as Eisenmenger's and the other difficult, heart type cases. That is one ground, I take it, where a clinical decision is taken in Northern Ireland?

Dr Lamki: Eisenmenger's – in the years I looked after cardiac patients, we had two women in the whole of that period of time**.** One of them refused termination of

pregnancy and we carried on and she and her baby survived. She came into labour on Christmas Day at 30 something weeks and she survived. The other one was brought from the country hospital too late. We could not do anything. She died within a matter of 24 hours of arriving in the hospital. It is not a very common condition but it does occur.

Chairman: Then there have been a number of court decisions in Northern Ireland, not unlike court decisions we have had here where evidence has been given of a threat to the life of the mother based on suicidal ideation, and so forth.

I think I am right in saying in one of those cases, although the court permitted an abortion to take place in Northern Ireland, the doctors refused to perform it in Northern Ireland and it had to take place elsewhere in the United Kingdom. Is that correct?

Dr Lamki: It must be before my time, Sir, because I do not think the consultants in Northern Ireland refuse to terminate pregnancy, truthfully, if there is ground for it. At present, we do not but we would perform termination.

Chairman: But in the cases based on psychiatric or psychological grounds there seems to be a tendency to have recourse to the courts in that area.

Dr Lamki: I do not know when that happened but certainly if a patient is referred to us by a general practitioner because of psychiatric grounds, as I mentioned earlier on, we do get the psychiatrist to see – one or two of them – and we do not go to the courts. We make a decision ourselves and usually, if there are good grounds termination is performed. Termination is a lot easier nowadays – medical termination in hospitals – because of the modern type of drugs that are used. I do not think people are wary of doing a termination as it used to be in the past. They were afraid of complications.

Chairman: Yes. The literature suggests that the widest ground in Northern Ireland – the most frequently used ground – relates to congenital abnormalities.

Dr Lamki: Absolutely correct. That is right.

Chairman: In one sense – I do not want to put you in a spot – that does not seem to be covered by the 1861 Act.

Dr Lamki: It may not be covered but the way they interpret it – because of the mental state of the mother. That is the way they consider it – that the mother would be so depressed about it.

Chairman: That is the legal context. Very good. Thank you.

Deputy McManus: We are very appreciative that you have come here to give us this information. It is extremely fascinating. I have a couple of questions.

Do you have patients coming from the Republic to have pregnancies terminated in your hospital?

Dr Lamki: Yes, we do.

Deputy McManus: In terms of the cases where there is foetal abnormality, one of the points that has been made to us by the masters of the hospitals here is their concern at the fact that they do not have access to autopsy information where they are trying to counsel the woman. Do you carry out autopsies on these terminations and is it possible to provide that kind of information?

Dr Lamki: Yes. If a termination is performed for foetal abnormality, yes is the answer. An autopsy is performed and not only just a hospital type of autopsy but the medical genetic department carries out analysis on the foetus. Yes, we do actually.

Deputy McManus: What is the cut off time, in weeks, for an abortion in Northern Ireland?

Dr Lamki: Most of the investigations of foetal abnormalities are carried out nowadays – what is known as the double test – at 15 weeks – the blood test. If it is indicated, amniocentesis would be done after that – at 16 weeks or whatever. If the foetus is abnormal, then termination is arranged. So usually before the twentieth week termination is performed.

Deputy McManus: And they are all carried out in the maternity hospital.

Dr Lamki: The Royal Maternity Hospital, yes.

Deputy McManus: Have you any idea, statistically, what the level of abortions is in Northern Ireland – the number of pregnancies that end in abortion, whether they are carried out in Northern Ireland or in Britain?

Dr Lamki: I used to get figures from the pregnancy advisory. Now, of course with the pro-life, they have burned the place, and so forth.

Deputy McManus: I am sorry?

Dr Lamki: They have destroyed the building. The people who are supposed to be pro-life have destroyed the building, as a result of which I do not get the statistics. We used to get the statistics, in terms of the age of people – how many pregnancies they have had before and so on – who go across the water from Northern Ireland for termination. I am afraid now I do not get those figures any more. The lady has given up counselling those women because of the situation that has taken place.

Deputy McManus: And this has happened in recent times?

Dr Lamki: Yes. It happened, I think, last year.

Deputy McManus: That was another question I wanted to ask in relation, first of all, to the idea of ensuring that young people do not become pregnant. Do you feel that enough effort is made to encourage good practice and sexual responsibility in Northern Ireland? Is much effort and resources put into that? In terms of counselling, is there a recognised procedure for people making this decision, whether it's for reasons other than those provided in Northern Ireland?

Dr Lamki: There are family planning clinics everywhere so people can avail of free contraceptive pills, condoms and so on. They are all free so there is no reason for them not to make use of them. There are also free intrauterine contraceptive devices whereby the new ones, which cost £100, are being given free of charge. No one would say the facilities are not available. The morning after pill is also available free of charge.

I did not understand your second question – whether you mean patients who have a termination regarding counselling or which ones were you talking about?

Deputy McManus: Who are in a crisis pregnancy and who have to make a decision about the future. Can they access counselling services?

Dr Lamki: That is what I was saying earlier. We had excellent pregnancy advisers who were volunteers and used to look after people very well. That has gone and we now depend on sending patients to our own psychologist in the hospital. We have two psychologists and they would see the patients, assess them and may see them again and again. We talk to the patient counsellor ourselves. Last year a young woman said that if she did not terminate the pregnancy she would jump out a window. It took time, involving social workers and psychologists, to work with her and she was all right However, it takes a lot of time and effort to work with people.

Deputy McManus: You mentioned the assessment you did of, I think, 519 women ....

Dr Lamki: Cardiacs, yes.

Deputy McManus: Three of them died, which is quite significant.

Dr Lamki: It is. It is a major cause of death in Northern Ireland

Deputy McManus: All those Ulster fries. Would those women have had access to the possibility of terminating their pregnancies? Would termination have been an important protection for them?

Dr Lamki: Yes and no. One patient did not even tell her husband when she got married that she had a major heart disease. She was diagnosed by a young lady who is now a consultant in Dublin when she was training with me in Northern Ireland. At that stage she was far gone – she was 17 or 18 weeks – which is too late and dangerous to terminate the cardiacs at that stage. She died. She refused to have a valve replacement during pregnancy and she agreed, when she went into labour at thirtysomething weeks ... I delivered the baby which was Down's syndrome, born dead. The mother died before she could have a valve replacement. It was a total loss for both mother and baby.

The third woman came rather late for any termination. None of the three women who died made an effort to come early or to declare their condition. Whether termination would have saved them, no one can say.

Deputy McManus: You mentioned that no one has been prosecuted yet. As I understand it, what you are doing is that you are depending on clinical judgment. You are not governed by the abortion Act so you do not have any legal reference in terms of that clinical judgment. Does that concern professionals in Northern Ireland?

Dr Lamki: Not really because of the reason I mentioned earlier. At least two of us, if not three consultants, would be the ones who see the patient and sign that they agree, or if they disagree it is not done. We work on the principle that it is highly unlikely that any court in Northern Ireland would prosecute three consultants who do not have anything to gain by agreeing to a termination, except for the benefit of the woman. That has been the case so far.

In terms of foetal abnormalities, the genetics department plays a major role as well – Professor Nevin and his department. So far we have not been ....

Deputy McManus: It is an argument against a written constitution.

Chairman: Yes, but the 1861 Act is the legal framework.

Dr Lamki: Correct.

Chairman: And in a difficult case you would get legal advice or interpretation of the 1861 Act.

Dr Lamki: We do, yes.

Chairman: So that sets the overall framework within which your clinical judgments are made.

Dr Lamki: Absolutely, yes.

Chairman: Although the requirement that two or three sign does not stem from the 1861 Act. It is an evidential requirement that protects you in the event of a prosecution under the 1861 Act.

Dr Lamki: It is a protection that legal advisers gave us. We get quite a number of women from the Republic of Ireland but they are referred to us through the maternity hospitals in Dublin or Drogheda.

Deputy McManus: Are you saying they are referred to you?

Dr Lamki: Yes.

Deputy McManus: Is that how you describe it?

Dr Lamki: Yes.

Deputy McManus: In what way? You get a letter of reference?

Dr Lamki: As I mentioned there are two foetal experts in Northern Ireland. One of them will be 'phoned by a colleague from down here saying they have a woman who has got this and this and she does not want to continue the pregnancy. She is brought up and she may have amniocentesis or whatever else and, possibly, a termination.

Chairman: And that is based on an interpretation of sections 57 and 58 that there is a threat to the health of the mother in the carrying of the ....

Dr Lamki: Possibly. If there is an abnormal foetus, yes. Of course, there is no problem in the case of anencephaly. Even in my own religion an anencephalic foetus has no chance of independent survival so it does not matter about termination. It is not illegal in any sense of the word. It cannot survive independently.

In a few cases, if the foetus is diagnosed as having some major abnormality, such as Potter syndrome, or something where the foetus has no kidneys or something, then of course it has no chance of survival. That is slightly different from other conditions like spina bifida and ....

Chairman: Yes, you are speaking of your own ethical perspective on it here, I think.

Dr Lamki: Yes.

Chairman: I think a similar view was expressed by the masters.

Senator Dardis: Thank you, Dr Lamki. It has been very valuable for us to get a perspective from outside the jurisdiction and to learn of practices in Northern Ireland. With regard to your situation in the North, are there any improvements or changes from the existing situation that you would regard as desirable?

Dr Lamki: There have been moves – people wanting to bring in a sort of blanket type of abortion like in Britain. A lot of us do not believe that is the right thing because we have a law which seems to be working fairly well. We have a family planning association which works very hard and we should encourage prevention rather than these problems of unwanted pregnancies for young girls. I think I am right in saying the majority of us would not welcome a change in the law in Northern Ireland, no.

Senator Dardis: Are you familiar with our constitutional provision and how it operates?

Dr Lamki: Having trained in Dublin I know something about it. I am married to a girl from Carlow.

Senator Dardis: Do you have a view as regards how we should proceed with these issues?

Dr Lamki: It is difficult. I was just thinking of a very difficult case. I was sitting in the institute debating the Green Paper. You know, you have got people in our profession who are ... I would call them yesterday's people ... one does not think there's need for changes. I trained in Dublin in the days of the rule of Archbishop McQuaid whereby the certain rules are observed and no changes are required. I think you are going to have that problem but you do need to make life easier in my opinion for legitimate cases whereby terminations can be performed in the Republic of Ireland without the fear of somebody being taken to court. At the same time I don't think it should be made open for social termination. I think that is not desirable. How you are going to achieve that I don't know.

Senator Dardis: From your point of view would it be preferable to deal with these issues by legislation rather than by any other way?

Dr Lamki: I don't know. I am always worried about legislation because there are always some sort of gaps or loopholes and somebody will abuse them or whatever. I don't know. I suppose if you get a very clever lawyer they may very well find something in it and use it.

Senator Dardis: In a certain sense are you not saying to me that a reversion to the original position prior to the constitutional amendment would be desirable?

Dr Lamki: No, I am not. I am not saying that at all but the way the situation is now at present in the Republic of Ireland probably is not desirable. You need to change. I don't know how you can achieve a position whereby it is not going to be abused.

Senator Dardis: You spoke about people being referred from the periphery. Are there no instances in which a decision will be made to abort other than at the central location?

Dr Lamki: I don't know. If they are certainly we are not aware of them. You see people in Northern Ireland ... the majority of the peripheral hospitals have got a couple of consultants or so. It is much easier to come to a centre where there are seven of us. Collectively we make decisions.

Senator Dardis: Is that by virtue of the expertise rather than by virtue of the practice?

Dr Lamki: No, expertise because in places like Northern Ireland, in the Royal Maternity Hospital, each one of us has picked up a special interest. There are people with a special interest in fertility, others in cancer, others in foetal medicine, others in urology – waterworks problems. Therefore it is easier there to get people and also to get other views, like neonatalogists' views. To my knowledge the Royal Maternity is the only hospital in Northern Ireland with two clinical psychologists who could help us with various problems, so it is to the advantage of consultants on the periphery to send patients to the centre for an opinion.

I came as a young man of 16 to finish school in Dublin and then went to .... After entrance to Trinity I ran away from going to Trinity because I had to study ... I had to read ... I had to do .... I did not want literature ... to do 13 literature books. I went to the College of Surgeons and I really can see an awful lot of changes in the Republic, some of which are not good, some are bad. You can't walk on O'Connell Street as I used to at 3 a.m. without fear but my wife and I – we come to Dublin very often – have seen the changes whereby women now have got a certain amount of freedom in terms of choosing whether they should have 15, 16 children or whether they should have two or three children. Therefore I hope after deliberation some sort of adjustment to give them that extra freedom of choice will be allowed and they will get something out of it.

Chairman: Thank you very much for coming down to us in Dublin today.

Dr Lamki: It was a pleasure.

Chairman: Thank you for your contribution. I am suspending the sitting for five minutes. The representatives of the Public Policy Institute of Ireland will then take place their places before the committee.

Dr Lamki: Thank you very much indeed.

SITTING SUSPENDED AT 1.04 PM AND RESUMED AT 1.09 PM.

Mr Tom Troy and Dr Gerard Casey

Chairman: We are now in public session. I would like to welcome the following representatives of the Public Policy Institute of Ireland: Mr Tom Troy, chairman, and Dr Gerard Casey to this meeting of the Joint Commitee on the Constitution. We have received your submission which was laid before the Houses earlier in the month and which is at page 307 of the brief book. The format of this meeting is that you may make a brief opening statement elaborating on the submission, if you wish, and that will be followed by a question and answer session with the members. I have to draw your attention to the fact that while members of this committee have absolute privilege this same privilege does not apply to you.

Mr T. Troy: I will not elaborate or condense because I think the submission we sent is pretty long.

Chairman: Yes.

Mr Troy: I just want to make two points. One is that what we are hoping for is the continuation of the *status quo*, not some leap in the dark but to keep what we have in medical terms. That means of course a change legally but fundamentally it's the *status quo*. In opting for that, while we have no medical knowledge, we accept the opinion, the testimony of the Irish medical profession about what the nature of the *status quo* is and what the strengths of that are. There are other external manifestations of how strong that is. For example, it is the best environment in the world in which to have children, I mean, the maternal mortality rate is actually the lowest in the world. At least that is the *status quo* and we support it. It requires a change in the law but that raises a very large issue.

The people in the Irish polity have a very direct sovereignty, to an extent that is unusual among Republics. The Constitution makes references to this. It acknowledges rather than confers it because it is the people who confer the Constitution. There is a very significant article there, article 6, which we quote in the submission, about the people determining all issues of national policy. The High Court case, that we mention in the submission, held that the eighth amendment to the Constitution was an exercise of such power by the people directly with the purpose of outlawing abortion and, for various reasons, that was not put into effect as intended.

It is quite normal where an Act doesn't work that you amend the Act or where a Constitution doesn't work you amend the Constitution. We think there is nothing wrong with coming back to get an amendment to get it right to provide, in fact, what the original intention was, and in this way to avoid opening up alienation between the people and the State and between the people and public representatives. To an extent, maybe we don't appreciate in this country there is a strong identification between the people and the State and the people even and the public representatives, a certain intimacy there and we wouldn't want to lose it. I think this is one such...people speak about dividedness and all that. This would divide the people from the Legislature and even the State. That is our vote for changing the Constitution more effectively to do it, but we have no ideas on what the exact wording should be, I'm afraid. We depend on the medical profession for advice on the nature of the problem and what the best means are. We accept that and so the draftsman has to get the words. My colleague has other ideas on that. Could I ask...would you like to add to that?

Dr G. Casey: I would actually prefer to answer questions but I would say that from our point of view the right to life is the most fundamental of all human rights. All other rights are dependent upon that. If that is in any way infringed or endangered then other human rights, all of them significant, are endangered as well in any democratic society. While we acknowledge the difficulties in pregnancies, and as men we can from the outside, as it were, sympathise with them, though not experience them, we have to accept the basic fact that any direct attack on human life is subversive of the entire legal and moral order on which the State is founded. We are asking, along with the pro-life groups who have made submissions already, that the Oireachtas discharge its obligations under section 6.1 of the Constitution to allow the people to decide the question of national policy here. That is not because we do not trust legislators but because the overall legal framework of the country is set by the Constitution. It is within the parameters of the Constitution that the legislators, yourselves and those members of the Seanad who are here, have the authority to make the available dispositions but not beyond those. That is why we think in this most fundamental area the determination should be made in a constitutional way.

Finally, just to be very specific, we would like to keep ... we would not envisage any change to the wording of the constitutional amendment passed in 1983 or its amendments since protecting the equal right to life of the child and the mother. While we would like to stress that that should be equal it should not in practice prioritise one over the other – child over mother or mother, in fact, over child. We think that the way forward constitutionally is to add to that a specific prohibition on induced abortion.

We think that the understanding of what that is, is reasonably clear and uncomplicated. In practical terms, as Mr Troy has said, we are willing in our layman's ignorance to accept the practice of the Irish medical profession pre the X case, in other words the concerted opinion in practice there in relation to the appropriateness of treatment in difficult situations.

Chairman: Do you accept the practice as explained by the masters in the hearings before us?

Dr Casey: I haven't got a full and complete knowledge of their particular submissions but, assuming that ... are they *ad idem* in this regard?

Chairman: You would have to form your own view on that but they are *ad idem* among themselves all right.

Dr Casey: Difficulties have been raised in relation to the question of what is or isn't indirect and what is or isn't induced. It seems to me that whatever the legal difficulties ... I admit there can be legal difficulties but they are not insuperable. The moral question is whether or not one directly and intentionally takes the life of the child or whether one in carrying out another procedure for substantial reasons and even knowing that the result of that action will be the death of the child that the woman is carrying. There is a huge moral difference between the two. We have no objections whatsoever nor, I think, does any of the major pro-life groups in this country to recognise medical treatments which have the inadvertent, if foreseen, consequence of the death of the foetus provided that the treatment is, in fact, necessary for the health or the life of the mother.

Chairman: The consensus ... I don't think there was any dispute on this before us. The consensus of the medical opinion was that the mother's life was paramount. You referred to the phrase 'the equal right' but that is a lawyer's phrase to prevent a ground other than the mother's life being used as an indication for the introduction of abortion here. The crucial point of that medical practice is that the mother's life is paramount. In effect, in the Medical Council guidelines it would be professional negligence to prevent or withhold necessary treatment. Taking that point about the mother's life as being paramount, do you accept that?

Dr Casey: I would ask how. I mean, there are certain ways of understanding that. If that is to be understood as prioritising or unequalling the equality that is constitutionally provided, it is difficult to see how that, in fact, would be fundamentally legal in any sense. In terms of practice ....

Chairman: I am sorry to interrupt. What the doctors said to us on the position before the 1983 amendment and since and universally, and entertained by all doctors, irrespective of their views about the nature of procedures carried out or how they categorise them, whether they want to call them abortions or terminations or procedures or indirect or direct effects ... what they all said was that the life of the mother is paramount, that if a conflict arises where the mother's life is at stake the mother's life is paramount. That phrase was used and comes back to me with great clarity. When the Constitution uses the phrase 'equal' that is to prevent any other ground being introduced to permit abortion in this jurisdiction. It does not equalise the rights in terms of a crises to the mother's life. Is that what you're suggesting?

Dr Casey: First of all, what you have there is a particular interpretation of the constitutional provision and included ....

Chairman: In the light of the existing medical practice since 1983.

Dr Casey: Fine, yes. If you want to talk about paramountcy then doctors have, in relation to their patients, to consider that the life and the health of the patient is paramount. In the case of a woman who is pregnant there are, in fact, two patients. There is the woman and the child she is carrying.

Chairman: That is accepted entirely by these doctors that they have a duty to both lives. But where a conflict arises the life of the mother is ....

Dr Casey: Again, our point would simply be that in a case where there is a danger to the health of the mother necessitating legitimate medical treatment, all such medical treatment can and should be provided, provided that we do not consider the medical treatment here as a direct and intentional inducement of abortion. If there is a medical treatment, for example, a hysterectomy or whatever is required, there are lots of them and so on, which would have, as a matter of fact, with the advance of human knowledge, the result that the death of the child would be encompassed thereby. Provided this is not done intentionally in order to bring about that effect and provided that the treatment is, in fact, necessary for the paramount treatment of the health and life of the mother, then we have no problem with that.

Chairman: One last question. I heard evidence from the masters of the maternity hospitals in this city that they would be unhappy in performing their duty if an absolute prohibition of the type you mentioned were put into the Constitution. Now can I, as a conscientious legislator, endorse a proposal that you have made a few moments ago in relation to the form of a wording when I have heard evidence of that kind?

Dr Casey: Are you saying that they said that they would be unhappy if they were legally prohibited to specifically induce an abortion?

Chairman: Yes.

Dr Casey: So could you repeat your question again to me please?

Chairman: My question is, as a conscientious legislator, can I be happy, having heard that evidence, in bringing in a form of wording which they say they would not be happy with?

Dr Casey: I mean, I would have to reflect more on the

reasons for their unhappiness but again, we do not see that the addition to the present constitutional situation that we envisage would in fact have the practical effect of inhibiting legitimate medical treatment, and therefore we are simply not aware what the grounds would be for their unhappiness in that regard.

Mr Troy: Could I come in on that?

Chairman: Yes.

Mr Troy: We have suggested in the submission that there could be a sort of removal of doubt clause added on to anything they do, you know, for avoidance of doubt it is hereby declared that ... and any procedure commonly practised in Irish hospitals before some date would be legitimate.

Chairman: But isn't medicine a dynamic profession?

Mr Troy: I know but at least they're covered. Anything they could do up to now, you can put the words, you know, in a way that suits similar circumstances, similar procedures. If they're done up to now, they can be done.

Chairman: You see, I think what I am leading to really was that in 1992, when the referendum on the substantive question was put, it's very difficult to devise a form of words that's more restrictive than was devised on that occasion having regard to what we've heard about the medical practice. It's very difficult to devise a more restrictive form of words. Would you like to comment on that?

Dr Casey: I'm not sure that I can agree with you on that nor am I – given the result of the referendum where the substantive question was in fact rejected by the people, again presuming that the majority of those are the people who voted in 1983 for the installation in the Constitution of the protection of life, of human life, nor would they seem to agree with you. It doesn't seem to be beyond the bounds of possibility to come up with a wording which is there. We are not in the position to do this. The pro-life groups – I've seen the various things that they have said and it would seem to me that the, sort of, common element, in addition to the retention of the equality of the amendment of 1983, would be something like the rejection of a specific form of induced abortion. There are different ways of phrasing it. There's the intentional and direct and so on. They are all different ways of doing this but whichever way it is done it would seem to me that that would in fact encompass what it is that we think is desirable in this State to prevent an attack, however well motivated or however well conceived or however it might be thought to be necessary in another regard, to prevent a direct attack on any human being in the State.

Chairman: But Dr Keane, the Master of Holles Street, said: 'If you put a complete and absolute ban on abortion, you could have compromised our position', and I have to listen to that.

Dr Casey: No, I understand. I mean, I think the statement ... Again, did he provide a rationale for that in his testimony?

Chairman: Well, he went on to say: 'How can we cater for a constitutional amendment' and he said: 'I think that we were not too far away from it in 1992'.

Dr Casey: Well, it's his opinion and so on but again, until such time as I saw the justification of that particular remark, there's no way I could comment on it. It would simply seem to me to be an opinion, however well founded and however much one must refer to it medically.

Chairman: But a conscientious legislator would have to have regard to evidence of that kind.

Dr Casey: It is evidence. It is evidence, among others, that one would have to take regard of. I'm not a medical practitioner. I'm simply putting the moral point of view here – nor am I pretending to be one – that it seems to be absolutely critical that the fundamental law in a democratic society should not allow for the direct and intentional taking of innocent human life because that is subversive of all other human rights. That is the position on which I take my stand.

Deputy J. O'Keeffe: We're into the complexities of wording at this stage, arising from your evidence. Do I take it that you ... How did you stand on the 1992 wording? Were you against that?

Dr Casey: I voted against the ....

Deputy J. O'Keeffe: You rejected that as not being ... Can you say in one sentence why?

Dr Casey: It's a long time ago but my understanding ... I mean, the situation was quite complex for a time and indeed people thought that it was consistent, if you like, with the 1983 situation. Upon reflection, myself and others thought that what it did was it allowed for the direct and intentional taking of innocent human life in certain circumstances, however restricted, and we found that we couldn't in conscience support that. That's not in any way to question the bona fides of the people who put this amendment forward.

Deputy J. O'Keeffe: I think it was put forward at the time as being a genuine effort to try and find a suitable wording that would match the ....

Dr Casey: Indeed, and one can accept those bona fides but nonetheless, it being the case that we thought that it allowed for these kind of exceptions, I can't certainly – I don't know what Mr Troy wants to say on this – but I found that I could not.

Deputy J. O'Keeffe: Before Mr Troy comes in, perhaps you should just remember that point. There's one other point arising from his earlier evidence that ... Mr Troy, you thought that if there was to be another constitutional attempt, the way to resolve it was by having what you might call an amendment plus a removal of doubt clause. Would that not be a rather unusual constitutional animal to ....

Mr Troy: Extremely unusual but what's wrong with saying, keep on doing what you've been doing up to now – what you've been doing lawfully up to now before some date?

Deputy J. O'Keeffe: Coming to that, and what we've been doing up to now, having read your submission and you talk about a complete ban on abortion which would save countless unborn lives -

Mr Troy: Yes.

Deputy J. O'Keeffe: I think there are figures out this week which show the Irish abortion rate at about 6,000 – up to 6,000. We are now talking of the complexities of changing words in the Constitution.

Mr Troy: Yes.

Deputy J. O'Keeffe: If we again tackle such complexities and if, by some miraculous intervention, we can find wording that suits everybody, how will that save countless unborn lives?

Mr Troy: Well, it's just extrapolating from what happens elsewhere, you know. If you look at every jurisdiction in the world, when abortion comes in it increases and increases and increases. There seems to be no case where it doesn't.

Deputy J. O'Keeffe: I think you miss my point. The Irish abortion rate at the moment is about 6,000 a year, according to the records.

Mr Troy: Yes, but you have to ....

Deputy J. O'Keeffe: How will it change in our Constitution here? I don't notice any reference in your submission to the 6,000 abortions that occurred in the last 12 months and, unfortunately, will probably occur in the next 12 months.

Mr Troy: You mean outside the jurisdiction?

Deputy J. O'Keeffe: People go to England.

Mr Troy: Yes.

Deputy J. O'Keeffe: You say, on the other hand, in your submission that if we put in a complete ban on abortion here, change the Constitution again, it will serve to save countless unborn lives.

Mr Troy: Yes, within our own ....

Deputy J. O'Keeffe: How will it do that?

Mr Troy: Within our own jurisdiction it will because otherwise it would have started here.

Deputy J. O'Keeffe: Is it your contention that if they go to England it's a matter we should accept as a matter of practice?

Mr Troy: No, we can't control. There are two things about the travel business, two things about that. It's been recognised since about the 1940s by legal men, you know, jurisprudence men and so on, that it's a mark of civilisation to be able to leave a country. You don't have to have a Berlin Wall to keep people in. That's a fairly advanced principle of law.

Deputy J. O'Keeffe: I accept that but if people are leaving to get an abortion, as they are now obviously in their thousands, the point I can't get my head around is if we change our Constitution again, will those numbers be affected one way or the other?

Mr Troy: Those particular 6,000 won't because people will exercise their right to travel.

Deputy J. O'Keeffe: But how then can you claim that, if there's a complete ban on abortion, it will save countless unborn lives?

Mr Troy: Because if you didn't have the complete ban here in Ireland, other people would be getting abortions here.

Deputy J. O'Keeffe: Are you saying then that in addition to the 6,000 ....

Mr Troy: Exactly.

Deputy J. O'Keeffe: .... who go to England, that there would be others here?

Mr Troy: Yes.

Deputy J. O'Keeffe: And is there any evidence to support that?

Mr Troy: Well it's kind of a reasonable conclusion that if they go to all the trouble, you know, that could be the deciding factor – I don't want to go to all that trouble of travelling and so on – but if it was quite easy next door, well ....

Deputy J. O'Keeffe: Is it not the case with the kind of modern travel, that it is there for somebody in ....

Mr Troy: I don't want to exaggerate it, but it must make some difference.

Deputy J. O'Keeffe: Is it then just that marginal difference that you're talking about, those who at the moment are not going to England, you would feel ....

Mr Troy: There might be people on the margin of indifference between 'yes' and 'no'.

Deputy J. O'Keeffe: Would you think there are many?

Mr Troy: I don't know, but ordinary reasoning would suggest there's a range of certitude as you go along. Is it not only that. If you create an abortion mentality and people are influenced by what they see and experience and what they see the institutions of State doing and so on, that will have its effect over time also, and you avoid that.

Deputy J. O'Keeffe: You feel that if there were to be a further change in the Constitution it would have an influence which would, to some extent, restrict, if not

reduce, the number of Irish women who are having abortions?

Mr Troy: It would, yes. Any public assertion, in any form, is bound to influence people because people … they think this and they think that and so on.

Deputy J. O'Keeffe: Would you not think that if we were really concerned about restricting the number of people or encouraging people not to have abortions that we should be spending a lot of resources in the areas which have been tried in other countries from the point of view of education and RSE and from the point of view of a controversial area, contraception availability? Wouldn't that make sense? If we were really trying to stop abortions, we should at least look at what is being done from that point of view. From the point of view of counselling, should there not be a major campaign of funding and resources to tackle ....

Mr Troy: Certainly, a big increase in children's allowance would have been one obvious thing to do ... to bring back tax allowances and so on. Every little helps. It must be hard for people that can see that, so we should make it easy anyway we can. Counselling and better arrangements about work, work sharing, flexibility and all that kind of thing ... There are plenty of things you could do.

Deputy J. O'Keeffe: You would be in favour of these measures?

Mr Troy: The whole lot, yes, certainly to do anything that would help. I think my colleague is getting restless.

Dr Casey: I wanted to come in to say that on the question of what might happen, we are obviously dealing with counterfactuals.

Deputy J. O'Keeffe: We are dealing with?

Dr Casey: We are dealing with counterfactuals or things which actually haven't happened; we are speculating about the future. If you look at every other modern jurisdiction whose form of government and lifestyle approximates to our own, you will see that the introduction of abortion, initially in restricted circumstances – always in restricted circumstances and for the hard cases, that is the way in which it is introduced – has led invariably, more in some jurisdictions than in others, to the granting of access to abortion for what can only be regarded as reasons that have nothing to do with the life of the mother, nothing as serious as that, and very often are regarded as simply matters of convenience. Therefore, in that case, accepting that the figure is something around 6,000 Irish women who go to England to have an abortion and that the introduction of new constitutional measures here would not of themselves necessarily affect that, it would prevent the introduction of an abortion regime into this country which, if it followed the pattern of other countries and there is no reason to think it would not, would make the difference between that number and whatever other number of people would have had abortions.

Deputy J. O'Keeffe: There is a constitutional and legislative prohibition on abortion here.

Dr Casey: We have a complex and debated issue, about which there is much discussion, on the interpretation. We want to see the restoration of the intent, if you like, behind the 1983 referendum, which we think was seriously damaged by the findings of the courts. We want to give the people the opportunity to express their views.

Deputy J. O'Keeffe: To go back to the basic point, would that affect the abortion rate here?

Dr Casey: It may not necessarily affect the rate as it stands now. One of the things that has to be said here, and this is not a charge that can be levelled against those of us who are pro-life, we do not support, condone or in any way encourage abortion regimes in other countries. It is not of our doing that they have an abortion regime in the island a little to the east of us, in France or in any other country. That is something that we very much regret, but it is something about which we can do nothing. That is simply a fact, but we can do something about the situation in our own country.

Deputy J. O'Keeffe: Can't we then put a lot of emphasis on – I don't know that there is a single reference in your submission ... – trying to provide for women in distress, trying to give them more facilities and trying to ensure they do not get into distress by improved education and other measures that have been tried in other countries ....

Dr Casey: There are a range of measures.

Deputy J. O'Keeffe: .... availability of and access to contraceptives and other things that have been talked about? Why isn't there any reference to that approach in your submission?

Dr Casey: Very simply because we cannot put everything into our submission. Let's take the fact of contraception. The testimony given by the previous speaker in regard to Northern Ireland where he pointed out quite clearly that there is really no question about whether or not people had access or could have access to these matters. It is more or less reflected in this State. It is not really difficult to have access to contraception. This is independent of my particular views on it. As a matter of fact, that does not seem to me to be a difficulty, nor is it the case that people have problems about information in this regard. There are Well Woman centres and all of these advice centres and they can get it from their medical practitioners. As a matter of fact again, independent of my own views on this, the fact of the matter is that there isn't in fact, it seems to me, much shortage here in terms of these particular facilities that you talked about. Therefore, there was no need for us to mention this in our submission.

Deputy J. O'Keeffe: You don't see any need for further facilities here?

Dr Casey: We would like to say here now and to amend our submission that we fully support, for example, the activities of those agencies, which take it upon themselves to give advice and counselling. If it is a matter of providing extra funding for these people and so on, then that's not a problem. We fully support that.

Deputy J. O'Keeffe: Thank you.

Deputy McManus: Thank you very much for coming here today and giving us the presentation. I really just have two questions. First of all, in terms of the point you've made that in every other jurisdiction we have, in effect, once you start going down the route of providing any abortion, you end up with abortion effectively on demand. Would you not accept that we have just had a presentation from the jurisdiction that is closest to us culturally, socially and in every other way, Northern Ireland, where it is quite clear they've had abortion for quite some time and that it has been contained and restricted very tightly and very carefully? Does this not actually show that it isn't an absolute that the floodgates open at all?

Maybe, I will ask my second point because I appreciate that you've been here a while. In terms of referring back to the three masters, what was very clearly said, and it has been very well covered in the papers for some time now, was that in certain rare conditions to save a woman's life, the treatment is abortion, that there isn't a side effect of abortion, but the actual way to treat the mother is to abort the foetus. The particular case of the cardiac condition is the one that was specified. This was certainly supported by the masters when they came here. Maybe you could respond to both those points. Thank you.

Mr Troy: One small point about Northern Ireland – there has been agitation, as you know, to extend the British law to Northern Ireland, so the law must have had something to do with restricting it there.

Deputy McManus: The law?

Mr Troy: Yes, the law. It must have had a role in … It must be a more stringent law than the law in Britain.

Deputy McManus: Yes, that's right.

Mr Troy: There is a lot of energy being put into getting them to adopt the British law, thereby believing that if that happened, abortion would become more free.

Dr Casey: Maybe I could answer that.

Mr Troy: There must be something in that.

Dr Casey: The 1967 Act does not extend to Northern Ireland. There is continuous pressure and agitation from those who support a wider extension of abortion that it should be extended and that has met with resistance from people with like views to mine in Northern Ireland. It is a permanent struggle. In other words, the situation there isn't simply because of the rarefied atmosphere or the weather conditions in Northern Ireland because people in Northern Ireland, both Catholic and Protestant, share a common pro-life ethos and, therefore, there has been enormous resistance in that part of the country to the introduction of the 1967 Act. There is no guarantee that can continue and the persistent pressure to extend the 1967 Act to Northern Ireland is something that demands continuous resistance. That is not a situation I would like to see in this jurisdiction.

Chairman: What you don't have in this jurisdiction because, even on your most unfavourable view, the present constitutional arrangement would prevent anything like the 1967 Act ....

Dr Casey: No, no, nor am I saying that is the situation. No, no. We are not saying that, but I am saying I would not like to see that.

Chairman: Oh yes. Sorry, sorry.

Dr Casey: Maybe if I could address your second point, which is this: sometimes the question of what is or is not an abortion is sometimes said to be a matter of semantics, where the use of the word semantics is meant to indicate that it is simply a sort of word juggling or logic-chopping or messing about with words. It is very often the case that the correct and appropriate description of a human action is a different matter. For example, there are many situations in which one can end up with a dead body on the floor but the question of whether you have manslaughter or murder or simply accident is relevant and has to be discovered. You have to find out, you know, what the intention was and so on and so forth. The net effect is still you have a dead body on the floor, but the correct moral description is often sometimes clear but often is a matter of considerable ... it takes considerable skill.

The situation then in regard to whether or not what is being described in the submissions that you referred to is in fact abortion as we understand it is in fact a moot point. All I can do ... I mean, I cannot make a judgment on that. All I can say is that from our perspective an action which results in the death of a child is not, in and of itself, abortion. As we understand abortion, as we are opposing the introduction of abortion, we mean, by abortion, an action which directly takes the life of the child in the womb. Okay. An action which affects some other part of the organic structure of the mother and which has an effect, however instantaneous it might be and however short the distance – and I understand here that this is conceptually a difficult matter – is not from our point of view, and we do not wish to intrude on medical practice here, but we do not consider that from a moral point of view, however regrettable it would be, we do not consider that to be abortion. More than that, we really cannot say.

Chairman: Deputy Kirk.

Deputy Kirk: Thanks, Chairman. Coming back to the constitutional position, I think the various groupings we had in...in the event of a decision being taken to have a constitutional amendment, most of the groupings seemed to shy away from a sort of suggested wording that could be incorporated into any possible amendment. Just clarify the position anyway, you see pre or post 1983 being the satisfactory position from your point of view. The 1992 amendment, you rejected it, you felt it was unsatisfactory.

Dr Casey: Yes, that is correct.

Deputy Kirk: How do you think this committee, in its deliberations and subsequent recommendations, should proceed to achieve your objective in that regard?

Dr Casey: Okay, if I may answer that. The first point I would like to take up, because it is an objective which has been put by many people and has come up frequently in the media and so on, and it is this: that the finding of a wording is a difficult matter and that the Constitution is not a place for such complexities. I would argue if that is the case, then you would have to throw out half of the articles we already have in the Constitution. For example, the amendments to Article 29 on the Maastricht and the Article 40.4 – the deprivation of liberty – are extremely long and complicated, and these are on serious matters but they are not on matters as serious as the taking of human life and, therefore, if we can get it right in these matters, we can get it right here.

My suggestion – and I am just making this off the cuff – is that if the committee were to consider the option of taking the referendum route, that they should consult with the various pro-life groups and maybe set up a co-ordinating body so that they could provide a unified and agreed wording which would satisfy their particular demands. I have already indicated what, it seems to me, the element of that would be and one way around it would be to keep the original '83 referendum and to add to that a rejection specifically of induced abortion. That is one way around it. It is not the only way. The key to it is the rejection of intentional and direct killing, however that is expressed.

Deputy Kirk: Your view on a possible constitutional amendment being combined with legislation ....

Mr Troy: Do you mean *in lieu* of or side by side? If the constitutional amendment refers to legislation, well then it can, but if it does not, I do not see how it would work.

Deputy Kirk: Supposing it is decided at the end of the day to have a constitutional amendment, for instance, to deal with the Supreme Court decision in the X case, you know, if it is deemed necessary to hold a constitutional amendment to change the position and, to cover the points which Dr Casey mentions in relation to setting the, or achieving the objectives which he has in mind, does he feel that can be achieved with a combination of a constitutional amendment and legislation?

Mr Troy: That would be that the amendment itself would say 'subject to law', or 'in accordance with law' would be added.

Deputy Kirk: Yes.

Mr Troy: That is what you are saying – or 'in accordance with legislation', so on and so on.

Deputy Kirk: As I see it, the Supreme Court decision in the X case, you know, where in effect somebody pleading suicide can have an abortion or be granted an abortion in those circumstances, that clearly is unsatisfactory. Now do you address that (a) through a constitutional amendment or (b) through legislation?

Mr Troy: Well, if you do not do it by the constitutional amendment, you cannot change it because the Supreme Court has said that is what the Constitution means, so you have to have an amendment to the Constitution. There is no way out. Like Mr Noonan, you know, the … Deputy Noonan made a famous statement back in the '80s, that he asked the Secretary of the Department of Justice what a particular phrase meant in this whole controversy and he said 'whatever the Supreme Court says it means' so ....

Deputy Kirk: They are the ultimate arbiters.

Chairman: On that note, I thank you Mr Troy and Dr Casey for your assistance today and I will adjourn the meeting until 9 am tomorrow, but I want to see the members in private session for a moment. Thank you.

THE COMMITTEE ADJOURNED AT 1.47 PM UNTIL 9.00 AM ON WEDNESDAY, 31 MAY 2000.

WEDNESDAY, 31 MAY 2000, 9.00 AM.
MEMBERS PRESENT:
DEPUTY B. DALY, T. ENRIGHT, M. McGENNIS, L. McMANUS, J. O'KEEFFE, SENATOR D. O'DONOVAN, F. O'DOWD, K. O'MEARA.

DEPUTY B. LENIHAN IN THE CHAIR

IN ATTENDANCE: SENATOR M. HENRY

Chairman: We have a quorum. We are now in public session. Before beginning the hearings today, there are two matters I want to deal with. First, the minutes of our nine meetings between 2 May 2000 and 30 May 2000 have been circulated to the members. Are the minutes of those nine meetings agreed? Agreed. There are no matters arising from the minutes.

Second, arising from the meeting yesterday, 30 May 2000, it is proposed to print in-house and publish transcripts of evidence from representatives of the Psychologists for Freedom of Information and Dr Harith Lamki together with the following documents received from Dr Moane and Professor Magee – letter, 9 May 2000, and attached submission; submission to the working group on abortion, March 1998, and two attachments, articles from *The Irish Psychologist*; and research article, material

supplied, 30 May 2000 meeting. Is it agreed that we print and publish the transcript and documents mentioned? Agreed.

We will move onto today's hearings.

PUBLIC HEARINGS ON ABORTION

Mr David Manly and Miss Claire Lahiffe

Chairman: We are in public session and I would like to welcome the following representatives of Family and Life, Mr David Manly and Miss Claire Lahiffe, to this meeting of the Joint Committee on the Constitution. We have received your presentation, which has been circulated to the members and laid before the Houses of the Oireachtas. The format of this meeting is that you may make a brief opening statement elaborating on your submission. This will be followed by a brief question and answer session with the members. We have until 9.30 am and I am proposing to enforce that time limit. I want to draw your attention to the fact that while members of the committee have absolute privilege, this same privilege does not apply to you. We received your submission and I've read it. Would you like to elaborate on it?

Mr D. Manly: Yes. Good morning Mr Chairman, Deputies and Senators. The Family and Life was founded in 1996. It's a non-denominational and independent pro-life organisation whose work is educational and promotional. Its principal public promotion is its campaign for the right to life of unborn children and the welfare of their mothers. We have an office in Mountjoy Square and are supported by our membership and various affiliated groups throughout the country.

My name is David Manly and my helper is Claire Lahiffe. I have been engaged in pro-life work since 1992. My role in Family and Life is mainly spent in research, writing and editing material for publication. I'm the author of Family and Life's written submission to your committee.

The passing of the amendment in 1983 appeared to all supporters of the pro-life position to give legal protection in an explicit way to the unborn and to outlaw abortion for good even though the word 'abortion' never appeared in the eighth amendment. The right to life of the unborn human being in Article 40.3.3º was a human right equal to that of his or her mother and, therefore, to all and every other citizen of this country. No one to my knowledge, whether favourable to the amendment or not, suggested that it permitted abortion and the courts gave every sign of sharing this understanding. So in 1992 those of us who had voted for the eighth amendment were in disbelief when the Supreme Court declared that the eighth amendment permitted abortion and, in particular, in the X case. With the one exception of Mr Justice Hederman, none of the four judges of the Supreme Court examined how one person could directly take the life of another human being. They just appeared to assume that it could be done. To me and to many pro-life people this decision set up a serious contradiction in Irish law and removed the constitutional protection from the unborn.

The question, therefore, before us, before you is one that is a major concern to many Irish people. An indication of this, I think, is the huge response to the working group on the Green Paper and now to your own committee. The subject of abortion is not just a legal and a medical one for experts. It's a human and a moral question that calls for a response from every human being from whatever walk of life. People may be confused by the complexities of strange sounding medical terms but they know what abortion is. They know what happens in an abortion and they know what the results are for both mother and child.

I'll just finish by saying that Ireland has the advantage of seeing the effects of legalised abortion in other countries, especially in Britain and the United States. Contrary to the hopes of those who supported legalised abortion in both those countries, the numbers of abortions have soared there. The negative effects on women become clearer every year. Perhaps the most negative consequence of legalised abortion is its acceptance as normal and the trivialisation of human life. Thank you.

Chairman: Do you wish to add anything? Have you looked at the transcripts of the hearings that we have conducted so far?

Mr Manly: I have looked at them briefly, not all of them. I got them last Monday. I did my best and I found them very interesting indeed.

Chairman: Do you want to express any view on them?

Mr Manly: Well, indeed.

Chairman: Perhaps that's too general a question. Just taking the earlier witnesses, the various medical and professional persons who spoke to us, would you have any comment to make on their evidence?

Mr Manly: On the very nature of abortion, there seems to be a certain amount of disagreement at exactly how it should be defined. But I think if you go and talk to your parents, the older people in the country who have seen how Ireland has changed over the last 30, 40, 50 years, they will have no doubt about what abortion is. It is rather an example of where a group of experts get together and they will almost inevitably start disagreeing. But the reality of abortion I don't think is in doubt.

Now I agree with Dr Whitaker that there is a technical sense in which doctors have used abortion for decades. He was speaking of his young years, his childhood, but there's something he left out. When I was growing up – I'm a little younger than Dr Whitaker – abortion was not mentioned in public. It would have been something that only doctors used. They wrote it up in their log books and it referred to a number of medical procedures. Now

since 1960, 1965, abortion has come into popular use and today, well, you can see what the papers say. It's discussed on television and radio and young people think nothing of discussing it. But when they talk about abortion, they mean what doctors and our grandparents used to understand by criminal abortion. They don't understand it as, say, the inducement of an early birth by doctors, say, four weeks before the birth. That, technically speaking, is abortion.

Chairman: Not if ....

Mr Manly: Not in the common sense.

Chairman: Not if the delivery is viable. Not if the child can live ....

Mr Manly: Is it not the early, the premature interruption of a pregnancy?

Chairman: Where there's no hope of viability.

Mr Manly: I don't think that's .... I think abortion can be at any stage before the natural end. If the baby dies in the mother's womb, the doctors will induce the delivery of the dead body. That is an abortion. And when they write in their log book, they put abortion. Now that is not what the ordinary person understands and that is not really what this whole dispute that has been disturbing Ireland over the last 15, 20 years is about.

Deputy J. O'Keeffe: One of the core problems here is in relation to definition, and if you've read the reports of the hearings, I think at this stage I must be listening to about the twentieth different definition of abortion. From that point of view, do you not accept the near impossibility of getting a consensus on an issue where in fact there is no agreement on what the definition of that issue is?

Mr Manly: Yes, I do sympathise with you. You've heard so many different words and speeches and definitions but let me put it to you this way. Thirty, 40 years ago if you called a doctor an abortionist you couldn't call him anything worse. An abortionist in those days was someone who doctors would not even think of speaking to or working with.

Deputy J. O'Keeffe: An abortionist in that sense was somebody who was breaching the 1861 Act and who was carrying out illegally ....

Mr Manly: Yes, for money or for other reasons was deliberately killing the human being of a healthy woman. I mean in that sense we're talking about criminal abortion. Now, if you come along today and say that Ireland's obstetricians and gynaecologists over the years have been performing abortions, you are really calling them abortionists. Now, I don't think any of the people who appeared before you would accept that. They would be highly indignant. They know they haven't been performing abortions.

Deputy J. O'Keeffe: But from that point of view, would you not accept the need for a great degree of sensitivity in the way people express themselves because of the complexity even in relation to definition, that one has to be careful how ....

Mr Manly: You have to be careful, yes.

Deputy J. O'Keeffe: .... and sensitive in the way the issue is dealt with?

Mr Manly: Yes, indeed you have to be careful.

Deputy J. O'Keeffe: Following on from that then, we've had very substantial evidence here, and in particular from the masters of the maternity hospitals, that from the point of view of saving the life of the mother there are certain rare conditions which crop up regularly, rare but regular ....

Mr Manly: Yes.

Deputy J. O'Keeffe: .... where abortion is necessary. I think that's a fair summary of the evidence we got from quite a number of medical experts.

Mr Manly: Yes.

Deputy J. O'Keeffe: If that is so, and it's difficult to discount that evidence, would you not feel then that there would be major complications in proceeding with a constitutional amendment which would be framed on the basis of a total ban on abortion?

Mr Manly: Yes. I think, to take your advice, you have to be extremely careful about what you call abortion. Now, in these particular cases I would follow Dr Eamon O'Dwyer and some of the other doctors, Dr John Bonnar, they are not in the popular sense abortions. The object of the doctor is to heal the mother, not destroy the child. If the mother was well, he would make no intervention of this sort. Once again, in 1983 the Constitution stated the right to life of the child. People said 'Women will die'. Prominent politicians said 'Women will die'. No women died. I don't think there was even a case of a woman having to leave this country to get an abortion elsewhere for health reasons because, if there was, wouldn't the papers have proclaimed it from the house tops? In fact – this has been said to you so often – Ireland's maternity record is first class.

Deputy J. O'Keeffe: But to get back the point of the medical evidence ....

Mr Manly: Yes.

Deputy J. O'Keeffe: .... in particular from the three masters, who are at the coalface, as it were, it seems fairly clear from that evidence that they would feel that a total ban on abortion would have implications, as far as they were concerned, for what they call 'normal medical practice' and, in particular, in situations where the life of the mother is at stake. You will understand our deep concern to ensure that whatever changes might be proposed would not affect the life of the mother in such situations.

Mr Manly: Yes.

Deputy J. O'Keeffe: From that point of view, as a group who genuinely bring forward an argument to which I am listening, do you not see the difficulty about a proposal in relation to a total ban on abortion, either constitutionally or legally?

Mr Manly: Yes. I think in that case there are two things I would like to say. First of all, the fears of the three masters have to be offset by the statement of the Institute of Obstetricians and Gynaecologists, which is signed by the chairman, Dr John Bonnar.

Deputy J. O'Keeffe: We had him in.

Mr Manly: I know you had. I won't go into it all because you have heard it. He said that what obstetricians have been doing over the years – these particular kind of treatments – he said they were not abortions. He didn't quite say it as briefly as I'm saying it. That statement, I know from an obstetrician I've talked to, was hammered over, was worked on, was passed backwards and forwards for months. It is so short but it does make that one point – they are not performing abortions.

Chairman: The masters accepted that they were very much part of the consultation process in relation to the statement. I'm sorry to interrupt Deputy O'Keeffe, but there is one point I want to put to you. You made judgments about particular medical practitioners, but Professor O'Dwyer spoke to us. I specifically questioned him on the question of the Eisenmenger syndrome. He concluded his evidence by saying 'I wouldn't quarrel with the people who take the opposite view or different view, and say that you have to interrupt the pregnancy. That's their view, and I respect that view, but there is another side and I think that it is only fair to be objective'. That was Professor O'Dwyer's view of that particular problem. In other words, it was an area where he had to recognise a diversity of clinical judgment.

Mr Manly: Oh, indeed, yes, yes, I know. There is a difference of opinion. At the end of the day, people are going to differ, just as scientists differ about various things. I don't think you can get complete agreement on this, sadly.

Chairman: How can we put a matter to the people where there is a diversity of clinical judgment?

Mr Manly: How can the institute of gynaecologists put a statement to their members where, again, there is a difference of opinion? There were some people who didn't agree with that statement. This, I think, is the very nature of realpolitik, democracy. There are times when we have to say there is a divergence here. It is not just a question of majoritism – it is that we should protect, I think, the life, rather than, say, the liberty. It is a question of taking the safer course in this whole thing of mother and child.

Deputy J .O'Keeffe: I understand the careful framing of the position of the institute and the great deliberation that went into it, word by word. What is clear to us from it, however, is that there is an acceptance by the institute in the letter under the hand of Professor Bonnar, that there are certain rare cases – 'exceptional situations' was the wording he used – where failure to intervene may result in the death of both mother and baby. So there is an acceptance, as a matter of fact, that there are these exceptional circumstances ....

Mr Manly: Yes, there are.

Deputy J .O'Keeffe: .... where failure to intervene could result in the death of both mother and baby. The further evidence we have from the three masters of the maternity hospitals is that, in some cases, that intervention amounts to an abortion.

Mr Manly: It is not a word I'd like to use.

Deputy J .O'Keeffe: It amounts to a termination. The only possible approach to be adopted is to terminate the pregnancy in those rare cases where it is necessary to save the life of the mother.

Mr Manly: Yes, but the institute avoids using the word 'terminate'. It says 'a loss, inevitable, of the child due to its immaturity".

Chairman: The unavoidable death of the baby.

Mr Manly: Yes, I have it here.

Deputy J. O'Keeffe: Herein lies the core of our difficulties.

Mr Manly: That is terribly important. A woman who goes to an abortion clinic goes for one sole purpose – not because she is necessarily sick – it is that that human being she is carrying be taken away from her. What the obstetricians, gynaecologists are doing in hospitals when these various rare disorders occur is, first of all, to try to save both. There is a world of difference. I am not a lawyer and I don't draft laws, but that is their job. If the Department of Finance can draft complicated laws to make us pay our taxes and to avoid the big companies from filtering away things or avoiding ... such complexities and complications in that field are taken head on, as part and parcel of their work. With the political will, we should be able to produce a ....

Deputy J .O'Keeffe: We all understand the complexity of the situation we are dealing with now. Despite the good intent of the doctors in the situation described, it is clear that in those exceptional situations, what they are doing is the intentional killing – I have to use the word – of the unborn child because it is absolutely necessary in the medical circumstances. In that situation, you actually have come up with a proposal in your submission for what you suggest should be now added to the Constitution. It is as follows:

> Where abortion is understood to signify the intentional killing of the unborn, no law shall be enacted nor shall any provision of this Constitution be interpreted so as to render abortion lawful.

Even in relation to that proposal, do you not understand the difficulties that could arise in the context of the circumstances I have outlined in the maternity hospitals?

Mr Manly: Yes, I can understand difficulties arising, yes.

Ms C. Lahiffe: May I say something?

Deputy J. O'Keeffe: Of course.

Ms Lahiffe: I think the whole problem with defining abortion is the fact that we are not using the word 'intent', or the word 'intent' is being misunderstood. Abortion, as we see it, is the direct intentional killing of the child for the sole reason of killing the child. Surely, we can come up with some sort of definition whereby abortion is defined as the direct intentional killing of that child. It is the intent that I think we need to look at. Women going for an abortion for social reasons have got that intent. Any doctor performing a medical procedure where it is necessary to save the life of the mother, surely should not be seen in the same light because it is a different intent.

Chairman: But no matter how we formulate the standard – suppose we were to put into the Constitution a phrase redefining abortion, prohibiting abortion as so defined – there's still going to be a controversial court decision on whether the intent was present or not in a given set of circumstances in a hard case. Isn't that the difficulty you have when you enter this world of constitutional prohibition – that the Supreme Court has to construe the Constitution in a particular context?

Mr Manly: Yes it is, but the intention is one thing, the action is a second thing. An action which of its very nature is an action that takes away someone's life – an assault on the right to life of the unborn – that itself is not something that the doctors themselves do.

Deputy J. O'Keeffe: The problem isn't just that in the situation we are discussing ... that the action is intentional, even though the motive is good. The motive is to save the life of the mother, but the action is, in fact, the intentional termination or killing of the unborn because it is considered in that situation to be absolutely necessary to save the life of the mother. So, isn't it here that we have the problem about intent? Intent for a proper motive ....

Mr Manly: Intent, yes.

Deputy J. O'Keeffe: .... would be different.

Mr Manly: Yes.

Deputy J. O'Keeffe: And you would say the intent for ... of having the termination for a motive which would be other than the highest and the best would be different?

Mr Manly: Yes.

Deputy J. O'Keeffe: I accept that, of course, but the action is the same.

Mr Manly: The action may be the same, but take a doctor who gives a strong pain killer to a patient or performs a heart operation; that patient may die. Is that doctor taken up for manslaughter or murder? No.

Deputy J. O'Keeffe: But there is nothing in the Constitution or in the law prohibiting him from so doing.

Mr Manly: Well, I mean, if he did it deliberately he could be definitely taken up. The action there is not a death-dealing action, but the possibility ... a side effect of that action can be, in the individual case. This idea of an action with two effects, the intended effect and the unintended or unforeseen effect, that is something which runs through the law in so many different areas. I think we should be able to work out a formula that distinguishes these two things, but again that is for the drafters of the law.

Senator Dardis: You speak quite frequently about the law and you make the comparitor with the Department of Finance in that they can deal with very complex issues. Now, accepting that there are no problematic areas at the extremes, we are getting to a point where there's a ... our difficulty is defining the line, so to speak.

Mr Manly: Yes.

Senator Dardis: How can that be done through the Constitution rather than by law, because everything you have said to us suggests that you see the law as being a solution to the complexity?

Mr Manly: Well, in a way, the eighth amendment, the 1983 amendment, did give you the solution, because it explicitly stated the right to life of the unborn child. Now, in doing that it makes it impossible legally that that individual should ever be the object of a direct assault on its life. And this, I suggest, is the contradiction that the X case has brought into it. It is the contradiction, really, that any democracy allows abortion. It does this because ... what is the essence of democracy but the unconditional respect for every human being? That basis ... it is the respect for the right to life, because, just as Mr Justice Hederman said, if there's no right to life there's no rights at all. Now, if that right to life is recognised in law then there never can be from anybody at all – doctors or anyone – a direct assault on that life.

Senator Dardis: But you used the words 'in law' again. And what we ... so, the point I am making to you is that there are two aspects – there's the constitutional aspect and there's the legislative aspect.

Mr Manly: Yes.

Senator Dardis: With regard to the original amendment ....

Mr Manly: Yes.

Senator Dardis: .... there was an unintentional effect, an entirely unintentional effect. By assertion of the amendment ....

Mr Manly: Yes.

Senator Dardis: .... something quite unintentional happened.

Mr Manly: That was?

Senator Dardis: The X case.

Mr Manly: Yes.

Senator Dardis: As a result of the insertion of the ... not as a result of it, but on the basis of the interpretation of it.

Mr Manly: Yes.

Senator Dardis: We come back to these words like 'understood' and 'intentional', and we insert those in the Constitution on the basis of your suggested wording ....

Mr Manly: Yes.

Senator Dardis: .... we're back to the courts again to define 'understood', to define 'intentional'. Is it not the case that it would be much simpler to define those words in legislation, to put into the Act and the preamble to the Act, what 'intentional' means, what 'understood' means?

Mr Manly: Well, maybe so. Again, I am not a lawyer, but the ....

Senator Dardis: Nor am I.

Mr Manly: The legislation must flow in this case from the Constitution. And, I mean, let's put it this way, when a country legalises abortion it allows a class of people – pregnant mothers – to do away with another class of people – children – in certain circumstances, maybe under so many weeks or something like that. Now, they can do this without recourse to the courts, without due process. Isn't this an extraordinary thing, now? And this is happening in democracies around the world. Does that not strike you as something that is just incredible; that one class of people will have the right to end the lives of another class of people? It doesn't make sense.

Senator Dardis: That's not at issue. You have ... I think I accepted the point that there is an area ....

Mr Manly: Yes.

Senator Dardis: .... that is extremely difficult, irrespective of one's perspective.

Mr Manly: I accept it's extremely difficult, yes indeed.

Chairman: Thank you very much for your assistance this morning. I would like to thank you for your contribution and I will suspend the session for two minutes until the next witness takes his place before the committee.

Mr Manly: Thank you, Mr Chairman, and thank you, members of the committee.

Chairman: Thank you.

SITTING SUSPENDED AT 9.38 AM AND RESUMED AT 9.40 AM.

Mr John Wood and Dr Phil Boyle, Donal Corrigan and Enda Dunleavy

Chairman: We are now in public session and I would like to welcome Mr John Wood of the Christian Solidarity Party and he is accompanied by Dr Phil Boyle, Donal Corrigan, solicitor, and Enda Dunleavy, to this meeting of the Joint Committee on the Constitution. A letter was received from your party and, as you're an organised body of opinion on this matter, we thought it appropriate that you should be asked to speak to us. So the format of this meeting is that you may make a statement elaborating on your position, if you wish, which will be followed by a question and answer session with the Members. I have to draw your attention to the fact that while Members of this committee have absolute privilege, this same privilege does not apply to you. I'd ask Mr Wood to make an opening statement outlining your position and questions will then be put by the members and you can decide who you wish to respond to them.

Mr J. Wood: Very good. Thank you. First of all, I would like to thank you, Mr Chairman, and the members of the committee for inviting the Christian Solidarity Party to be represented here today. CSP is a registered political party and we have been active in contesting elections since our foundation in 1992. As a political party we are interested in every aspect of the political process and, as such, we have policies on a broad range of issues. However, the right to life and the protection of that right is one of our core values. It is because of this, because we value human life so highly, that it pervades all our party policies.

With regard to the matter being considered by this committee, I would like to briefly mention five aspects of our policy. Firstly, the right to life is the most basic of all human rights and, on this basis, we would like to see it explicitly expressed in the Constitution. It is our party policy that human life should be respected and protected from conception until natural death. Secondly, we acknowledge the difficulty that exists in finding a format and format of words whereby this can be achieved. However, we believe that the problem is not intractable and that a formula can be found that would provide legal protection for the right to life of the unborn without posing a threat to the life of the mother. In no circumstances should medical treatment be denied to a woman because she is pregnant. This clearly does not include direct abortion.

The third point is that Article 6.1 states that the people, in final appeal, have the right to decide all matters of national policy. It is our policy that the decision of the people in the 1983 amendment has been interpreted in the X case in a way that was not foreseen by the people

in the referendum and, as a result, has reduced the level of legal protection to the unborn. It is our policy that the only way to restore that level of protection is to give the people an opportunity to have their say in another referendum.

Fourthly, we don't wish at this stage to propose any specific form of wording but our approach would be firstly to retain the existing acknowledgment of the equality of the right to life of the mother and the unborn; secondly, to get over the difficulties posed by the X case, we propose a specific prohibition on the deliberate and intentional destruction of the unborn human life. Our fifth point is that we believe that structures should be put in place by the State to support women in crisis pregnancies. Thank you, Mr Chairman.

Chairman: Thank you very much. Have you looked at the transcripts of the evidence we heard from the masters of the various hospitals and the obstetricians?

Mr Wood: Yes, we have.

Chairman: And they seem to envisage that direct abortion is, in very rare cases, but regular – regular, but rare, I think, as Deputy O'Keeffe formulated it earlier – is an option they would wish to entertain.

Mr Wood: Yes.

Chairman: Have you any comment to make on that?

Mr Wood: Yes, we have. Again, I think this, to a certain extent, comes down to the definition of what we mean by an abortion. I realise that your committee here is looking at that issue. We would define abortion as the deliberate destruction of unborn human life and while we acknowledge .... Obviously, you've got, I think, different opinions from some of the medical experts that came in but there did seem to be a convergence that, at some stage, it may be necessary to terminate the pregnancy in order to protect or to save the life of the mother. We acknowledge that this situation can occur and again we would look at it not in terms of an abortion, but as an action which indirectly results in the death of the unborn. Now I'd just like to ask Dr Boyle, who is a medical practitioner based in Galway … he would like to have some comments on that.

Dr P. Boyle: I am a general practitioner working in Galway with a special interest in women's health, infertility, and I do some crisis pregnancy counselling as well. And I'd very strongly agree with the obstetricians and the statements and I read through them as well that it is necessary at times to induce labour to bring on a premature delivery of unborn children. But I would see that as a distinct and separate thing from deliberately destroying the life of the unborn child and what we would like to see is that the life within the womb would be recognised as a human life, as a citizen of Ireland, that would have equal protection and right to life as you or I would have and that sometimes as a result of necessary medical treatments in rare circumstances, it may be required to induce labour early where the probability of that life continuing to exist is significantly reduced and, at times, would be extremely unlikely and the child would die.

But there is a very distinct difference in that between actually taking the child's life, for example, as would be commonly practised with an abortion procedure in the UK where potassium fluoride is injected directly into the vein, of the umbilical arterial vein, to kill the child and then the dead baby is actually delivered. What we would propose would be that a live baby be delivered at whatever stage of the pregnancy it's at and that we would treat that patient, if you like, who is born in that circumstance as a terminally ill patient if they're born prior to 24 weeks and that they're likely to die at that stage but they would be treated with dignity, with the respect that's due to all human beings.

We'd say that it's a regrettable but, on occasion, necessary side effect of medical treatment to save the life of the mother in those rare cases that were outlined but we think there's a fundamental difference between saying we're going to destroy this life because it's like the pregnancy is being viewed, if you like, as a disease or an illness that has to be destroyed, like a bacteria or a viral infection, whereas we're saying that is not the case, we respect this person, we bring on pregnancy to save the life of the mother, the unfortunate side effect is that the baby is going to die most likely on the basis of our current medical knowledge. But, in time, perhaps babies at 20 weeks and 18 weeks, we may come up with the technology to keep those babies alive because originally the term abortion applied to babies who were born at 28 weeks and we now know that we can keep babies alive for 24 weeks onwards. And it is possible with advances of medical science that perhaps younger and younger babies may be able to be kept alive outside the womb at that stage.

In summary again, what we'd be looking for is that, you know, the taking … the deliberate taking of a life, like injecting potassium fluoride into a vein to kill the life and deliver a dead baby, that we're not in favour of taking human life, born or unborn. We're in favour of induction of labour if that is the only necessary medical means to save the life of the mother and, unfortunately, it results in the unwanted death of a child.

Chairman: For legal and constitutional purposes you've expended quite a number of words there. Is it really possibly to move very far beyond what was provided for in 1983 in terms of a concrete constitutional restriction?

Dr Boyle: I think it is because a similar principle would be applied in cases of euthanasia and there was a case in point that was brought to the attention of the media about a year ago about a Dr Moore who was being charged for taking the life of his patient. It was a terminally ill patient. His primary intention was to relieve the suffering of the patient by giving medications to the make the patient comfortable. A foreseeable but undesired side effect was the death of the patient. Some people were not happy with that and they challenged his practice to say that he killed this person. He said no, 'I applied good medical care and an unintentional side effect was the death of the patient.'. So, it is currently good medical practice and it is also recognised in law that this whole thing of intention is a recognisable thing, whereby you can foresee a side effect where somebody will die but that is not the primary intention of the action and I think it could be enshrined in the law.

Chairman: But in law and jurisprudence there is a distinction between intention to commit a particular act and motive.

Dr Boyle: Yes.

Chairman: It seems to me what you are talking about is motive in relation to the medical profession rather than intention in the legal sense.

Dr Boyle: I would be talking about the intention to induce the pregnancy, induce labour. The motive is to save the life of the mother, so you have got two patients, you have the mother and her ongoing child and your motive is to save both of them if you can at all. In some circumstances that is not a realistic option and there is a way whereby you can save one of them by inducing labour, but there is a world of difference between actually taking the life of a child and inducing a labour whereby the child dies of natural causes and is treated with the respect and dignity due to human people, whereby the child would have a burial and be treated like a person whose loss would be grieved and recognised as such. So, we would seek that the unborn person be recognised as a citizen of this State and have the same protection to life as all citizens do.

Deputy J. O'Keeffe: Could I ask you, in your view are there abortions carried out in Ireland as of now?

Dr Boyle: It depends again on the definition of abortion – it is a very wide ranging kind of a thing because abortion covers spontaneous miscarriages as well as, you know, therapeutic interventions and the therapeutic interventions that are carried out, yes they are carried out now for cases, for example, of pre-eclampsia, because some of the definitions in the text books have not caught up with current medical advances whereby an abortion is defined as inducing labour prior to 28 weeks. But the advantage is now that with advances in medical science babies born prior to 28 weeks, despite being technically classified as abortions, can actually live.

Deputy J. O'Keeffe: So, simplifying it for non-medical people, there are therapeutic abortions carried out for good reasons, good medical reasons ....

Dr Boyle: I would say that there is early induction of labour, but not destruction of the life.

Deputy J. O'Keeffe: You want to see a regime in existence, a constitutional legal regime in existence which would permit such situations to continue.

Dr Boyle: Yes.

Deputy J. O'Keeffe: Outside of that, outside of terminations that are carried out for good therapeutic reasons ....

Dr Boyle: You could say induction of labour. It is more palatable ....

Deputy J. O'Keeffe: Well then, inductions of labour. There are not, in fact, any other inductions of labour carried out for wrong reasons in Ireland – or as you would see it, wrong reasons.

Dr Boyle: I am unclear as to what a wrong reason would be.

Deputy J. O'Keeffe: Well what I am really trying to get at is apart from, can I call it therapeutic abortions, would that be an abortion that you would consider acceptable?

Dr Boyle: Well, we are talking, yes, early induction of labour is what we are talking about.

Deputy J. O'Keeffe: Yes. The realistic situation is that we do not have other abortions carried out within the country at the moment.

Dr Boyle: The deliberate destruction of unborn life, no.

Deputy J. O'Keeffe: Am I correct that that is the practice? If people want other abortions they go to England. Is that not the situation?

Dr Boyle: That is correct, for social reasons, yes.

Deputy J. O'Keeffe: What am I trying to get at is the practical situation as it exists today.... you are satisfied with in so far as it applies within the country?

Dr Boyle: Well, you are saying that I would be satisfied that, for example, 6,000 women per year go to ....

Deputy J. O'Keeffe: No, sorry, I want to come to those separately, but in so far as what happens within our hospitals here in Ireland, you have no complaint. What is happening is good medical procedure.

Dr Boyle: I believe that there is good medical practice with the obstetricians ....

Deputy J. O'Keeffe: And our legal, ethical, constitutional framework covers what is happening there.

Dr Boyle: I do not believe that it is covered sufficiently yet. I believe some of the masters had some difficulty and concern about what the legal standing is and I think that it could be clarified further to say that early induction of labour, whereby you do not actually take another person's life is an acceptable practice, but the deliberate destruction of a human life and delivery of the dead baby would be medical malpractice.

Deputy J. O'Keeffe: But to get back to the three masters who were mainly, with slight variations in nuance, singing from the same hymn sheet. The general impression I got was that a total ban on abortion in the Constitution could cause problems to them in relation to existing medical and therapeutic practice.

Dr Boyle: And I would agree. I would feel that something like the current law that is there, Article 40.3.3º ... that perhaps if there is a clause added on to that, that that might give us further clarification, that is to say that the deliberate destruction of unborn human life would be prohibited, but to induce a labour to bring on a pregnancy whereby you do not actually take a person's life, but you resolve the problem of the crisis pregnancy causing the

medical condition, you do not take the person's life but it is likely the life on the basis of current medical knowledge would expire as a result of the treatment – I would find that acceptable. But, I do think it could be clarified further by adding on a clause.

Deputy J. O'Keeffe: But if you go back to the Green Paper and the proposal that we adopt option one. Option one is an absolute constitutional ban on abortion.

Dr Boyle: Yes.

Deputy J. O'Keeffe: You accept that an absolute constitutional ban on abortion without provisos to cover the situations we are talking about, the medical and therapeutic situations we are talking about, would not be acceptable.

Dr Boyle: To me that is not acceptable in the light of … but again, what you would need is.… I know that our proposal says we propose, you know, option one as the only one that will actually respect the right to life of the unborn person, but I would think it would have to be modified to a degree to put in this clause to say that in cases where we have to induce labour but not destroy the life to save the mother … I think that that would be preferable.

Deputy J. O'Keeffe: So, if you cannot accept in the light of our present discussion option one as it is baldly stated – an absolute unconditional ban on abortion, we are then into the problems of definition. How would you modify this absolute constitutional ban to take on board the kind of situations we are talking about?

Dr Boyle: Again, the ban would be the direct taking of a human life as opposed to early induction of labour. I would also include things like, for example, a hysterectomy where there is a pregnant uterus and the woman has uterine or cervical cancer and the medical treatment is a hysterectomy – so you are removing the life and the womb at the same time as well – to be included in that as well.

Chairman: Thank you very much for your assistance this morning. I would like to thank all of you for coming here today. We did not anticipate there would be four of you, but we are observing strict time limits this morning. Thank you for your assistance and I will suspend the session for two minutes until the representative of Pro-Life take their place.

SITTING SUSPENDED AT 9.58 AM AND RESUMED AT 10.00 AM.

Professor William Binchy, Dr Berry Kiely and Ms Caroline Simons

Chairman: We are now in public session and I would like to welcome the following representatives of the Pro-Life Campaign, Professor William Binchy, Dr Berry Kiely and Ms Caroline Simons, to this meeting of the Joint Committee on the Constitution. We received your presentation, which has been circulated to the members and laid before the Houses of the Oireachtas. It is at page 181 of the book. In fact we received quite a number of your submissions and they have used as a working document by the committee in its consideration of the issue as the basic working document, in fact, in the context of the pro-life argument.

The format of this meeting is that you may make a brief opening statement, if you wish, elaborating on your submission which will be followed by a question and answer session with the members, and I have to draw your attention to the fact that while members of the committee have absolute privilege, this same privilege does not apply to you. Professor Binchy ....

Professor W. Binchy: Thank you very much.

Chairman: Professor Binchy, you will be interested to hear that it is my personal opinion that you have a qualified privilege but I am not sure whether the Houses of the Oireachtas agree with me on this point.

Professor Binchy: Thank you, Mr Chairman. I would point out that we are definitely relying on that advice on your part there.

If I may, just in response to your marks there, thank you very much Mr Chairman and members of the committee, for giving us this opportunity. We think it is a privilege. We think it is an opportunity to present our views to you and to have an exchange of views. We hope that it may not necessarily be the last communication on this issue.

I think it is fair to say that this, as far as I know and I think our colleagues know ... I cannot think of any other country in the world that has approached the issue, this troubling issue of abortion, in such a deliberate, calm and comprehensive way as this committee has done. I can think of no precedent internationally and I think you are to be congratulated for that.

I am going to give you a brief presentation. I will say a few words. On my left, Caroline Simons will say a few more and Berry will say a few more, and we would hope to have completed our opening remarks in about nine or ten minutes, certainly no more than that.

I would say to you just, and I do not think it will come as a surprise to you, that this issue is a very important issue because it is an issue of human rights in our judgment. It is an issue which .... Every generation, I suppose, has its blindness towards membership of the human community. If one looks back on history, both a long time ago and in the recent past, certainly the last century in Europe, for example, there have been blindnesses to the humanity of certain members of the human community, and I think it is perhaps the experience of the present generation that the unborn, for some people, have become

invisible as regards their humanity. And I think it is important really that one should be conscious of the fact that all members of the human community are worthy of democratic, equal protection and that it is necessary for society, if you like, to be conscious of the danger of excluding from its reception and perception all members of the human community.

That is not to say that members of the community have equal power, have equal abilities at any particular stage. There are people of great intellectual ability, great physical ability obviously, and they differ sharply from those of their peers. When we are dealing with the unborn, we are dealing with a member of the human community at an early stage of development, at the correct stage for the development of the time – one can ask no more of the unborn than to be at that stage of development at that time – and nonetheless, that unborn member of the community requires equal protection.

We would stress that because we do see this ultimately as an issue of values. Much of the debate at this committee has been in the specific context of medicine and the treatment of pregnant women, but the wider international picture is clearly one of values and the value to be ascribed to the unborn.

Our argument, as you know, is that essentially it is important when you are dealing with members of the human community that you do not directly take and intentionally take the life of a member of the human community, and on that basis we suggest that abortion is wrong. We equally and emphatically say that medical treatment for pregnant women is of course essential. It should be given, is given in Irish hospitals, where the medical treatment experience is absolutely up there at the top of the world internationally. I think Irish hospitals can hold their heads high in this area in terms of the success they have in the treatment of pregnancies without an abortion regime, and it is crucial that that distinction be retained and supported by the law.

Our concern is that the X case misunderstood the relevant legal principles; introduced a principle which is at variance with the medical ethics guidelines of the Medical Council, at variance with the Institute of Obstetricians and Gynaecologists, at variance with the recommendation of the IMO and at variance with daily experience in Irish hospitals today. And what we are looking for, legally speaking, is legal support – no more and no less than legal support – for the existing medical practice in Irish hospitals. Now we are not looking for something theoretical and abstract and metaphysical. All we are looking for is the assurance that the law comes in behind existing medical practices. We have internationally an interesting situation, which is that medical ethics have reiterated their position after the X case on two occasions, making it clear that abortion is contrary to medical ethics whilst medical treatment is entirely consistent with it and a necessary part of it, and what we are looking for essentially is that legal support.

I am not sure if I have broken my three minute regulation there, but maybe Caroline can take it up at that point.

Ms C. Simons: I will be briefer just to make up for it in case you did.

Chairman: They are self-denying ordinances but the exchange is of value. You know, to exchange opinions ... there is no pressure.

Ms Simons: I do not have an awful lot more to add on it because we are obviously going to be responding to detailed questions. The one thing I have noticed from the attempted detailed read I did of all the transcripts of the medical witnesses that you had last week is how much common ground there is. I think everybody has seen at this stage that doctors are primarily concerned in a number of particular types of conditions in pregnancy to act in a particular way, and Dr Kiely will be dealing with that in more detail later, but these .... There is nothing new in the treatments that are being meted out to women in these conditions. There may be new methods of dealing with them, but the actual procedures have been around for a long time, by and large, and it seems to me that an awful lot of the difficult ... the apparent difficulty now is that there are a certain few who would choose to characterise this kind of treatment of women in pregnancy as abortion and therein lies the problem.

It was interesting to see the different witnesses and their ideas of what abortion was, and I think I was encouraged to see one of the ICTU representatives saying, well we all know actually what abortion is. The doctors said the same thing, that, you know, it is in common exchange; it is used in common conversation among people in the street. But then she continued to say an abortion is an act which terminates a pregnancy, which we all know a Caesarean would do.

I think we are all very, very clear on the points we want to particularly address today and, that is, abortion, as it is commonly understood, and that is, an act which is done with the sole purpose of terminating the life of the foetus, not terminating the pregnancy. Because if you terminate the pregnancy and have a live infant, you have not succeeded in your abortion. And I think we need to try to be clear in relation to that. I do not know if Dr Kiely wants to add anything there.

Dr B. Kiely: The point that I would actually like to make, because I think we can't make it often enough and we can't do enough in this area, is that as well as looking at abortion from the point of view of the legal situation, we must also address the issue of women who have unwanted pregnancies and what we can do to reduce the numbers of those women who will opt for abortion, and provide real alternatives. There is an awful lot that can be done and that's the message that, I think, doesn't perhaps get through enough to people. There is a certain sense, when you talk about this issue, of people sort of saying 'Well, you know, there's nothing we can do about the 5,000 or now nearly 6,000 women who go to England to have abortions' and that, therefore, this is all a little bit sort of academic.

In reality, I think, when you look at what people in other jurisdictions have attempted to do, there is an awful lot that can be done and that remains to be done. It has been done quite successfully in other places. Some of you are probably familiar with the work that's being done by the Caring Foundation in the United States where they found that getting women ... asking women who had had abortions to help them design their programmes for

women with unwanted pregnancy, that using the advice and the help of women who had had abortions they were able to design advertisements and various other programmes which reduced ... which were actually effective and sort of reduced the incidence of abortion by figures like 30% and 40% after one month of just running this programme. Now, that's very interesting work. It would be nice ... I think it's important that we would see some of that being done here as well.

Another point – I think you've already had submissions on this so I won't delay on it – but the whole area of adoption. It was .... I think one of the most saddening aspects of reading the Trinity study on crisis pregnancy was the negative attitude that so many of the women had towards adoption. I found it hard to understand exactly why that would be. I suspect it has to do, in part at least, with the negative media treatment of adoption. I think, that again, is something which there is an awful lot we could do about and which, if we did do it ... if we tackled that particular issue and sort of gave a more positive approach towards adoption and explained it better .... A lot of people are not aware, for example, of the changes in relation to adoption, the various forms of open adoption which are now available. Even saying that, it should be a question of ongoing research to see ... to continue improving the manner in which adoptions are organised and the way in which they function.

All of these factors can actually significantly help a woman who is faced with an unwanted pregnancy. While I appreciate the brief of this committee is purely to look at the questions of legalisation and the law surrounding abortion, yet I think I would make a plea for us not to leave it at that. At the end of the day when we have, hopefully, got our constitutional amendment and, with or without legislation to back it up, there will still be an issue there which I would hope even the people on this committee, having put so much thought and work into it, would continue to have an interest in that area.

Chairman: Thank you. Senator O'Donovan.

Senator O'Donovan: A couple of questions. First of all, thank you for coming in here, you are more than welcome. I think you made your submission very succinct and clear. One worry that I would have, as a lay person, is ... it has come across to me from all of the expert witnesses that have been in here and practically all of the groups, I'd say without exception ... that every group and every expert wished to see current medical and ethical guidelines as set out and current medical practice protected and retained. My difficulty, as a lay person, is when you hear the different definitions of abortion. Some people tell us that technically speaking where there is any ... I think somebody used the word 'emptying' of the uterus – either direct or indirect ... whatever the terminology – that that in fact is technically abortion, that miscarriage would technically be seen as an abortion which is sort of educating me or confusing, I'm not sure which. How would you propose – my first question would be – in a constitutional amendment to protect existing good medical practice?

Professor Binchy: Well Senator, I think you're right in the way you read the situation. In other words, we know what we want to do in the sense that the witnesses who came before you were anxious to protect existing medical practices and then it's just a legal challenge to express that in language which incorporates existing reality. I think it's fair to say that the word 'abortion' ... the word 'abortion' as opposed to the whole philosophy that surrounds the direct and intentional taking of unborn life has no magic in this particular area and is not part of the legal code at the moment. I'm sure that point has been made by a number of witnesses. So we are not talking about the magic of a word here, what we are talking about is the basic philosophic principles which are easy to understand and are entirely humane, which is that you do not directly and intentionally kill other human beings. And that is really the crucial element here, the philosophic principle that underlies the relationship of people to people.

How should that be expressed? It can be done in a variety of ways. It can be done .... We've offered two possible manner ... draft amendments, one expressed in general principle, another more focused. But, we are not in any sense wedded to language ... not at all. If there is any concern on the part of anybody about specificity and tying matters down, then one just simply translates the concern for a specificity into more extensive language. It can be done, that's not problematic. It's relatively unusual, in a constitutional text, to have a long and detailed text, but, if necessary, that can be done. It can be done in a variety of ways by linking it into legislation and incorporating the two in the constitutional proposal and the legislative proposal ... the detailed legislative proposal in tandem. There are many, many ways of doing this, but the one certainty is that it is not a legal impossible task to translate existing medical practice and give legal protection to it.

It would be strange .... I think, an ordinary person who is not versed in law would be quite surprised to learn that everybody knows what they want to do, they know they want to give legal protection to it and in some way there is a legal incapacity to deliver on that. It is not at all impossible to do. What one does, as I say, is ... it has to be done, unfortunately ... there has to be an element of constitutional change here because the X case introduced a principle which we would argue is unjust in terms of the right to life of the unborn. But, the actual detail, the manner in which the constitutional amendment is linked into legislation, the degree of specificity is entirely a matter for those who are policy makers in this area. As I say, we are not wedded to any word and we are not specifically wedded to the word 'abortion' appearing in any particular text.

Senator O'Donovan: Would it be fair to say that in addition to a possible constitutional amendment, which you would propose, that one would also need to have legislation maybe to define abortion legally? Because the worry I have, again as a lay person, that there has been ... the medical interpretation, that I gather from the various witnesses, of abortion is very wide and it would include maybe a definition that I, prior to this, understood as not being abortion.

Professor Binchy: You're right ... you're entirely right. In medical literature the word 'abortion' can be used – my medical colleague here will confirm this – but the word 'abortion' can often be used in terms of a natural

termination of pregnancy where there is just a premature delivery. So, the word 'abortion' used by doctors is not where one should look for a legal definition, if you follow me, here or a legal approach. That's medical terminology and there's nothing that one says critically of that. Doctors use their own language in this area. But, it's not so much the language that counts here, it's the activities that are done and the context in which they are done that's important – the principles that underlie the activities in question.

The doctors themselves are clear enough on what they're doing there. The Medical Council is entirely clear. I think we're clear in terms of our attitude towards those principles. So there's no lack of clarity about the principles in this area. You're quite right in saying there's a range of conventional definitions, both in the medical and legal world where the word 'abortion' or 'miscarriage' ... various words are used and they do, you are quite right in saying that, they carry a multitude of meanings. But, this thing is not going to be solved by looking up a dictionary and taking the definition one gets and sticking it into an amendment. That's not the approach that has to be used. The approach that has to be used is a principle based approach, linking it into the existing reality that we have all heard about over the last several weeks and giving that then the legal support. As I say, it can be done through an amendment alone, it can indeed be done through an amendment and legislation but it can't be done – I wish it could – it can't be done through legislation alone because, as long as X remains there the principle which that case incorporates is one which, if it were to be translated into practice by the medical profession, would allow for, effectively, wide-ranging and legally uncontrollable abortion.

Senator O'Donovan: Could I ask one further question of Dr Kiely? You mentioned the position about the very sad saga that, whether we like it or not, we have approximately 6,000 people going abroad each year for abortion. It's an Irish problem which we will try to resolve. You mentioned the attitude towards adoption that ... I've rather a different view on that having regard to the fact that after the overthrow of Ceaucescu in Romania around '89 there were about 400 Irish couples went aboard and there are still ... even in the area where I live, I know several couples who have, unfortunately, maybe after a decade trying, been unable to succeed.

I can't figure out if there were 400 couples from Ireland prepared at least to travel to Romania, some of them two or three times, and went to a lot of trouble on the adoption issue, I thought we had a significantly positive attitude towards adoption as a solution. Quite rightly, one of the big issues, even though our committee may not have a brief in that regard, is the big problem is how do we reduce the 6,000 in Ireland by education or whatever? Maybe adoption is just one of the ....

Dr Kiely: Let me clarify that when I talked about the attitudes to adoption I meant on the part of the pregnant woman. That was what came out in the Trinity study. For example, some of them had phrases in it which I personally found very shocking where a girl who was opting for an abortion when she was asked has she not considered adoption, her reply was that adoption seemed to her a worse solution for the baby than abortion was. That's the attitude I mean, that there are people there who would think that to give your baby for adoption is somehow cruel and is something that is even worse than to abort the child. It surprised me, I have to admit. I wasn't aware because like you I would be so aware of many couples who would dearly love to adopt and would be delighted to adopt and we have seen all the increase in the foreign adoptions and just how willing people are to help somebody and delighted to give a home to the child but it's not from that angle. It's more from the point of view of the girls who have the unwanted pregnancy.

That is very amenable to change because what underlines it, funny enough, is they at some level want to do good by their child, which sounds strange when you think that they are going the route of abortion but that's what we have to try to understand, the mentality of the girl in that situation. It is not a question of choice for her. She feels she has no choice and when the choice of adoption is put to her, that seems to her like a worse option. Those are things we have to research more and look at more in detail and see how we can approach them.

Professor Binchy: Could I just add one supplement to that? Two things that were understandably very heartrending for the mother would be the secrecy aspect and the finality aspect of adoption, that it's goodbye to your child forever more and it's a total termination of relationship. The whole trend, legally speaking, internationally now is towards open adoption. Elements of this have crept into the Irish system slowly, breaking away the notions of secrecy, for example, and the whole notion of the finality aspect can also in terms of goodbye to a child, never seeing the child again, that's the area were the heartrending pain came in. If those areas can be broken down and have a form of informal adoption which has been worked quite successfully – incidentally has been part of the culture of many countries for generations but is increasingly coming into the English speaking countries – that would take away some of the anxieties that the choice involves in those circumstances.

Deputy McManus: First, can I thank you very much for coming forward and putting so much work into the presentation and the documentation? I certainly agree that there is a lot of common ground and that's very hopeful. I would like to, though, come back to the points that you made, Professor Binchy, because there is an area where there isn't common ground in relation to the possibility of another constitutional amendment. Maybe you would comment first on the comments that have been made by medical consultants that the medical practice that they currently are able to carry out would be affected, impacted on, if there was an absolute ban on abortion, also, the view expressed very thoughtfully by Dr Ken Whitaker and the review group that was set up to look at this issue and other issues in the Constitution where they clearly have taken a different route and have proposed legislation.

Professor Binchy: You're right. I think some doctors who are not versed in law feel that any dimension of law, looking over their shoulder as it were, is a source of concern and, therefore, any new dimension or potential dimension of law is another anxiety but that is not what

we are proposing at all. On the contrary what we're proposing is what they do every day which at the moment is at variance with the law, even though that dissonance hasn't impacted yet at a practical level. As a result of the X case what the doctors do every day is at variance with what the legal principles are. All we're looking for is an assurance that what the doctors do every day has the support of law so any doctor who expresses concern that what we're proposing is to change practices is mistaken. What we're proposing is to ensure that the practices that doctors do receive the support of the law. You're right in pointing to a concern that has been expressed but that concern is completely misconceived. What we're looking for, as I say, is for legal support for the Medical Council guidelines, the Institute of Obstetricians and Gynaecologists, the IMO. What we want is that the law should support practices and the ethics that underly them rather than that it should be in conflict.

So we're not looking for any retrenchment of the law in this area but what we are looking for is the removal of the X ground which says that you can carry out an abortion in life threatening conditions. If that ground were to be implemented, international experience very clearly establishes that a ground which in itself seems when one uses the language that is used there to be one that is perhaps intuitively attractive but when that is translated into practice, it allows for wide ranging abortion in practice. What we want is for the kind of decisions that the doctors that you have had in front of you, that the decisions they make where they are concerned with two patients rather than with killing one of the entities that they're dealing with, that they do their maximum to save both lives in these circumstances and provide the best medical treatment. So medical anxieties in this area are, as I say, groundless, but what doctors should be concerned with is the existing situation which, legally speaking, hasn't translated into practice. But if it were to translate into practice would be a very great source of concern for all of us.

Deputy McManus: Maybe I'm a little dense so you're going to have to be a bit more specific.

Professor Binchy: You can discount ... that's hypothesis.

Deputy McManus: No, I have difficulty ... I accept the viewpoint you're expressing. It's just I have a difficulty understanding where it's going in terms of words in the form of a constitutional amendment. For example, it's quite clear from the evidence we have heard that there are very rare conditions where abortion is the treatment to save the woman's life and that it is quite clear that even though it is reduced danger there is such a thing as suicide among pregnant women and, indeed, that the proposal that I would have thought you're suggesting now in terms of taking out the X case decision was put to the people and rejected by the people already. So there are two aspects there that concern me, but I'm still not clear what you're talking about in terms of how the amendment would be framed. You have to explain it to me as a non-legal person.

Professor Binchy: Berry is champing at the bit so I'm going to let her in.

Dr Kiely: Just one bit I have to clarify before William deals with the legal part if I might.

Deputy McManus: Okay.

Dr Kiely: It's just in relation to your use of the term, the phrase 'that abortion is necessary in some rare situations'. There you would have to clearly define what you mean by abortion. If by abortion you mean ending the pregnancy, delivering the child but most people don't mean that, right? The better way of putting it is to say – and I think all of the doctors would agree with this – there is no situation in medical practice, there is no condition in a mother which requires the death of the child as part of its treatment. You do not ever need to kill the child in order to treat the mother. There are situations in which you may not be able to save the life of the child, right? One of the situations that was put to you, for example, was the very severe pre-eclampsia and the HELLP syndrome which might have occurred, let's say, at 18 weeks, 20 weeks before there's much chance of the baby surviving *in utero* but when you look at what's involved in those cases that maternal condition is extremely toxic to the baby in the mother's womb. In the majority of cases the baby dies *in utero* so there isn't that much that you can do about it and usually at that stage that you are terminating the pregnancy or inducing delivery in most cases the baby is already dead. In the cases where the baby might not yet have died you're left in a situation where this baby's life is already very much at risk *in utero* and possibly what little chance it has of surviving, it has a better chance if you deliver it early, even though you know that the chances may not – those are the sort of things, for example, that Dr Keane was talking about. I think he gave you a very specific example in relation to it. Now, used in that situation, you may end the pregnancy, you may induce delivery, but there is no need to kill the child.

Deputy McManus: I was actually thinking of Eisenmenger's and Peter McKenna's – Dr McKenna's evidence, which, I mean, I think, you know, there is a certain amount of discussion on that, but I really would prefer to concentrate on the legal aspect, because that's where my difficulty lies.

Ms Simons: Just in relation to Peter McKenna, I think there were some certainties made on that, which follows the various points – you may need to empty the uterus, and that was the word he used, and I would add, or the fallopian tube, but you don't necessarily intend to extinguish the life of the unborn child. The treatment may be to empty the uterus and for preclampsia, that is the treatment. For Eisenmenger's ....

Deputy McManus: He seems to have no difficulty using the word 'abortion', but I really, that is not my central question here.

Professor Binchy: I think that Dr McKenna quite fairly said that he is not fixated by language. He said: 'I might call it an abortion, I'm quite happy for it not to be called an abortion.' He has certainly said that in another forum I know, on the radio, but the bottom line is I think you're concerned about what we're trying to achieve and how

we should achieve it, I think, are your concerns, Deputy, as far as I know. What we're trying to achieve, from a principle point of view, is clear, which is, if you like, one doesn't target an individual and take their life away and that one does not make a direct and intentional attack on anyone, whether they're born or unborn. But, of the nature of things and the context of pregnancy, where there's an intertwining of the mother's life and the child's life, treatment of the mother in these circumstances can have, and in some circumstances very definitely will have, a detrimental outcome on the unborn. Where the treatment of the mother is targeted towards the mother, even if the detrimental impact, including a lethal detrimental impact occurs to the child, that is morally acceptable and we would argue should be legally supported, but targeting the unborn child, seeking its death in these circumstances, which is in a conventional sense, as opposed to in the sense that some doctors use the term abortion, conventionally speaking, what abortion is about; in other words, that the continued life of the child is a concern and there's an attempt to extinguish the life of that child. That is what we would argue is not justified and which the law should not support. Unfortunately the X case, not just in the context of the suicide threat, but generally, does support the targeting of the child – the taking of the life, the intentional taking of the life of the child in these circumstances, it is not limited to the idea of providing treatment for the mother with detrimental consequences for the unborn child. So, X is bad, not simply on the basis of suicide, but also on the basis that it formulates a principle that allows for the targeting of the child. If one were to bring in a principle based on the targeting of the child and translate that into medical practice, the practicalities are that that would lead to wide-ranging legal abortion, in our view, and our view is based on pretty wide-ranging international experience.

Deputy McManus: Just one brief last question, because I appreciate time is limited. How do you define 'unborn"?

Professor Binchy: How one defines it, one has to know what one means by it and what one is seeking to achieve. I think it's fair to say that the pro-life campaign is seeking to protect all of the human experience from conception to death and it is a question then, of affording protection. We don't believe in that long saga from conception to death that any particular moment in that journey, even if you're not particularly well-developed, mentally formed in the early stages or even in the latter stages if you're to some degree falling apart mentally or physically, we don't believe that on any stage of that journey one can create an artificial line and say, 'before this line, no protection or less protection is given.'

Deputy McManus: Thank you very much.

Deputy J. O'Keeffe: Good to see you again. We obviously haven't found a solution to the problem since you last appeared before the committee a couple of years ago. As of now we have the seven options in the Green Paper and option one is an absolute ban – a constitutional ban on abortion and I think it's clear you're for an absolute constitutional ban on abortion.

Professor Binchy: Yes.

Deputy J. O'Keeffe: Do you remember the discussions and the debates of the constitutional review group, which was headed up by Dr Whitaker and on that group were some of the very heavy academic hitters in the country – constitutional experts, legal experts and so on. You would accept that that was a high-powered group of academics.

Professor Binchy: Well, if you're emphasising heavy, I would point out that physically I can ....

Deputy J. O'Keeffe: Pound for pound. But you'd respect obviously that their views have to be respected.

Professor Binchy: Yes.

Deputy J. O'Keeffe: The constitutional review group said in relation to the proposal to introduce an absolute constitutional ban on abortion, they said:

> If a constitutional ban were imposed on abortion, a doctor would not appear to have any legal protection for intervention or treatment to save the life of the mother if it occasioned or resulted in termination of her pregnancy.

How do you react to that? Do we not have to give enormous weight to such a statement coming from a major academic group who have examined this issue very carefully?

Professor Binchy: You are right in what you say of course, but I think there's a world of difference – and this is said with no disrespect to the constitutional review committee, which was reviewing as many articles as there are in the Constitution, 50 or 60, something in that region ... and this particular committee, which is focused on one very specific issue and which has had the opportunity of receiving – and this is crucial in this area – detailed evidence of submission from those who are actually in the business of providing medical treatment and that's the crucial element. I think what was wrong with the X decision was that the court in that case did not receive medical evidence at all, but, if one were to criticise the constitutional review committee, or at least depart from its recommendations, that committee did not receive, as I understand it, very detailed, comprehensive submissions and evidence such as you have received. And if you don't receive that type of evidence it is terribly easy to fall into the kind of trap that the court did, which is to not make the kind of crucial distinction it is necessary to make between, as I say, direct targeting of the unborn and the provision of medical treatment. When you phrased your question initially you said: 'You, the pro-life campaign, are in favour of an absolute ban on abortion.' The word 'absolute' there I find a little bit scary as it seems to suggest...what about all those kinds of conditions that can affect women during pregnancy? Well, we are in favour of an absolute ban on abortion in the sense of direct targeting of the child, but we're equally in favour of absolute medical treatment being given – absolutely full medical treatment being given to the mother in those circumstances. I have a number of criticisms of the analysis as well as the recommendations of the constitutional

review group you are talking about there, its recommendations in this area, but I think the simplest explanation for the error made, and the error is visible not so much in the recommendation as in the analysis, the error by omission, that's visible in the analysis, is that the working party made no, gave no evidence whatsoever that it was aware of the crucial distinction between medical treatment and direct targeting of the unborn. If one is not aware of that, one is definitely going to come to the wrong conclusion.

Deputy J. O'Keeffe: Of course, in relation to the wording, 'absolute constitutional ban on abortion', I am merely quoting option one, which is the one you say ....

Professor Binchy: Yes.

Deputy J. O'Keeffe: Those are not my words.

Professor Binchy: I appreciate that.

Deputy J. O'Keeffe: If you say that the group was in error in coming to that conclusion because of lack of medical evidence, you're aware that we had a lot of medical evidence here and I'm referring in particular to the evidence of the three Masters of the maternity hospitals, which was very compelling and which, in effect, the conclusion appeared to be again that an absolute constitutional ban on abortion would not be acceptable to them because of the danger that it might inhibit or restrict ordinary medical or therapeutic practice in so far as saving the life of the mother was concerned.

Professor Binchy: Deputy McManus made that point, and the extent to which any doctor would have that misapprehension, all the committee can do in those circumstances is make it absolutely plain that the proposal – the option one proposal – is not intended to have such an effect and does not have such an effect. In fact, on the contrary, it is designed to support existing medical practices rather than to change them and if the doctor's concerned about that, all one can do in those circumstances is to make it quite plain that the whole purpose of the exercise is to give the protection rather than to take it away.

Deputy J. O'Keeffe: Then if we go back to the word 'absolute', effectively you're agreeing and accepting then that it shouldn't be absolute.

Professor Binchy: No.

Ms Simons: It is a question of how you characterise what the doctors are doing. Each of the doctors is terribly careful to say that they didn't really know what you were to classify what they were doing as. What was abundantly clear was that what we do in this country is for very many of the complicated conditions you have been told about in some detail. In other jurisdictions, doctors take the easier option. They terminate first and treat second because it is inconvenient and far more difficult to look after two patients than it is clearly to look after one. Notwithstanding that they do that, their maternal mortality rates, for instance, in England and Wales, are double what they are here, even though we don't have abortion in the accepted sense of that word.

So, what you have to look to is .... Everywhere in the Green Paper, and this is where I found it rather odd, they couldn't find any Irish literature to support the hypothesis that abortion was necessary to save women's lives. In fact, in the immediate aftermath of the 1992 referendum in the last set of guidelines that the Irish Medical Council had, they invited all and sundry, anybody with an interest or expertise, whatever, to make ... to give information to them on the necessity of abortion in this context, and they were not persuaded. They said the necessity for abortion remains to be proven. Given that that's the case, for some reason we're .... The Green Paper then turns to jurisdictions where there is already a culture of abortion and where abortion has been accepted as a legitimate part of medical treatment, and by abortion I mean the terminating of the foetal life, not the pregnancy, prior to treatment or in conjunction with treatment.

What we are talking about in the Irish context in each of the disparate conditions that you have dealt with are perhaps the premature delivery of a child and every effort that can be made, if any effort can be made, to then support the life of that foetus, that baby, once it's born, will be made. That is a very different thing from extinguishing the life first and then treating the mother. That is the fundamental distinction of what the Irish doctors do.

Deputy J. O'Keeffe Could I go back to the medical evidence that we did have, and we had a lot of it here?

Ms Simons: I know.

Deputy J. O'Keeffe: The evidence is that on rare but regular occasions it is necessary to terminate the pregnancy ....

Ms Simons: The pregnancy, yes.

Deputy J. O'Keeffe .... to save the life of the mother.

Ms Simons: Yes.

Deputy J. O'Keeffe: You accept that that's ....

Ms Simons: I do ....

Dr Kiely: Could I make a simple point there too? Remember, usually very often the indication for the termination of the pregnancy is a foetal indication. I think, somehow, the impression has been created that you have a sick mother and a well child in the uterus. The reality of the situation is that the health of the baby is largely determined by the health of the mother and that the baby does not have the option of living if the mother dies. Those situations which cause the illness, the baby is also affected by the maternal illness. Very often in practice, a doctor is left with a situation where they have a very ill pregnant woman and, consequently also, an ill child *in utero*. They find themselves in a situation where, having used all possible treatments, the situation is not coming under control and now they are left with the only option left to them for both the mother and the baby is to terminate the pregnancy and giving the baby in consequence the best possible chance of survival.

Deputy J. O'Keeffe Forgive my lack of medical knowledge but, if the baby *in utero* clearly isn't viable, and yet if the medical intervention involves the termination, abortion, ending ....

Dr Kiely: Inducing delivery.

Deputy J. O'Keeffe Yes, that unborn baby in that situation can't live.

Dr Kiely: Let me put it this way. It is rarely that absolute.

Deputy J. O'Keeffe I know, but they did say there were rare situations where they're confronted with that situation and, in that situation, they say they have only one option and that is ....

Dr Kiely: Deliver, and it is the only option for either. The baby may not survive. I've certainly been in situations where I've been called as a paediatrician to the delivery suite and the obstetrician says: 'Look, there's really no chance for this baby. It's too ill, but just in case, we want you there and we want ....'

Deputy J. O'Keeffe: Can I just put one last one on that point because I see we have a vote over in the House we have to get to? The review group also said to ban abortion *simpliciter* could thus criminalise medical intervention or treatment necessary to protect the life of the mother if such intervention or treatment required or occasioned the termination of her pregnancy. Would that not be what they're referring to?

Professor Binchy: That sentence, I think, reveals the misunderstanding on which the recommendation is based.

Deputy J. O'Keeffe: You'd see that as an error?

Professor Binchy: Totally.

Ms Simons: The bottom line now is – I know you're hurrying to go to a vote – but the bottom line, even taking the case of pre-eclampsia, we are talking about possible pre-viability. A woman is in a situation where, because they have now discovered some reaction in her to a protein in the partner's sperm, there is a creation being conditioned in her body which is inimical to the life of the baby, indeed, inimical to her own life. If she is left in this condition, there is organ failure, kidneys will stop, everything stops, she dies, the baby will die too.

This is what brought me into this debate and I have said continuously in public fora I would not be involved in this were I convinced that there was even one situation in which the termination of the foetus's life was necessary to save the life of the mother. The situation which I found myself at death's door necessitated the delivery of the child. In my situation, happily after many months in hospital, that child came home. In some situations, the child doesn't survive and we know that. The fundamental bottom line in all this which is common to all of the doctors who are talking about current medical practice being supported and who wish that is what they are dealing with is perhaps the early delivery and perhaps pre-viability. They are not talking about going in and doing a procedure which involves terminating the foetal life. They are talking about delivering it, and it may that you can help it survive, it may be that you cannot.

Deputy J. O'Keeffe We're back into definitions again.

Ms Simons: It's terribly important that we understand what we're talking about.

Chairman: I have to suspend the session because we have to respect the plenary assembly.

Deputy J. O'Keeffe: Our life won't be worth living.

Chairman: Can you wait for us?

Ms Simons: Yes.

SITTING SUSPENDED AT 10.46 AM AND RESUMED AT 11.03 AM.

Chairman: We will resume in public session.

Deputy J. O'Keeffe: Could I switch my focus to Dr Kiely because some of the things you were saying were music to my ears in terms of the need to focus on the actuality of abortion – the 6,000 Irish women who are having abortions. The figure is about 100,000 overall since the English Act came into operation. Without being in any way critical of those who focus on the theoretical or the constitutional side, would you think that, because of that heavy emphasis and that focus, the kind of issues you are talking about – the social context of abortion and what we should be doing to prevent or discourage abortion – is not getting enough emphasis?

Dr Kiely: All I can offer is an opinion. I would not actually link the two in that way. There is value in having clear protections for the unborn in our laws. Not even thinking in terms of the law as a means of.... I am not thinking in terms of enforcing the law, but the educational value the law has. If we as a country state that the unborn is of equal importance to the born, that we treat all human beings equally and give them all the same rights and whatever, that has a powerful value in helping people and teaching them to respect unborn life. If you do not have that underlying respect for unborn life it will be harder to find the commitment and the will to do all that we should and could be doing to help women who find themselves with an unwanted pregnancy. If, in contrast, we consider the unborn to be not particularly valuable, then I would worry that we don't give enough importance to the problem.

Deputy J. O'Keeffe: I would not want to force you into defending the debate about the Constitution because I accept that is an important aspect of our discussion. My concern is that, in relation to the points you raised, because of the major focus, and in some instances the total focus, on the constitutional aspect, the other issues are hardly debated at all. Do you agree there are real, serious issues to be debated there, some of which are controversial, but which there would be great merit in having teased out from the point of view of the kind of education we should be having in our schools, the kind of contraceptive availability, or whether we should have more – there is a real controversy about the availability of and access to contraception – the issue of counselling, the issues of adoption that you mentioned?

Perhaps I will phrase the question differently. Would you agree there should be a lot more debate on those issues and that, generally, there should be many more resources made available by the State and otherwise from the point of view of the prevention of or attempts to prevent crisis pregnancies and, indeed, from the point of view of giving assistance to the 100,000 women who have had an abortion – from the point of view of counselling and otherwise?

Dr Kiely: I can only agree wholeheartedly with what you are saying.

Deputy J. O'Keeffe: There is disagreement on what is the best approach.

Dr Kiely: The best way of doing it – agreed.

Deputy J. O'Keeffe: We should be teasing out those disagreements and putting together a major package of resources. Would you accept that?

Dr Kiely: I would. There is disagreement but there are huge areas of agreement. If we focus on that and move with it and continually research and update what we are doing, we cannot ever again, if we have ever done it, sit back and say we have dealt with that problem and let us forget about it. We cannot afford to do that. It is too important. Even in terms of some of the issues you raised in terms of sex education, particularly in relation to teenagers, that has to be a huge concern. We are not yet seeing anything like the problems they are seeing in the UK in terms of teenage sexuality. It is an issue that we have almost been able to ignore or we have not been forced to pay too much attention to it. However, we have to presume that it will become a much bigger issue for us as our society moves in line with the way the US and UK have gone.

There are all sorts of health issues allied to this, not directly related to pregnancy but in other areas of health and subsequent fertility, sexually transmitted diseases – all of these sorts of things. They need a lot of input and a lot of resources and everyone would be supportive of that.

Ms Simons: I was interested to see the committee looking to other jurisdictions to see what the experience was there. Deputy McGennis suggested we were all going to go to Holland or whatever. I wondered if the committee had looked at the statistics from Poland, for instance, which made me very interested. In 1960, there were 669,485 births and 150,418 abortions in Poland. In 1997, there were 412,635 births and 3,171 abortions. There has been a huge decline in the number of abortions in Poland. I will not go through the list but if you want information on this we have it. A more restrictive abortion law was introduced in 1993 than had hitherto operated but even before that the rate went from 150,418 abortions in 1960 and you get to 1992 and they are already down to 11,640. We are now down to 3,171, and the doctors there have said that the decline began with the education of what abortion involved. This decline started long before the 1993 Act was enacted. I would like ... You have heard from other people – I know, I watched the video of Breda O'Brien's evidence to you last night and I know that she talked to you about the difficulty in relation to looking at Dutch figures because they are not all inclusive. The figures here are, and it's just ... there's a dramatic decline and you must ask why, and I think education has got an awful lot to do with it, and the type of education that you give people.

Deputy J. O'Keeffe: Without getting into the area of figures and statistics – and the old saying of lies, damned lies and statistics has some relevance in that I understand all figures are higher from the point of view of abortion than the Dutch figures where there's a liberal abortion regime. On the other hand people say that certain things are not counted there ....

Ms Simons: Yes.

Deputy J. O'Keeffe: .... and therefore that would change, but ....

Ms Simons: There is a difficulty in that they do not include the hospital figures – they include private clinic figures. Nor do they include the very popular early menstrual extraction.

Deputy J. O'Keeffe: Essentially we have agreement that there should be a major focus and resources put into the question of education and adoption and counselling and so on. Would you include counselling and care for the 100,000 who have had abortions? Would you include that?

Ms Simons: Yes.

Deputy J. O'Keeffe: You would be quite prepared to agree with that.

Dr Kiely: Oh, I think so. It's one of the issues that, I think, we always have to keep in mind in talking about this issue and in the manner in which we talk about it.

Deputy J. O'Keeffe: Okay.

Dr Kiely: There are so many people out there who have been touched in one way or another by abortion and still probably bear sometimes very deeply hidden scars, but nonetheless very real, and that's an issue that ought to have resources.

Ms Simons: We in fact did not do all we could have done before. I think there's a lot more knowledge now and an awful lot more research has been done, even by people who perhaps are coming before this committee. Given the state of knowledge, we must accept everything that you've said and I am delighted to see that there is ... that the impression I get from the committee is that there may very well be recommendations that further funding and resources be put to this issue. We would like to see that; we would support it.

Professor Binchy: There are other practical things which the Trinity study identified which are very easy to deliver on in terms of crisis pregnancies, housing and the interruption of education – those are concerns that can, at relatively small sums of money, have hugely transformative effects.

Deputy McGennis: With all the confusion, hopefully the one thing that there's total agreement on is that existing medical practice should not be compromised. Now, that may not have been a position not so many years ago. I think there was a perception that certain groups held the view that the child's life was paramount and whatever, you know, needed to be done to save the child's ... Maybe that's a long way back, but anyway, I suppose if we have agreement on anything maybe that's the area of agreement we have.

You mentioned – at least Deputy O'Keeffe did – the constitutional review group's recommendations – the previous recommendations. I think you, Professor Binchy, stated that the error they made was that they probably didn't go about their job or work as we have done in terms of inviting submissions, meeting the people who have expertise and knowledge and who are working in this area every day. The only point I would make to you is if you look at the evidence from the three masters of the major maternity hospitals, in fact that doesn't support your view because they are concerned – they are very, very concerned – that an absolute constitutional ban on abortion would compromise existing medical practice. So I would have a concern that what you've identified as a shortcoming is actually becoming part of the case that's being made to us in terms of not going the route of option one.

I have only two other points to make. We had witnesses in, recently who mentioned the 1983 referendum and they said they predicted that if the wording of the 1983 referendum went ahead they could predict the outcome of the X case. I don't know whether they could or not, but they said they could. If we were to go on the evidence which we have had so far and if we were to go about the 16th – I presume if it is the 16th – amendment to the Constitution – no, it would be more at this stage – to go for the absolute constitutional ban on abortion we might find ourselves, or is there a possibility that we might find ourselves in the exact same position, that there would be a challenge to procedures – medical procedures – brought by somebody ... by people who may have given evidence to this committee already saying we believe that is abortion therefore it is not permissible.

The third part of my question is, we have had a lot of discussion, debate and comment about the X case and I'd like you to expand just a wee bit on your view as to what we would need ... what you would see the State needs to do in order to roll back the decision of the X case. Now when I say that, I mean specifically to address the case and not the legalities of it. I mean, the case was a young woman, a very young teenager who was raped and who sought to go to Britain for an abortion and because of our laws she was prohibited. So when you address the rolling back of the X case I want you to tell me exactly what that would mean. Now, you've told us what you're concerns are in terms of the X case as the judgment stands in that it permits or possibly can permit, you know, very liberal abortion, and I think that's probably acknowledged. But I want you to tell me what it would mean in that case. I know we have since then changed the Constitution. Therefore, we allow information and travel, but if you take us back to that point – and I think Deputy McManus referred to it – during the 15th amendment to the Constitution which was rejected by the people because there was outrage that this State would stop a young girl in those circumstances from having a termination. So I think – just if you'd look at it in its social context.

Just a follow on point to Deputy McManus, and that was the definition of the unborn. You did – you answered her question. Can I just ask you in the context of what we are talking about in terms of the constitutional ban, etc., what would be your position in relation to the morning after pill? Would you prohibit it or would you say that it should be permitted?

Chairman: While you reflect on those questions, Deputy McGennis, a vote was being called. What I am proposing to do, because there are two Senators present and there isn't a Chair or a Vice-Chair, I am going to apply a principle in the guide to procedure and practice that I am obliged by another commitment to be absent from this meeting for a time. Is there any objection to me nominating Senator Dardis to take the Chair?

Deputy McGennis: No.

Chairman: I will do that and the Senators can question the members present until we return. The session will be suspended because there are certain questions I want to put myself, so if the Senators conclude they will suspend the session and I will come back and put the questions.

Professor Binchy: A number of points were raised there. The ones that I think we'll give an immediate response to ... The 1992 referendum on the substantive issue of abortion – I would have to say I would disagree very definitely with what the Senator's interpretation of that amendment and its outcome was. We don't know the reasons, necessarily, why people voted in the manner in which they did, but if one looks at the poll that took place, the context in which the referendum was put to the people, I would be confident, and I think that most dispassionate commentators would be confident too, that the reason why that amendment was defeated was not that people wanted more abortion, but rather that they wanted a complete prohibition on abortion. I've not the slightest doubt that that is so. Undoubtedly a number of people would have been intimidated, perhaps, by the Government's strategy of the day into voting 'yes' on the basis that there was a promise of immediate legislation if

they were to vote 'no' to that particular referendum. So undoubtedly the 'yes' vote of 40% contained a number of definitely anti-abortion people who were concerned that if they didn't vote 'yes' they were going to get even more abortion. The 'no' camp, it is true to say, would have had two elements in it, the kind of element that the Senator mentioned, which would have been people who wanted wide-ranging abortion – legalised abortion – but undoubtedly it contained a very substantial number of people who were voting against it because they did not want any legalised abortion. I think if there was any doubt on that one only has to look at the polls consistently from 1992 onwards and in that particular context poll after poll on a consistent basis, as recently as just last month, has shown a substantial majority of the community against legalised abortion in all circumstances, in favour of a constitutional referendum. These are polls that are taken, not by campaigning organisations, but rather by the professionals in the area.

Again, I would have to disagree with the Senator's concerns based on what the masters mentioned, just reiterating what I said there. The masters are anxious, and understandably anxious, that existing medical practice should not be rolled back on and that the law should not intrude in areas where it does not at present intrude, and we in the pro-life campaign would agree entirely with that particular matter. The only basis on which any concern could be expressed there, is on the basis of a misunderstanding of what the intention of the pro-life campaign is in this area, and as I say to some degree attributable perhaps to the manner in which the word 'abortion' is used in medical parlance, which doesn't even profess, and understandably doesn't even profess, to have a legal connotation. It has this wide meaning of premature delivery.

The Whitaker committee, doing an excellent job on the Constitution as a whole, did not as I understand it receive detailed medical evidence and one only has to read the very short analysis of a couple of pages on Article 40.3.3 to realise that underlying the analysis is a misapprehension about the crucial distinction between targeting the child and directly and intentionally killing the child which we would argue is unjust and giving necessary medical treatment to the mother even though it may impact on the child detrimentally or even fatally, which we, the doctors and everybody say, is something which should be necessarily given.

What else is on the list? The morning-after pill is covered by existing legislation and we are happy with the legislation which exists. We are not seeking to change practices in this area. All we are seeking to do in this area, legally speaking, is to reiterate the existing legal situation.

Ms Simons: We support the Medical Council on that issue which was dealt with in a very detailed way by Dr Kiely.

Professor Binchy: On the facts of the X case and what was wrong with it, the X case was undoubtedly a tragic and heartrending case. At the end of the day, the pro-life campaign would argue that rape is not a ground for directly killing the unborn child. The unborn child is an innocent victim and the rape victim is an innocent victim. We have two innocent victims in these circumstances and it is society's obligation to provide maximum support for the mother in these circumstances. It is a bad idea and it is unjust to target the unborn child and terminate the life of the unborn child in these circumstances. The principle of equality we would suggest ensures in these circumstances that the unborn's life should be protected and that full protection should be given – practical, psychological, medical, economic, social protection – to the mother in these circumstances. We would certainly argue that in these circumstances the unborn child, being innocent, is not entitled to have its life directly terminated.

Senator O'Meara: I welcome the group and thank you for your submission and for the excellent work you have been conducting. One cannot but admire Professor Binchy's dedication to this issue and the erudite light he casts on it. We are lay people and I certainly feel inadequate in many ways in dealing with the legal issues. We are here as representatives of the people with a mandate and have, as you know from reviewing the representations, heard a good deal of wide ranging information, particularly from the medical side. I'll come to that in a moment but I want to zero in on the X case for a moment.

You said, quite rightly in my opinion, that the vast majority of the people in this country are not in favour of introducing legalised abortion. I think we all know, as public representatives, that that is the case. Indeed, I haven't heard from your side of the table any demand for the introduction of freely available legalised abortion in this country. While the majority of people are not in favour of the introduction of legalised abortion in this country – Deputy McGuinness referred to the X case – there is no doubt that at the time of the X case and, indeed, also at the time of the C case I think from the details that emerged in the media, there was a huge public reaction to the notion that the State would force a child, in effect, to conduct a pregnancy ... to go through a pregnancy so much against her will in the circumstances of rape.

You say that rape is not a ground for the killing of the unborn child, you talk about the economic, social, financial and other supports the State should put in place. The fact is we, in effect, don't. There will always be hard cases. We can argue, I think quite reasonably, that the circumstances surrounding the X case are rare – one would hope that they are in that an under-age child finds herself pregnant as a result of a rape, one would hope that there is not a widespread incidence of that throughout the country. The fact of the matter is that when we put together laws – as you yourself Professor Binchy know right well – we have to legislate, in effect, for the hard cases too. So, you know, what you are in effect saying is that the State and all its institutions and all its structures should be preventing in a case like this – the hard case – a child who has been raped and is pregnant as a result, and suicidal as we were told at the time, from leaving the country to have an abortion. Put like that, it is a cruel, inhumane and horrendous situation and one to which the public reacted very strongly. You might recall *The Irish Times* cartoon at the time, the notion of internment with this child figure holding a teddy bear being prevented from leaving a country surrounded by barbed wire. That was a horrendous notion and one which really produced a very negative reaction in the body politic and the population as a whole.

What do we do? Clearly, we don't want legalised abortion. You're saying that rape is not a good ground for

killing an unborn child, a view with which a very large section of the population would agree, but if you don't legislate for the hard cases, you are in effect saying that the State and all its institutions should prevent a child basically from terminating pregnancy in a situation like that. Isn't that what you're saying?

Professor Binchy: I agree with your proposition entirely that one should legislate for hard cases but the question is how one should legislate for hard cases.

Senator O'Meara: Precisely, that is our dilemma.

Professor Binchy: I would suggest really that it's through the hard cases that society's principles of justice and practical humanitarianism have an opportunity to come to fruition. You said yourself that we don't do what we should do on the social and economic side. The logic of that is not that we should continue not to do those things and terminate the life of the unborn rather that we should start doing them or in certain cases develop what we are doing in that area. Some things are done, it's fair to say, on the social side and, undoubtedly, on the psychiatric side. It's not as if there is a complete deficit of support there but they could undoubtedly be improved.

It's not just a question of narrow legalism and abstract principle, unconnected with humanitarianism. Humanitarianism and a humanitarian society, in my judgment, gain their strength from confronting the hard cases and doing the right thing rather than the wrong thing in those hard cases. If one excludes the option of the easy but ultimately unjust solution in those circumstances, an obligation falls on the society to make a greater effort. We do know in the medical context, which is not the context you're speaking in but which is a more measurable context it's fair to say, where the option of abortion – which to some extent is the easy option and an option which is easily resorted to in other jurisdictions – is taken away, in those circumstances, measurably a greater effort is made for the protection of the life of both the mother and the child in those circumstances and the outcome for the child, as well as for the mother, is measurably and empirically better.

Now, in the context, of a rape victim, at the end of the day, it is unjust to terminate an innocent unborn child in that rape victim's body. It is unjust and what one does in those circumstances, in those hard cases, is provide as much support as possible. There are other situations dealing with exclusively born people – you don't need me to tell you – in the context of people who may be caring for elderly relations, Alzheimer patients, young children who are sick or disabled in some way in the home of their parents and we know at an instinctive level that we don't propose terminating the lives of these born children even though they are tremendously demanding and lay incredibly heavy demands of an interpersonal nature. So, when you're dealing with a situation which is one of these very hard cases, the best approach I think is to adhere to justice but to follow the consequences of adhering to justice, which is to provide the necessary humanitarian support. If ever we were to claim we don't have the resources, that excuse is gone now. We certainly do have the resources at this stage to provide the necessary infrastructure.

It is a hard case, I accept what you're saying but I think one has to be faithful to principles of treating all human beings fairly in these circumstances. The idea of terminating a life is a fairly significant injustice.

Senator Dardis: I'd like to thank the pro-life campaign for clarifying a lot of issues for us and for the way you've approached this subject. I don't want to go back over ground which has already been covered but there are a few things I wasn't clear about and clarification would be useful.

Your submission referred to the valuing of all human life and the option or the need for a constitutional referendum. When you were talking to us, you spoke about that dimension and also legislation. So it is to clarify the degree to which you think legislative back-up is required on foot of the referendum.

Professor Binchy: I am personally of the view that the kind of legal change that is necessary at constitutional level could be done in such a manner as to not require legislation. In other words, I do not think that legislation is necessary in these circumstances if the principles are soundly and clearly articulated, that everybody knows where they're standing in terms of existing medical practice. Truthfully, that should be the clarification that is necessary and one would not need legislation, but I think it's important for the pro-life campaign to make it clear that it is not fixated with any wording in this area or any strategy. We're not in any sense saying to the legislative side of Government that you must do it in this way and that we say this is the only way. There are a variety of ways of doing it. One option is not available – I wish it were – which is legislation alone, because legislation alone has to be in consistency with the X decision. Unfortunately, the X decision does allow for the direct targeting of the unborn and the direct termination of the unborn's life, and that is unjust, we argue, and not acceptable. So any legislation simply has to be in consistency with the X decision and, therefore, will not be enough.

A constitutional change in conjunction with legislation, fine, we have absolutely no problem with that. Constitutional change in conjunction with the legislative facility, in other words, giving a facility for legislation with the guidelines clearly spelt out, we have no problem with that either. You asked me do I think that legislation is absolutely necessary. I don't, I think that if the principles are stated unambiguously, it can be done at a constitutional level. We have no problem whatsoever with legislation in conjunction with that constitutional clarification.

Senator Dardis: There is a related question. In one of your appendices you look at the review group's proposals. Proposal C relates to reverting to the pre-1983 situation. I appreciate your position on that but you state that without the constitutional protection for unborn life throughout the eighties, the situation in Ireland might now be very different. Medical experts might say that it mightn't be very different. I would like you to elaborate on that.

Professor Binchy: Legally speaking ... a lot of people said in 1983 when internationally attitudes to abortion weren't perhaps as starkly developed as they are today that there was no need for the 1983 amendment because

the Constitution would probably provide enough protection already. There had been a couple of dicta by a couple of judges which indicated that might be so, not focused on any particular provision in the Constitution, but they were what could be called pro-life noises by a couple of those judges. However, I think it should have been clear then, and it's clear now in retrospect, that without the change made in 1983, having regard to the development of constitutional analysis specifically in the context of privacy, the constitutional right to privacy, I think it would be fair to say now that what you would have had if the courts were to address that issue, let us say now, without the 1983 changes that were made, on the one hand, if you like on the side of the protection of the unborn, you have a constitutional series of provisions which specifically limit their protection to citizens, and unborn children are not citizens, citizenship happens at birth, not pre-birth. The first problem is that the actual literal words of the Constitution professedly don't go as far as providing protection to the unborn. That's one major problem.

On the other side of the fence, there is a panoply of rights that have been recognised internationally, and specifically in the Irish Constitution, beginning, of course, with the right to life on the part of the citizen, right to bodily integrity, health, freedom of association, privacy, dignity and autonomy. These rights have been developed very much, especially in the last five years or so. In the ward of court case, a number of these individuated rights have been developed and articulated by the court. In those circumstances, where you have no specific protection given to the unborn, at best a kind of shadow analogy with the born in terms of the protection that might be given, and that's even generous, and, on the other hand, a series of very specific rights, all of which would have an impact in the context of the decision to have an abortion. I would have thought that the Constitution would be a very frightening place in respect of protection for the unborn. So the 1983 amendment, I think, was undoubtedly wise in seeking to address that issue at that time. It is unfortunate that it was interpreted by the Supreme Court as providing for direct killing, which clearly was not the intention at the time.

Without the 1983 amendment, one would have a very radical situation of the absence of any overt protection for the unborn and a very wide-ranging series of what could be called constitutional protection for the decision in favour of abortion.

Senator Dardis: I have a final question. In terms of the professional psychological and psychiatric evidence we have heard, that would be from a perspective of saying that – leaving aside completely the X case, just on a medical basis – that's just as real as a physical threat from heart disease and so on. If you accept that it is as real, of course, it leads to the consequence that it would be a direct interference or that the so-called indirect effect would not operate. First of all, would it be right to accept that suicide is just as real and, second, if it is, what consequences flow from that?

Dr Kiely: One of the problems is that obviously somebody who actually commits suicide, that is as real as somebody who dies of any other condition. So in that sense it is real. I think you had a submission from Dr John Sheehan. He made the very interesting and practical point from the point of view of psychiatrists of the extreme difficulty there is in actually predicting suicide. You are not really in such a difficult area in almost any other condition. If you're talking about somebody who has liver failure, kidney failure, heart disease or whatever, you can, with some greater degree of accuracy, predict what the likely outcome is going to be. You have a very particular difficulty in relation to suicide, that is, it is notoriously difficult, in fact, you could say, impossible to predict with any degree of certainty whether or not somebody is going to commit suicide.

Senator Dardis: That point was made.

Dr Kiely: Therefore, you don't have any actual empirical evidence to back up that particular course of treatment. What should be clear to everybody is that anybody who is deemed to be suicidal should be given the best possible psychiatric care available, whether or not they're pregnant. The fact that they're pregnant should be incidental in that sense. There is no textbook of psychiatry anywhere that I have been able to find which would propose abortion as a useful way of treating a suicidal tendency. There is also the very worrying evidence, particularly there was the report from Finland a couple of years ago, reported in the British Journal of Medicine, which strongly suggests that abortion is a risk factor for suicide. In that situation, you are allowing something which may of itself in fact compound the suicidal risk. When you look at the consequences of abortion for the woman, when you look at who are the people who are statistically more likely to suffer adverse consequences of abortion, those who are psychiatrically disturbed are high on the list of those likely to suffer long-term consequences. So in reality, you have many factors there suggesting that, leaving aside the ethical considerations, on purely medical grounds, abortion is a very bad way of managing somebody's suicidal tendencies.

Senator O'Dowd: I listened carefully to your opening remarks and I am very impressed by the points raised. The difficulty is that if we were all in favour of the last amendment to the Constitution and yet we ended up in such a mess as a result of it, how can we be sure that if we go down the amendment route, we won't end up in a worse situation and that issues such as the morning after pill and so on may be outside the law? What view do you have on that?

Professor Binchy: I am not in any sense passing the awesome responsibility back to you, but it is obviously the task and challenge for those legislating in this area in terms of producing an amendment rather than specifically just legislation to deal with these matters in a manner that clarifies the situation and resolves the matter beyond debate. What was done in 1983 was the articulation of an absolutely fine principle in the confident expectation that that principle would translate, on the basis of proper medical evidence in those circumstances, into a correct application. What's good about the 1983 amendment is the recognition of the equality of the right to life between the mother and the child, that both are members of the human community and that both have an equal right to

life, in conjunction with the requirement of practicability, which is exactly what one would look for in these circumstances. The principle in 1983 was stated entirely correctly. It fell down in the context of the X decision, obviously, which we were talking about, and the high degree of concern that surrounded that case compounded, incidentally, by the international dimension to that case and precisely what Senator O'Meara was mentioning in those circumstances.

The court, in a rush, admittedly hearing a case that had been decided in the High Court without medical evidence, came to this conclusion, incidentally on the basis of a concession by counsel for the Attorney General that the amendment did allow for legalised abortion. That was a concession made on behalf of counsel for the Attorney General in response to a question by one of the members of the court. So, they're the circumstances in which that decision happened.

One can see in retrospect why they happened, that the relevant medical evidence wasn't included and the whole culture of medical treatment wasn't given to the court at all. It's a well reported case. All the interchanges are reported and it was quite plain from the entire several days of that litigation at a Supreme Court level that none of the judges – I think one would accept Judge Hederman did have an understanding of this area – certainly none of the majority judges in that case and the counsel similarly were addressing the issues in the context of the kind of information that you have.

We're now eight years on. You have a huge fund of information in this particular area. You know what you're about and it is the legislative task in this area when producing an amendment to produce the degree of clarification that will ensure that the kind of concerns you have will not occur. Is that difficult to do? I would respectfully suggest, no. Similar types of things have happened before in constitutional history and they haven't admittedly on such controversial matters caused any particular difficulty.

For example, the whole question of the adoption process was cast under a constitutional shadow by a Supreme Court decision in which there was a question of whether the Adoption Board was engaging in the process of judicial decision making. This would have radical implications retrospectively for the adoptions that had taken place. I wonder do you remember it. It was such a remarkably unimportant event in most people's lives but an amendment was actually put to the people, the Constitution was changed in that area and the problem that arose in the Supreme Court case was resolved.

So the idea that a Supreme Court case can come up with a surprising interpretation which calls for a constitutional amendment, there are precedents in this particular area. The degree of clarification, as I say – bear in mind that the Supreme Court is seeking to do justice, that is the thing that one shouldn't forget in this area. It's not a case of the Supreme Court versus the people. You do not have a court there which is designed to subverse the democratic will. Those judges are trying to do justice in this particular area and they will take as much guidance as they can from the documents which they have ....

Senator O'Dowd: They clearly did so, theoretically, in the case of X.

Professor Binchy: Absolutely, but unfortunately they were badly served in the sense that they didn't have the relevant medical evidence, matters were being rushed and, as I say, the analysis found ....

Ms Simons: Can I just say something on that particular point? I see that you're concentrating on the X case and I'm always aware that it may seem to be arrogant on our part to be disagreeing with the Supreme Court and the way in which it made its decision. However, people on both sides of the debate, lawyers on both sides of the debate, agree that it was a bad decision for all the reasons that Professor Binchy has outlined. He's mentioned the concession that was made by counsel for the Attorney General. We've written about that in our submission also.

You might also be interested to know that if you are to look at the official Irish reports of the case and to look at the official publication, the blue book, which contained the judgment that came out immediately in the aftermath of the judgment, there is a difference. Both of the those reports are meant to be identical in every respect, but if you look at the blue book and then look at the subsequent official reporting of the case, you will see a difference even in the argument tendered by the counsel for the Attorney General to the courts on fundamental aspects of this, which is very interesting and ought to be noted. It shows confusion on counsel's part which one doesn't like to draw attention to, but it was a confused case, badly argued, and the judges themselves did not fully understand what was going on.

The bottom line is if you look at Article 40, as Professor Binchy has said, there is equality of rights to life, but there is not equality in the manner in which those rights to life may be defended or vindicated. Article 40 in its wording actually reflected medical practice and reflected the limits of human endeavour and the limits of what doctors were able to do when they said that, in relation to the right to life of the unborn, they could only defend or respect that right as far as practicable. In other words, there was an implicit acceptance that it is not always practicable and those situations in which it is not always practicable to defend and vindicate the life of the unborn have been spelt out to you by doctors over the course of the last week, with whom we are in agreement.

The difficulty, as I've said before, is how do you characterise what they are doing? There is a very big difference between not being able to defend and vindicate a right, delivering a child pre-term, and actually doing an act the sole purpose of which is to ensure the extinguishing of the life of the unborn child in the womb.

Deputy McManus: Why didn't you support the 1992 proposal on the substantive issue?

Professor Binchy: Because the 1992 one actually does allow for the direct termination of the unborn. It does allow for termination.

Dr Kiely: It does. It allows for terminating the life of the unborn, an actual act to terminate the life of the unborn. That's our difficulty with it.

Deputy McManus: Okay.

Chairman: Your submission referred to Eisenmenger's syndrome, I think. Can you draw my attention to the relevant section?

Ms Simons: It is pages 6, 8 and 9.

Deputy J. O'Keeffe: Sorry, Ms Simons, my confusion related to some degree to your reaction to the 12th amendment. It is as well if I try to clear it up. I think the question from Deputy McManus was as to how and in what respect you differed from the approach outlined in the 12th amendment. This is the amendment that was rejected by the people and seemed to be rejected by those on opposite ends of the spectrum of the debate and, therefore, was substantially defeated. The people in the middle supported it, I think, and the opposite ends rejected it.

Professor Binchy: You had a seesaw with a lot of pros on one end, a lot of no's who were objecting to any abortion in these circumstances and a lot of rather frightened yes's in the middle of the seesaw it would be fair to say.

Deputy J. O'Keeffe: It said that it shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life, not being a risk of self-destruction. So we get the suicide aspect out of the way. If we're talking about an amendment which would permit current medical practice where the life of the mother is at risk, I don't see how that amendment doesn't actually cover the situation we're talking about.

Ms Simons: I will make a preliminary comment on that and I will pass it then to both of my colleagues. The wording specifically deals with termination of the life of an unborn. Implicit in that, first, is the acceptance that it is necessary to terminate the life of an unborn child to save a mother's life.

Deputy J. O'Keeffe: That is the evidence that has been given to us.

Ms Simons: No, no. What the medical evidence to you thus far has indicated is that it may be necessary at times in certain specific conditions to terminate pregnancies, not to terminate the life of an unborn. There is a distinction.

Deputy J. O'Keeffe: What is the difference?

Ms Simons: As I've said to you, for instance – we'll come back to suicide in a second – pre-eclampsia is a situation in which I found myself. It was necessary to terminate the pregnancy, by which I mean in order to save my life it was necessary to deliver a child, which was then delivered into an incubator in a neo-natal care unit. That is very different from saying it is necessary to terminate the life of an unborn to save a mother's life. The medical evidence ... and the Medical Council has said this to you. It invited everybody to make submissions and said there was only one submission made to it that there was any medical necessity, and it did not hold up, out of the hundreds of submissions made. There has never been shown to be any medical necessity to terminate the life of an unborn to save a mother's life.

Deputy J. O'Keeffe: Could we talk about the situation where the unborn is not viable, in the womb, a life threatening situation which the doctors have told us can happen on rare occasions? A decision has to be made and the decision, regretfully, having tried all other approaches, is that – I will choose my words carefully – the pregnancy has to be terminated. If the pregnancy is terminated effectively you have an abortion which in a situation where the unviable, unborn child has no hope of viability having been delivered. That's the situation as described to us, in particular by the three masters of the hospitals. Is that not the situation that's covered by the '92 amendment which was rejected?

Dr Kiely: The problem ....

Deputy J. O'Keeffe: And if so, then the next question is if that so how in the name of goodness can we get another wording that could possibly satisfy the concerns of people? That's the core of the problem that confronts us on the constitutional side.

Dr Kiely: I will let William or Caroline deal with the legal aspects, but just briefly on the medical side of it this is precisely why the last Medical Council was more specific than ever before in its guidelines. It was dealing with this distinction and it was very clear in the fact that the deliberate and intentional killing or destruction of the unborn is professional misconduct, right? This wording allows for the deliberate and intentional killing of the unborn. That would be a reasonable interpretation of it.

Deputy J. O'Keeffe: Where necessary to save the life of the mother?

Dr Kiely: Yes, but you're talking about the means that you're choosing to use it is the destruction of the life of the unborn.

Deputy J. O'Keeffe: So it's the manner of expression rather than the intent you ....

Dr Kiely: This is open you see ....

Professor Binchy: Where it will lead to a wider range of interventions. That's where we would question ....

Dr Kiely: Yes, I think so, whereas the Medical Council goes on to state is that where the unborn may suffer damage or even death as a foreseen but unwanted side effect of treatment necessary to save the mother's life, that would not be unethical. As I was explaining to you earlier on, the reality of the situation that you are in – and it is always important to remember this – is that you are talking about situations where the typical one or the one that the masters maybe referred to was the situation of pre-eclampsia which ordinarily only occurs in the third trimester when the baby, the foetus is viable. right? But there are borderline cases where it may occur that little bit earlier where in all probability the baby is not viable. There's very little that's absolute in medicine. That's the reality.

Deputy J. O'Keeffe: I accept that.

Dr Kiely: You don't have that sort of certainty.

Deputy J. O'Keeffe: Sure.

Dr Kiely: But you are in a situation where you suspect this child is most likely not viable outside of the womb, right? But you're also in a situation where it is equally not viable within the womb. You're in a situation where in fact there is nothing you can do that is likely to save the life of this child. You still don't directly attack that life, you still don't destroy that life but you may well deliver that woman, you may well terminate the pregnancy, you may well induce delivery and at the same time – and this is a situation I have been in as I was saying already a number of times myself – you are called to the delivery suite, you're told that there's very little chance but just in case have all your equipment ready, put it all together and very occasionally you do manage to save one. That's the big difference between this situation...this is a treatment which is necessary, which is not putting the baby's life at some sort of extra risk. The risk is already there. You're doing everything you can to save both of those lives ....

Deputy J. O'Keeffe: I fully understand that.

Dr Kiely: .... but you're limited by what you can do.

Deputy J. O'Keeffe: You've got to go back. It's a question of definition and how you describe what you're doing and what now seems to be ....

Dr Kiely: .... and the deliberate ....

Deputy J. O'Keeffe: .... a virtual impossibility of getting a wording to describe such an approach satisfactorily from everybody's point of view.

Dr Kiely: The deliberate and intentional is a very important part of it. I am sure there are better legal ways of putting that but in essence that's what you're talking about.

Chairman: That's your submission.

Dr Kiely: Yes.

Chairman: There's just one or two points I wanted to raise with you. Dr Whitaker spoke to us and it was put to him that we could just devise a package of measures to reduce the rate of abortion and ignore the possible legal approaches on this question and he characterised that as an evasion of responsibility. Do you agree with that?

Professor Binchy: If I may speak on that one. Yes, we have a situation at the moment, a kind of an artificial failure on the part of implications of the X case to be worked out in practice but if the implications of the X case were worked out in practice one would have a situation which would be a source of very serious concern. If one were to present a situation, abortion is discovered as having taken place and the person who carried out the abortion says 'well I think this was a life threatening condition. What is anybody to do in those circumstances ....

Chairman: No, I appreciate that.

Professor Binchy: There is a problem, in other words, but how to act on it to lead to the ....

Chairman: Before we deal with ... I just want your confirmation on that point ....

Professor Binchy: Yes.

Chairman: .... because Dr Whitaker's point on that was – I agree with it – he says it's not acceptable to the public, it means leaving to the courts awkward decisions like the X case. The public in general was not too happy with the X case decisions and we've heard you views on that this morning. He went on to say 'I think the responsibility of the Parliament is to set the guidelines of law as clearly as they can and not to leave deliberately to the courts the settlement of a whole lot of obscurities and by Parliament here can mean ordinary legislation or legislation to amend the Constitution'. I am not prejudging that.

Professor Binchy: Yes.

Chairman: But would you agree with that general proposition?

Professor Binchy: Yes, I would.

Chairman: That we have a duty, as legislators, not to leave matters in a state of obscurity.

Professor Binchy: Yes.

Chairman: In relation to medical ethics, it is a fact that medical ethics have to be formulated in the context of the legislative arrangements that obtain in the country. Isn't that correct?

Professor Binchy: It's a sociological phenomenon that they are, but if the implication of the question that they have to be altered, in other words, that the ethical content changes by virtue of a particular legal norm that exists at the moment, no.

Chairman: No, I'm not suggesting that and I wasn't trying to insinuate that. What I was putting was that any Medical Council in this jurisdiction that has statutory responsibilities clearly formulates a guideline for the profession of ethics but that's distinct from the legal definition of the beginning and end of life. That's a separate issue which we, as legislators, have a moral responsibility to make a decision on.

Professor Binchy: Again I hope this doesn't sound as if I am misunderstanding you I would agree with you but sound a proviso. Legislation is about legislation and the function of legislation is a Legislature. Medical ethics are for doctors and that is for them to determine. I am sure there isn't but if they were to be interpreted as any suggestion that there is or could or should be a gulf between the normative content of medical ethics and the normative context of law in this area that's something that I would counsel against because the whole purpose of medical

ethics is to have principles, ultimately justice, in the relationship between the treatment of the doctor and his or her patients. The whole function of legislation and the constitutional structures of this country is to ensure in so far as practicable the protection of justice in this area. So any suggestion of a kind of gulf or divergence between medical ethics and the law in this area is something that I would counsel the committee to be very cautious of because the two should sing in harmony, frankly, because they're both seeking the same goal.

What's striking about the Medical Council and what it is to be commended for is that in respect of two controversial decisions – the X case was one, the ward of court case was another in 1995 – the Medical Council has had the courage – and it does require some degree of courage – to reiterate its medical norms in this area, the ethical principles that apply, even though that puts the findings of the Supreme Court at variance with the norms. It's courageous because it would be dreadful if medical ethics were to be seen in any way – and I know this is precisely what you're not suggesting, Chairman – but it would be in the community dreadful if medical ethics were to be seen as in any sense following on or servants of the particular positive laws of the day because that's precisely their strength that they're not or not necessarily.

The committee's function is not to set its goals modestly on the basis that it has to plough a different furrow but rather to see what underlies the Medical Council's principles of justice here. We suggest that it has got it right essentially in this area, that it does capture what Berry was mentioning there, the, I wouldn't use the word 'complexity', but the inevitable consequences of the fact that within the mother's body there is another human entity at an early development stage. That's what it's about.

Chairman: I take it that's your submission on that but still the Medical Council is established under legislation here, so their ethical system is positive law. It's not some higher norm derived from a higher consciousness or moral consciousness. It is an ethical system that is formulated by a statutory body under an Act of the Oireachtas.

Professor Binchy: But its ethical content is seeking to engage in the world of norms, of values, of justice. That is what it's addressing. It is addressing issues of justice in the doctor/patient relationship.

Chairman: But we're trying to address issues of justice on a more fundamental question, namely the constitutional and statutory provisions that apply in this ....

Professor Binchy: I would respectfully suggest that for the committee the two are pointing in the same direction, frankly, when properly understood and it would be strange if they were not. It is strange that they are not at the moment. That strangeness, I would respectfully suggest, should be removed because frankly at the end of the day doctors are trying to treat both patients in a just manner and I think the legislators are trying to do the same.

Chairman: Is it not strange that Dr Keane, who is the master of Holles Street, one of the most substantial maternity hospitals in the State – and I do not want to unfairly characterise it, but it was always an institution closely identified, broadly speaking, with a very pro-life point of view – made the following very candid comments to us here?

> In answer to your question, we, as medical practitioners in this country, are governed by the Medical Council and we do feel somewhat exposed in the field of obstetrics and gynaecology that we are not protected for these already mentioned rare cases because technically any form of termination of pregnancy or abortion is against the law of this country and, therefore, despite the serious considerations that are given to these individual cases, the technical termination of pregnancy that we occasionally and very rarely, thankfully, have to perform ... we are technically on the wrong side of law in doing so and we feel exposed in that area.
>
> The proposed amendment to the Constitution in 1992, I think, was trying to effectively tackle this situation.

In effect the master of one of the most substantial maternity hospitals in the State has said that he would have been comfortable with the 1992 wording.

Professor Binchy: The master has also put forward a proposition that any lawyer in this State will say it is misconceived.

Chairman: What is that?

Professor Binchy: The proposition that technically they were acting contrary to the law in the procedures which they carry out. That simply cannot be true. We would argue that the procedures which they carry out are entirely protected by the 1983 amendment without the X decision. If one throws into one's consideration the X decision it is absolutely incontrovertible. I would argue that one does not and that one should not have to do that. But if one does for the moment because it was decided by the Supreme Court, quite clearly the kind of procedures that Dr Keane is talking about in those circumstances are emphatically protected by the law. There is no question that they are not. We would argue that they are protected under the basis of the treatment model which we have presented here, but the truth is I think that any lawyer would say that there is no legal concern under the existing law at all. The idea that the 1992 amendment which restricted the scope of the X decision would in some way have improved the position for masters of obstetric facilities is equally misconceived and more emphatically and obviously misconceived. The medical principles which the hospitals are working on are entirely sound but, not surprisingly, doctors' understanding of law is not necessarily their strongest suit.

Chairman: Professor Binchy, we have to give very serious weight to the opinions of the masters of the maternity hospitals.

Professor Binchy: Absolutely. Everything they say, medically speaking, you should listen to very closely and everything they say, ethically speaking, you should listen to very closely. But legal views such as the ones that you have articulated, expressed on the existing law which are I think views, and the anxieties that underlie them, that

could be put at ease by any lawyer in this country in the light of the existing legal system. I do not think it would be wise to proceed on the basis of the error that underlies them.

Chairman: If we enacted an amendment to the Offences Against the Person Act and said that, in the principal maternity hospitals in the State, consultants could carry out all necessary procedures which were essential to safeguard the life as distinct from the health of the mother. Would you object to that?

Professor Binchy: We would look at the wording. First of all, we still have the X case. Would you let us imagine that that was a constitutional amendment?

Chairman: I accept that. Aside from the X case.

Professor Binchy: The kind of wording that you are talking about is something that we would look at very closely. It is certainly something that we would look at with interest. Essentially, what we are trying to avoid is the direct targeting of the unborn. We face the reality that unborn children die and will die in circumstances as a result of the medical treatment that is given. That has always been the situation. It was the situation before 1983. The intent of the 1983 amendment was not to change it but rather to ensure that the kind of practices that took place in medical facilities would be protected. The kind of wording that you are talking about is something that we would look at.

Chairman: Leaving aside the medical ground, a lot of the argument seems to evolve around nomenclature and definitions and what people are doing, what the state of affairs is, I take it that you are opposed to all other grounds or all other indications for abortion. Sorry, the word 'other' prejudges my characterisation I gave at the start of my original argument. I mean the other option.

Professor Binchy: Yes.

Dr Kiely: There is one particular area in which we do differ from Dr Keane and I think it would be good to clarify as most of what he said would be pertinent. That was in the area of the abortion of defective unborn or where there was a significant abnormality of the foetus. I think he was making out that possibly there should be abortion available for that. We would disagree with that.

Chairman: No, in fairness to him he did not suggest that. What all the masters suggested was that in the case of one particular case ....

Dr Kiely: Anencephaly.

Chairman: .... of a lethal deformity. Yes. They were all quite unequivocal that that, in their view, was the only known medical instance of a lethal deformity. They were unhappy with the idea of extending it beyond that on the basis of any other case. I have to suspend the session.

Ms Simons: Can I make a point in relation to that? I want to deal with that point because it was very interesting in the way in which it was mentioned. There was also a slight comment in relation to spina bifida. I know from having been in the national maternity hospital ....

Chairman: I ask Senator O'Donovan to take the Chair as I have to vote.

SENATOR O'DONOVAN ASSUMED THE CHAIR AT 12.06 PM.

Ms Simons: In relation to anencephaly, I read Dr Keane's submissions to you very carefully in relation to that. I know that the practice in the maternity hospital so far has been summarised somewhat vernacularly, if that is the way to put it, to me as parents meet, greet and grieve for the baby. The babies are born normally, they come when they come and the parents are given these children. Their faces, for all intents and purposes, look normal. Unfortunately, from the forehead upwards there is no developed cell or brain at the top or back of the head. Traditionally a bonnet is put on such babies. These babies are given to the parents and they hold them. They even take photographs and the babies die.

I noted that nobody asked Dr Keane why was it preferable to do an abortion on a woman in that condition to having her go through the normal physiological process of giving birth. Nobody actually asked that question. The only doctors I have spoken to in relation to it, to whom I put Dr Keane's point, said that due to the discomfort of the mother and the fact that these pregnancies can linger on after the 40th week, maybe even to the 42nd week, there might be indication for a caesarean or whatever at 36 weeks, but nobody specifically asked Dr Keane was there any physiological advantage or whether there was a disadvantage to interrupting the normal natural process that will inevitably take place.

In case you all leave with the slight impression that maybe the 1992 wording would have done it for us I would just like to say that there is a very real difference between a wording which says that you can terminate the life of a foetus, in other words you can kill the life of the unborn, and that you can deliver, possibly pre viability, do what you can if you can do anything at all for the foetus and then let nature take its course. That is very different from directly going in and terminating the life of the unborn child. We objected to the 1992 wording because it specifically allowed direct killing of the unborn in the womb.

Dr Kiely: I would like to make a small point in relation to anencephaly and spina bifida. It is important that everybody is aware that most of these can be prevented. Our whole approach to that condition should be in preventing it. It is a simple matter of giving a woman before she becomes pregnant if possible or as soon as she becomes pregnant a small dose of folic acid. That is what is required to prevent neural tube defects. That is a public health problem which needs to be addressed much

more actively. I appreciate that it is not part of the brief of this committee. As this has come up so many times, I think it is important to emphasise that we should be preventing neural tube defects, not being concerned about whether we should terminate them or not.

Acting Chairman: I would like to sincerely thank the Pro-Life group for coming in and giving us a very detailed and informed submission. We have a difficulty with a time constraint – we must vacate this room by 2 pm and we have five more groups to meet. Your submission went on for much longer than we had planned with vote interruptions etc. On behalf of the committee and the Chairman I thank the delegation for its views which were very helpful to us. I propose we suspend the meeting until the vote is over.

SITTING SUSPENDED AT 12.09 PM AND RESUMED AT 1.08 PM.

Ms Marie Vernon and Ms Cora Sherlock

Chairman: We are now in public session and I would like to welcome the representatives of the Society for the Protection of Unborn Children, Ms Marie Vernon, secretary, and Ms Cora Sherlock.

Ms C. Sherlock: I'd like to apologise for the non-attendance of Dr Lucey. Her husband was taken ill last night and she has to be at his bedside so she sends her apologies.

Chairman: I am sorry to hear that and convey our best wishes to her on his recovery. This meeting of the Joint Committee on the Constitution received your presentation and it has been circulated to the members. It is on page 277 of the book. The format of this meeting is that you may make a brief opening statement which will be followed by a question and answer session with the members. I have to draw your attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you. I also have to advise you that I have to limit to ten minutes the amount of time available to you because of the repetitive votes in Dáil Éireann this morning. The rule and practice of the Whips is that we must attend for the votes – there is no exception for a committee in hearing.

Ms H. Vernon: We represent to Society for the Protection of Unborn Children which is the oldest pro-life organisation in the country. We were set up in 1980. At the time the women's right to choose movement was very active and we came to see that there was a great threat to the life of the unborn, we came together and formed a society. It is a single issue society with members of all faiths and none. We agree on one thing, that the deliberate destruction of the unborn child is not to be tolerated and we have taken an active part in vindicating and protecting the life of the unborn and tried to prevent women from going to England for abortions by all legal and caring methods.

Chairman: Very good. I take it you'd agree with the submission that was made here by Pro-Life earlier.

Ms Vernon: Yes, in fact we are one of the organisations that is affiliated to the pro-life campaign so we would actually agree with everything they have said.

Chairman: Right. You agree entirely with the substance of what they said in their very detailed presentation.

Ms Vernon: Absolutely. Mine pales into insignificance in comparison.

Chairman: Would you be happy to leave it at that, at this stage?

Ms Vernon: Unless the committee has any questions they would like to ask. I would also like to talk a bit about the X case, which has landed us where we are today. At the time of the X case – just a social note – the society was dealing with a girl who was pregnant as a result of a similar situation. She had gone on holidays to her uncle's farm, she was aged 14 and she was there seduced by a man who worked on the farm. She, at the same time as the X case was going on, was in exactly the same situation but her parents had a completely different reaction to her situation. The society took care of her, we found a place for her to stay and her baby was born and was adopted. That child will be eight years old now. It just shows you that there was a different way of dealing with the X case at the time.

Chairman: Was there any other point you would like to reiterate or draw our attention to?

Ms Vernon: Other than that, maybe Cora would like to speak as well. The direct intentional killing of the unborn child is never necessary in today's medical situation to save the life of the mother. The society would like to draw attention to the definition of abortion of page 279, which says that abortion, for us, is defined as the direct intentional destruction of the unborn child.

Deputy McManus: Thank you very much for being so patient. I am afraid it is very disruptive, going backwards and forwards, and we appreciate your patience and your coming here.

In terms of the points that you support that were made earlier, have you thought about any form a constitutional amendment could take that would actually meet your requirements or are you simply talking about a constitutional ban on abortion?

Ms Vernon: The wording would have to be such that would protect present measures of practice and would save the unborn child from abortion as well. I am sure, with all the legal minds we have in the country today, such a wording is not impossible to find. Something to

the effect that nothing in the Constitution would be taken as allowing for direct abortion.

Deputy McManus: You are probably aware from the presentation made by the masters that a very rare situation can occur in the area of cardiac disease, where the only treatment medically, so far anyway, is to actually abort because the medical indicators are that the actual pregnancy is causing such a response in the mother's health that she is very likely to die unless there is an abortion.

Ms Sherlock: It is important that we do not blur the distinction between what is an indirect and a direct abortion, as has happened in other countries. To me that would seem to be a fundamental starting point before we actually think about the wording. In that situation, I am not a doctor but I would be guided by the Medical Council's assurances that such a situation does not occur where a medical condition forces a woman to have an abortion. It seems to me that in other countries they have blurred the distinction and I think it is important that what we should look at is the aim and the intention. If you consider from the point of view of the mother, if she goes in and has an abortion and if she has a treatment which then results in the death of her unborn child, the effect and the psychological impact on the mother is very different. If you treat a woman for a medical condition and the unborn baby dies as a result then a live baby would be a bonus, but in the situation where she goes in purely to have the abortion, then a live baby is failure.

Deputy McManus: One last point on that. There are two difficulties I have with that. The first is that there are conditions where there is, as a side effect, the loss of the foetus to the treatment, but in this instance the treatment is to remove the foetus. My other difficulty is one that was highlighted by one of the other masters, Dr Daly, where he makes the point:

> Medical Council guidelines suggest that we cannot wilfully destroy a foetus or a baby and while none of us would wish to do that, ultimately that may be the result of what we do. I think the whole issue of intent, which is the point you are making, is an important one, in that intent can be a double edged sword. I could claim to be trying to do some heroic therapeutic intervention to a baby and inadvertently cause a miscarriage. I never intended to do it but, in essence, I should not have been doing it in the first place. I could get myself protected under the law by that.

I think his concern as a medical practitioner would be that if intent is the measure a doctor could actually be covered for malpractice because he intended to do good but actually didn't do good – he did harm. I have a difficulty about intent because the way to hell is paved with good intentions. Do you know the point? There is a problem there.

Ms Sherlock: I take your point but what we have to be guided by is the Medical Council's guidelines. I am not a doctor so I have not read the submissions of the doctor you are talking about. The Medical Council states that the direct intentional destruction of the unborn child is professional misconduct and to me that seems to be the starting point. Doctors have decided for themselves, 'This is what we consider to be professional misconduct: if you deliberately go in there and, essentially, kill the child without any thought for the treatment'. It is not as if you are intending to treat the mother. Your intention is to kill the baby.

Ms Vernon: I think the scenario you paint is rather unreal, in that early delivery of the baby is different from deliberately killing the baby. Okay, they deliver the baby and they hope that it will survive. They know maybe the chances are slim but, in fact, even a lay person can see that if you do not intervene in some way you are going to actually lose both your patients whereas if you do intervene you will at least have one and perhaps two, which is a much different thing than killing the baby because direct abortion does not cure any disease. To go in and kill the baby and remove it piecemeal, as they do in an abortion, does not cure any disease of the mother. Pre-eclampsia mostly happens at a later stage in pregnancy when the baby can be delivered early with a good chance of survival. In the earlier cases the baby is treated as a person, is afforded some dignity, may die but hopefully will not. The doctor's intention is to save both his patients. I do not know who would take a case. If the mother is going to die and the baby is going to die, who is going to take this case against the doctor because he is doing his best to save both his patients? To me, that seems to be just semantics. Who will take the case against the doctor when he is trying to save both people? I cannot understand the thinking behind that and I have heard it raised again and again. Is it the father, is it the husband? I really do not know who is going to take that case.

Chairman: I thank you for your interest and contribution. I suspend the session while we await the representatives of Youth Defence.

SITTING SUSPENDED AT 12.28 PM AND RESUMED AT 2.30 PM.

Ms Niamh Nic Mhathúna, Dr Sean Ó Domhnaill and Mr Justin Barrett

Chairman: We will now continue public session. I welcome to this meeting of the Joint Committee on the Constitution representatives of Youth Defence, Niamh Nic Mhathúna, who is the chairperson, Dr Sean Ó Domhnaill and Mr Justin Barrett. We have received your presentation. It has been tabled before the Houses of the Oireachtas.

You can find it on page 289 of the brief book and it has been circulated to the members.

The format of this meeting is that you may make a very brief opening statement if you wish, which will be followed by a question and answer session with the members. I have to draw your attention to the fact that while members of the committee have absolute privilege, this same privilege does not apply to you. Mr Barrett, I presume you will open the batting.

Mr J. Barrett: I will open. As Deputy Lenihan will be aware, the strongest defence in a libel or slander case is the truth. So in that case we are not worried particularly about privilege. The thing that I would like to bring most strongly to the committee's awareness and attention is the fact that these committee hearings do not occur in isolation from the political facts, the social facts and the legal facts which surround them. I would like to remind the committee that at the end of the day no matter what terms of reference they have been given by the Oireachtas when it comes right down to it, the State is not the master of the Irish people, the Irish people are the masters of this State.

If you were to look at the abortion debate as it has been conducted in this country over the past eight years, you could be forgiven for drawing a different conclusion beginning first of all, of course, with the X case decision and the manner in which it was handled by the then Taoiseach in receiving an unrepresentative character from a rabidly pro-abortion position while refusing to meet with any pro-life grouping whatsoever; the fact that the State, in an unprecedented way, funded a case against the Constitution, which had never been done before; the fact that the Attorney General failed to argue that the eighth amendment completely prohibited abortion; and the fact the then Government proceeded to ignore pro-life submissions at that time, proceeded onwards through the Maastricht referendum onto those November referendums, deliberately attempted to confuse the Irish people in so far as to bring one member of the Government party to describe it as a three card trick referendum – that is how strongly he felt about it.

There was an attempt to confuse people into believing that travel and information had nothing to do with abortion, even though that was the section of the Constitution in which they were put in. The substantive issue, which allowed for limited abortion was accompanied by a threat, a very direct threat by the Government at that time, that if abortion was not legalised on these grounds that it would be legalised on significantly wider grounds. This is not the kind of behaviour one would expect from a Government in a republic, but it is the kind of behaviour that we got.

The Government thereafter, with the failure of the substantive issue, did not legislate. In not legislating they, in fact, politically recognised this simple fact, that the substantive issue had been rejected by the people on the grounds that it permitted limited abortion. So when people say that both the pro-choice view and the pro-life view were both against the amendment, I think, the Government has recognised and every single party that has been in Government since then have recognised that simple fact, that the pro-choice view on this made no significant impact in that referendum. It made no significant impact on the final vote. In fact, what one had was the vast pro-life majority rejecting limited abortion and some people who had been frightened into the 'yes' camp by the threat of worse abortion, who would also have preferred an opportunity to totally prohibit abortion.

We move on from that point. The Government of the day legislated for abortion information. It legislated for abortion referral, in fact, in practice. This was occurring at the same time that pro-lifers, myself included, and various members of the Youth Defence organisation, were being arrested and thrown into Garda waiting cells for exactly handing out leaflets about abortion. The Government was co-operating with the advertising agencies for abortion at the same time as the gardaí, under Government direction under the public order Act, were arresting people for simply handing out leaflets about abortion.

The workings of this committee ... again, as I say, I would remind you, it is working under an illusion really to think to yourselves that because the terms of reference that the Oireachtas have given you are so wide that you really have that much discretion. If we understand the simple fact that the Irish people are at the end of the day the masters of the institutions of the State, then we understand that there is really only one option that this committee has before it, which is option one, to totally prohibit abortion. The terms of reference for this committee ought rather to have been to give the Irish people in law what they want in fact. It was really only the matter of the details of how we totally prohibit abortion that is before this committee, whatever they might believe.

The X case decision itself is profoundly flawed. We had Dr Anthony Clare go so far as to say that the Supreme Court knew this fact, they knew it, but that they wanted to give a right to abortion on the grounds of rape and incest and since they couldn't do so under Article 40.3.3°, as it reads, they had subverted the Constitution essentially and delivered a verdict on grounds of suicide on very poor evidence. We have had Members of the Oireachtas sit quietly to listen to how the Supreme Court had subverted the Constitution. You will be aware, of course, that it is the duty of the Oireachtas in cases where the courts are guilty of stated misbehaviour that the Supreme Court is subject to impeachment at that stage. If the committee members believe ....

Chairman: Sorry, I have to stop you there. I am not aware of any information that was brought to our attention in the course of these hearings that would warrant the impeachment or raise the question or the incapacity or unjudicial conduct on the part of members of the Supreme Court, so I would prefer if we passed on from that.

Mr Barrett: Well, it remains simply a fact, whether we pass on from it or not.

Chairman: No, I'm sorry, excuse me. This is a committee of the national Parliament.

Mr Barrett: Of course.

Chairman: The national Parliament is elected by the people you referred to, and I am the chairman of this committee. You either accept my rulings on a point and pass on from it or you don't.

Mr Barrett: Of course. As I say, I would simply remind the committee that it is, as you say, the Irish people at the end of the day, who have the right to make the final decision in this case. While it may not be possible in the time available to us to go entirely through all the transcripts and every single word that is in them, I would remind the committee that law does not make for right. You will understand that the Hague Convention is currently hearing war crime trials concerning legal activities, if you like, under the Governments in those areas, in that place. So there is a legal precedent for a situation, whereby if this committee's decision or if this Government's decision is to finally legalise abortion, it is not beyond the bounds of possibility and it's certainly within the frame of what we would think would be likely that you may have a legal situation whereby abortion is in practice for 20 to 30 years, but at the end of that time – I would caution people to remember this – it is quite within the remit of a Government, which would follow that, to bring before the courts on a charge of a crime against humanity any person who actively conspired for the purposes of the murder of human beings, which is essentially what abortion is. I will deal with any questions now.

Chairman: I just want to clarify the ruling I made in relation to the Supreme Court. There is no objection, indeed, full and fair criticism of court decisions is permitted in the Oireachtas. What was not permitted was an allegation that judges behaved improperly in office without any evidence to back it up.

Mr Barrett: Well, that was Dr Anthony Clare's allegation in fact.

Dr S. Ó Domhnaill: I am reading from the submission on page 8 of 23 from Professor Clare. He does directly address the X case decision. He says that the reason the X case went the way it did was that the only way, it seemed to me, the compassion of the Supreme Court could be expressed was through this interpretation and having been present at that particular hearing, the committee acknowledged their agreement. So I don't think we are saying anything that is untrue.

Chairman: We will pass on from that. I call Deputy O'Keeffe.

Deputy J. O'Keeffe: Thank you for coming here. What do you feel about or what is your attitude towards the hundred thousand Irish girls and women who have had abortions over the last ten to 15 years?

Dr Ó Domhnaill: If I might make one point in particular .... As I say I have read the briefing document and I have read the transcripts of all the medical experts and the one thing that I felt was missing – I know it was addressed subsequently by Professor Patricia Casey – was that for all the compassion which was being expressed in relation to women's health and the treatment of women there was very little reference at all to the adverse effects of abortion on women. If you were to look at the document from the Royal College of Obstetricians and Gynaecologists – the document which suggests the prenatal discussion that should be held with each woman who is about to have a termination – it gives a list of the complications that the woman should be informed that she might possibly experience. The reason for this of course is that informed consent must be given, so the patient must be informed. The Royal College of Obstetricians and Gynaecologists gives a long list of complications with the relative incidences of each. Even if you want to take the highest proportion of complications from abortion they would seem to be in the area of psychological and psychiatric sequelae. To quote from the textbook of psychiatry, Puri and Hall, the standard textbook in psychiatric training, published in 1998, they refer to a figure of 10% of women who undergo abortion who suffer severe and-or prolonged psychological sequelae.

Deputy J. O'Keeffe: Could I get you back to the question I asked you?

Dr Ó Domhnaill: Yes.

Deputy J. O'Keeffe: I asked you what's your attitude to the 100,000 women who have had abortions in the UK over the last ten or 15 years. Perhaps I might add another part to it. Would you agree that in discussing or talking about this issue, and bearing in mind in particular the situation of that tranche of our citizens, it is necessary that we be sensitive in how we discuss the issue?

Dr Ó Domhnaill: Absolutely, yes. I work in psychiatry myself and I have treated quite a number of women who have undergone abortions – women from the Republic of Ireland, women from the United Kingdom and, in particular, women from the island of Jersey. I was present in Jersey at the time when they introduced legal abortion there in 1997. My attitude in relation to the 100,000 women that you are referring to over whatever period of time that might be is that I think it is dreadfully sad that our society would offer nothing but the council of despair, that in response to what is essentially a psychosocial problem which would be dealt with most sensitively by compassionate support we would instead direct them to undergo a surgical intervention to terminate the lives of their unborn children. I would far prefer to see a situation whereby women who found themselves in crisis pregnancy- .... Again, I have read the report, Women in Crisis Pregnancy. I would find that it would be far more beneficial to society as a whole, to women in particular, if there was far more support for women who found themselves in that crisis situation. Again, I would say if you use the figure of 100,000 women over an unspecified period of time ....

Deputy J. O'Keeffe: Since '67.

Dr Ó Domhnaill: .... it is also a very, very sad reflection, that it would infer that there were at least 10,000 women over that period of time who have developed severe and-or prolonged psychological sequelae which obviously are not being addressed because I am not aware of any institute, if you like, within the Department of Health which is dealing with this. It is very, very much a haphazard thing ....

Deputy J. O'Keeffe: Could I take it in short then that

your attitude is that we should be sympathetic to the situation of such people ....

Dr Ó Domhnaill: Absolutely yes.

Deputy J. O'Keeffe: .... both in our language ....

Dr Ó Domhnaill: Absolutely yes.

Deputy J. O'Keeffe: .... and in the resources that we make available for counselling?

Dr Ó Domhnaill: Absolutely yes. In relation to our language, as I said I work specifically in the area of psychiatry and I have had the experience of working with women who were contemplating abortion and later women who had terminations of pregnancy and I have seen the fall-out, so I am certainly in a position of compassion with them.

Deputy J. O'Keeffe: The second issue I wanted to raise with you was the question of abortion or termination here in Ireland. We have had evidence from medical experts, in particular the Masters of the maternity hospitals, that in certain rare cases to save the life of the mother it is necessary to terminate the pregnancy. What's your view on that?

Dr Ó Domhnaill: Its interesting you should use the term 'terminate the pregnancy'. This was something which obviously arose in the discussion earlier this morning. There is a difference between a termination of a pregnancy and a termination of the life of the unborn child.

Deputy J. O'Keeffe: What's the difference?

Dr Ó Domhnaill: The difference is that you can terminate a pregnancy by going into labour. You can terminate the life of a child by killing it. Every pregnancy is eventually terminated.

Deputy J. O'Keeffe: Where the unborn foetus is not viable and where the decision has been made that the only way to save the life of the mother ....

Dr Ó Domhnaill: Is to terminate the pregnancy.

Deputy J. O'Keeffe: Here we get into the language 'have an abortion', 'terminate'. Essentially the result is the same.

Dr Ó Domhnaill: Exactly and probably the most glaring omission ....

Deputy J. O'Keeffe: Do you accept that that happens for a start, by the way?

Dr Ó Domhnaill: Absolutely yes, I accept the fact that there are cases .... I am very, very aware of cases whereby in order to treat the mother adequately to protect her life it is necessary to generally deliver the child at an early stage. Sometimes these children are viable, sometimes they are not viable but the intention is there to treat the mother. I personally believe that this whole argument comes down to the area of intent. Someone mentioned earlier that it is very difficult to perhaps legislate for intent or to frame a constitutional amendment which would encompass the area of intent but of course we do this every day. If you look at the courts – if you want to differentiate between what in America would be first degree murder and second degree murder and in Ireland murder and manslaughter – we very much take into account the intent of the person who is doing the act.

In relation to the three Masters, I certainly would recognise that they are eminent physicians. I would consider the earlier witnesses, Professor Bonnar and certainly Dr Clinch, as being what I would term pre-eminent. They have managed to practise each for over 40 years without in their opinion performing an abortion. None of the Masters said that they themselves had performed an abortion, insisting that they are providing the same treatment as is allowable under the Medical Council guidelines, so I can assure you that no woman in this country has been asked to sign a consent form for an abortion.

Deputy J. O'Keeffe: The follow-up on that then is that you probably will have read the report of the Constitution Review Group. The Constitution Review Group consisted of renowned constitutional lawyers, academics and other people whose opinions I have no doubt ... I would respect anyhow. It was headed up by Dr Whitaker. The conclusion of that group was as follows: if a constitutional ban were imposed on abortion a doctor would not appear to have any legal protection for intervention or treatment to save the life of the mother if it occasioned or resulted in termination of her pregnancy. Do you feel that a committee of the Oireachtas has to take note and give very due weight to that view since its the view as I say of the leading constitutional experts in the country?

Dr Ó Domhnaill: Absolutely but I would suggest to you that if we look at recent history and at the fact that the care of expectant mothers in this country is second to none anywhere in the world and if you look at what they have suggested there that it is impossible to protect medical practice by an absolute ban on abortion I would say to you that as far as the Irish people have been aware we have had an absolute ban on abortion, certainly prior to 1983 and I have not heard of any cases nor have I heard of any cases mentioned here before the committee of women whose lives were lost because doctors felt that their hands were legally tied.

Deputy J. O'Keeffe: No, they were talking in the context of a proposal to introduce, say, something along the lines of your amendment which you propose as follows: no law shall be enacted nor shall any provision of the Constitution be interpreted to render induced abortion or the procurement of induced abortion lawful in the State. That's your proposal for an amendment. I am putting it to you that the report of the Constitution Review Group, on the face of it, suggested that the adoption of such a proposal would result in a doctor not appearing to have any legal protection for intervention or treatment in the situation described.

Dr Ó Domhnaill: Yes, the three masters of the maternity hospitals suggested that they felt legally exposed by the present situation.

Deputy J. O'Keeffe: Convince us then that your proposal for an absolute constitutional ban along the wording you have suggested in your submission is justified. How could we justify putting the lives of women at risk? In fact, that's the medical view ... the view of the constitutional lawyer.

Dr Ó Domhnaill: I will answer from the medical perspective and I'll ask Mr Barrett to answer from the legal perspective. From the medical perspective we would consider that while this view expressed by the constitution review group in relation to the legal exposure of obstetricians has not proven to be the case we haven't had any incidence, and the Medical Council would have been in a better position to inform you of this, where any obstetrician or any practising medical practitioner has been reported to the council for improper practice or for negligence or for misconduct in relation to a position whereby they terminated a pregnancy i.e. that they performed an early delivery in cases as rare as health or pre-eclampsia or Eisenmenger's syndrome. It would be fair to say that the historical evidence in this country is that there is no legal requirement for abortion to protect medical practice. That's what we have experienced. That is what the country has experienced over the years in which we have led the world from the point of view of obstetric and perinatal care.

Deputy J. O'Keeffe: So you would still think that the proposal you are making ....

Dr Ó Domhnaill: I feel that the proposal I am making ....

Deputy J. O'Keeffe: .... despite the advice of the constitutional experts and despite the established position as highlighted, in particular, by the three masters of the maternity hospitals is justified.

Dr Ó Domhnaill: Absolutely. I think you have to again come back to the area of intent. If your intent is to protect the unborn child, then you will interpret the early delivery of a child of a mother whose medical position is compromised ....

Deputy J. O'Keeffe: There is no reference to intent in your proposal.

Dr Ó Domhnaill: What I would suggest is that the Constitution and the law presume intent. Again I will bring you back to something as simple as if someone killed someone else. This is a situation where we are talking about that. It does come down to the area of intent. Did you intentionally kill this person? Was this person killed by you unintentionally, in which case the law will act in different ways? The intentional killing of someone would be punished and the unintentional killing of someone will be, perhaps, punished more leniently but certainly there would be a different approach taken to it. The law deals with intent on an everyday basis.

Mr Barrett: May I just add to that? There is no reason whatsoever that the constitutional amendment which we have proposed ... indeed I would not suggest it should stand in isolation. During the course of the judgment in the X case, several of the justices made references to the absence of legislation to direct them in the application of the constitutional principle in 40.3.3° and, therefore, said, that in the consequence they were forced, as it were, to make up their own minds as to what that meant. There is no reason whatsoever why legislation could not define exactly what is meant by induced abortion because certainly some reference was made by the committee members previously that there is no such definition given in the Green Paper and how that might be considered a failing in the Green Paper. I would suggest there are many others but certainly that is one of them. There is nothing whatsoever to prevent the Dáil from legislating to clarify this situation beyond any possible doubt. It is quite clear that the Supreme Court would follow that direction.

Deputy J. O'Keeffe: You are actually amending your proposal to suggest that we should have the amendment to the Constitution and, in addition, legislation.

Mr Barrett: No, at all times we have been of the view that the legislation was required as well. The 1861 Act is inadequate. It is inadequate quite simply because of the phraseology used that, 'it shall be a felony to perform an unlawful abortion'. The phrase implies that there is such a thing as a lawful abortion. Therefore, the 1961 Act is inadequate. I would follow that with the necessity for legislation in accompaniment with an amendment to the Constitution.

Deputy J. O'Keeffe: Would you not accept that legislation couldn't override a constitutional provision.

Mr Barrett: No, of course, it couldn't. It can clarify exactly what is meant. This is what the Supreme Court suggested in the X case judgment. They felt they were acting in a vacuum in the absence of legislative direction as to what 40.3.3° in application would mean. Certainly we would see that if there was a constitutional amendment which would clarify the meaning of 40.3.3°, therefore superseding the X case decision, that clarifying amendment would be accompanied by legislation. It would be accompanied, I presume, by very wide legislation which would do more than simply define the exact application of that amendment but would also include various other measures directed for the purposes of protecting the lives of both mother and child in this country.

Chairman: Were we to enact on foot of the present constitutional basis of the 1983 amendment we can only legislate as far as practicable. Isn't that what the Constitution ....

Mr Barrett: Absolutely, and as far as is practicable is the total prohibition of abortion, abortion being defined in the terms that we have defined it and abortion being defined in legislation.

Chairman: 'As far as is practicable' does not, in fact, relate to a total ban on abortion, it relates as far as is practicable to two lives which are referred to in the Constitution.

Mr Barrett: This is assuming there is a conflict between the right to life of the unborn child and the right to life of

the mother and that, in fact, abortion is sometimes necessary in order to save the life of the mother. This is a political opinion. It's neither a medical opinion nor is it valid legally.

Chairman: The drafter of the 1983 amendment clearly envisaged the possibility that there might be a conflict or he or she would not have referred in express terms to both rights.

Mr Barrett: Exactly, and perhaps this was one of the failings of the 40.3.3° amendment in so far as it declared a high-sounding principle but wasn't clear. If you look at the submission which your defence has given, would you not want to remove 40.3.3°, nor do we even want to amend that provision? What we want is a clarifying subsection to make it exactly clear what 40.3.3° meant ... was understood to mean by the people who voted for it and it was subsequently ... the Supreme Court made a contrary decision. The clarifying subsection we are asking for is not to change 40.3.3° but simply return it to its original purpose because that conflict of rights is not, in fact, in practical existence. What we are dealing with is a provision which was, if you like, to make the politically sensitive comment, a comment that we would all wish to have made, which is that the equal right to life of the mother was an absolute thing, that it was something that we were not in the business of saving the lives of the unborn child in killing women, that we were not in the business of saving the life of women and killing children, that there was no conflict between the two and the equality, as the Supreme Court understood it, was not an absolute equality. Justice McCarthy referred to a hierarchy of rights and tried to suggest that the rights of some people were more important than others. This is why we need a clarifying subsection, I believe, to make it understood that a provision which protects the life of the unborn child equal to the right to life of the mother does not require in any instance an induced abortion.

Chairman: Can I come back to Professor Bonnar, whom you may have heard? I thought he was very clear. He said, 'In dealing with complex rare situations where there is a direct physical threat to the life of the pregnant mother we will intervene always.' That was the position in 1983 as well.

Mr Barrett: Yes, of course. Intervene is not an abortion. We have been playing around with terminology ....

Chairman: Who has been playing around with terminology?

Mr Barrett: Certainly the committee has been playing around with terminology because it has continued to use the word 'terminate'. As Dr Ó Domhnaill pointed out, all pregnancies end in termination. Termination is not an abortion. As a father of two children myself, you could say that I am a father of two terminated pregnancies if you want to put it as bluntly as that. What we are dealing with here is whether there is going to be legalised abortion in the country, not whether there's going to be legalised termination. When people use the word termination they are attempting to confuse the issue and they are attempting to suggest that women who have their pregnancies terminated have abortions. That means that every child born in the country would fall into that definition of abortion. This clearly cannot be the case so there must be some other definition of abortion, and of course the Green Paper is remiss in not giving us a clear definition of abortion. It is the duty of the Legislature to in fact give us first of all a clear definition of abortion and then it is the duty of the Legislature to give the Irish people an opportunity to, as I say, enact in law what they wish to have in fact, which is a total prohibition on abortion.

Chairman: When the Constitution was enacted in 1937, the direct input came from Mr de Valera and since then the proposal is formulated here in the Houses of the Oireachtas. So what our Constitution envisages is that there's a process of deliberation before an amendment is put to the people. It doesn't in fact permit a group to make a proposal to the people. It suggests that those who the people elect have the wisdom to devise an appropriate proposal.

Mr Barrett: Absolutely, and this is what we're talking about. The role of the Legislature here is to give the people in law what they want in fact. I don't think there is anybody who ....

Chairman: No, sorry, that's precisely what I was contradicting. It is not the role of the Legislature. The role of the Legislature is to deliberate on what an appropriate proposal might be.

Mr Barrett: So what you're suggesting is that the Dáil has it within its remit to decide to legalise abortion, for the specific example, in the certain knowledge that the vast majority of the people are opposed to that decision?

Chairman: No, certainly not.

Mr Barrett: Certainly they have it within their power but whether they have it within moral justice is another story.

Chairman: No, we stand by the Constitution. We have to operate within the constitutional limitations ....

Mr Barrett: Obviously.

Chairman: .... and if we seek to amend the Constitution, what I'm saying really is that ... you've used the people, and referred to the people a lot in this context, but the people and their Constitution have provided for a Parliament as well and it's Parliament that draws up the particular proposal that goes to them, and that involves a process of deliberation. Now in the course of those deliberations that we have had, we've heard very cogent evidence, about the words we were arguing about a few moments ago, from the masters of the three principal maternity hospitals in the State. Have you any comment to make on what they said to us?

Mr Barrett: Well I would refer medical questions to Dr ....

Chairman: I really don't want to go back into definitions.

They said that they have to carry out certain things which they want to characterise as abortion. Now that's something that we, as legislators, have to have very serious regard to.

Dr Ó Domhnaill: You said there that they want to carry out procedures which they want to characterise as abortions. We, on the other hand, would not characterise them as abortions and certainly the most experienced obstetricians in the country would not characterise them as abortions. When you have to look at the statement from the institute of obstetricians and gynaecologists which, as you know from speaking to Professor Bonnar and Dr Clinch, represented, if you like, a consensus of 95% of the obstetricians in the country, certainly the views expressed by the three masters of the maternity hospitals in Dublin do not reflect in any means the views of 95% of the obstetricians in the country.

Chairman: Well in fact the masters agreed with the letter from the institute. What the letter from the institute did was to do something which we have found it difficult to do – many of the witnesses before us have found it difficult to do – and that is to avoid becoming involved in definitions about nomenclature.

Dr Ó Domhnaill: At the same time I think if we are going to use certain terms such as abortion, termination of pregnancy, termination of life or whatever, they have to be defined. There are too many definitions of the word 'abortion'. Every English dictionary has a different definition of abortion. Certainly medical textbooks have different definitions of abortions and as time goes by, because of the fact that viability of the unborn has reached an earlier and earlier stage, the definition keeps on being changed, but it's important from the point of view of the interpretation of law that there should be a legal definition of abortion and we would suggest that the legal definition we would provide would be that which would be recognised by most of the Irish people.

You know from your electorate that most people who will approach you to talk about the matter of abortion are not actually coming to talk to you about the matter of the termination of pregnancy so as to protect a woman who's suffering from pre-eclampsia or such a condition. Most of the people who would come to you to talk about abortion are specifically talking about, if you like, the deliberate and intentional killing of the unborn child and so our point is that it should be possible, and I'm quite confident that it is, to frame a legal definition of abortion which will be in tune with the wishes of the people.

Chairman: If I was to return to my constituency, one political interest there, the principal rival interest, would support the right of choice so the people wouldn't give me these definitions in my constituency. I'd have my own view on this but I'm just explaining to you it's not as simple, you know, appeal to the people.

Dr Ó Domhnaill: No, there's nothing simple about this, I suppose, in some respects. The fact that such a large committee is deliberating on it would suggest that it isn't a terribly simple issue but we have to remember that if the intent of the committee – it is actually the intent of the committee which becomes important – were to allow current medical practice to continue while at the same time protecting the right to life of the unborn child, it is perfectly possible for the committee to do that. There are legal means available to you. There are certainly legal terminologies which can be used by the committee so as to protect the vast majority of unborn children.

Deputy J. O'Keeffe: Don't we really get into the issue of terminology and definitions and again, to get back to the constitutional experts, they said that in relation to what is an abortion, first of all they pointed out that in some instances an abortion is unlawful and in some instances it's lawful. They said that the word on its own must therefore be understood to refer neutrally to the termination of a pregnancy or procurement of a miscarriage. They followed on that, by the way, and this is obviously something we have to take note of, their view then was that to ban abortion simplicitor could thus criminalise medical intervention or treatment necessary to protect the life of the mother if such intervention or treatment required or occasioned the termination of her pregnancy. That's the argument in their report by the most renowned constitutional and legal experts in the country.

Dr Ó Domhnaill: Absolutely. I'm sure they are. I would though argue that they are being somewhat disingenuous by saying that. I would take the view that it is possible to frame a definition of abortion which would reflect the views of the majority of the people, and I would consider it very remiss if these constitutional review group of, as you said, the most pre-eminent constitutional lawyers and so on could not do so. I would be very concerned about that. Certainly it doesn't make sense that they cannot frame a wording which would express what has been the understood situation in this country over the past, shall we say, as far back as 1861 but certainly as far back as 1983. It would be strange that they would find themselves unable to frame a wording that would reflect that situation that existed. There have been no doctors, as I said, censured for terminating pregnancies in the treatment of women with, as we said, very rare medical complications of pregnancy. There have been no doctors censured.

Mr Barrett: I think the constitutional review group, as I understand it, would have been reviewing the current constitutional provision and the 1861 Act. It couldn't anticipate, obviously, clarifying legislation. Would that be correct?

Deputy J. O'Keeffe: No, it's dealing with the issue of a proposal to introduce an absolute constitutional ban on abortion.

Mr Barrett: Yes, but I understand that they gave no consideration to the possibility of clarifying legislation which would accompany such constitutional ban and in the absence of that then I could see how they might draw that conclusion, but there's absolutely no requirement that we here, speaking about the matter, must be similarly limited.

Chairman: If I might help you, I think Professor Binchy made the point this morning that we have had far more

consideration of this issue now than the constitutional review group ....

Mr Barrett: Absolutely.

Chairman: .... in terms of what we have heard. Are there other questions?

Senator O'Meara: Very briefly, you referred, Dr Ó Domhnaill, to this report. You said you had read Women in Crisis Pregnancy, and I'm delighted to hear that you have because while we're here discussing terminology and definitions and so on, we can be pretty sure, based on statistics, that there are women who have either already made a decision or are about to make a decision to terminate their pregnancies abroad. This report shows that the reasons for those terminations are many, varied and complex and also that many people travel without counselling, with very little counselling, many travel alone, many make a decision alone and it also paints very clearly a picture of a climate of fear, intolerance and very unhealthy secrecy. I want to put it to you that in many ways your group has contributed to that atmosphere of fear and intolerance. Secondly, I want to put it to you what, if any, words can be put into the Constitution that would persuade any woman not to travel for a termination?

Dr Ó Domhnaill: First of all, you made the suggestion that we have largely contributed to ....

Senator O'Meara: No, I didn't say 'largely'.

Dr Ó Domhnaill: Then to a degree.

Senator O'Meara: I said I put it to you that you have contributed to that climate.

Dr Ó Domhnaill: I would consider that the Irish people as a whole have contributed to that climate, that they have done so over a very prolonged period of time, that in fact the situation has improved greatly in recent years and that people are far more inclined to have a more compassionate approach to women and girls who find themselves in this situation. That, of course, is reflected in the figures, if you look at the maternity hospitals, for the number of single mothers, particularly young unmarried, single mothers.

Senator O'Meara: Why are the figures not dropping then, figures for abortion?

Dr Ó Domhnaill: I would suggest that the reason the figures for abortion are not dropping is that ... there are several reasons. Certainly since the Freedom of Information Act and the addition of the provision of abortion referral in this country, the figure for the number of women having an abortion has risen dramatically. Something that was supposedly meant to reduce the number of women going for an abortion has increased it. It hasn't been very helpful at all. The prevention of information has become the provision of abortion referral. I would suggest, on the other hand, that we, in what we do – we have been in existence for eight years as a group – are available to general members of the public every week in several centres around the country and we provide them with information on abortion. We certainly would provide them with information as regards how best they would be served were they to find themselves in the situation of a crisis pregnancy. We certainly would refer many people to Life and CURA and we would offer whatever support, as individuals and as a group, whatever help we would be in a position to provide.

Senator O'Meara: We have been actually given evidence, indeed by a group who is here this morning, the Pro-Life Campaign, that in countries where there is a programme of education, counselling and information, that in actual fact the abortion figures do drop.

Dr Ó Domhnaill: There has been a common thread that has been, if you like, present in the abortion debate since 1992. One of the points, which has been constantly recurring, is that the Netherlands has some particularly good educational programme and, therefore, its abortion rate is lower than anybody else's, but in fact the Netherlands don't record an abortion as having taken place if it were to take place before the 14th week. In that situation, most abortions, the vast majority probably, 90% to 95%, occur before the 14th week, so we, in that situation, would probably end up having the lowest abortion rate in the world, were we to say that anything that happens before 14 weeks is not an abortion.

Senator O'Meara: Are you saying then that you wouldn't support or you don't think there is any value in putting in place a far broader availability of counselling, information and education?

Dr Ó Domhnaill: No, I certainly support counselling, information and education and I would personally be more than happy in any capacity to provide such. I would hate to see more and more women going for abortions because, as I said, I have had to deal with the human wreckage that results from abortion and I can honestly say I don't gain any joy from it.

Ms N. Nic Mhathúna: Can I come in there, Senator O'Meara, to rebut, in the strongest possible way, the suggestion you made that Youth Defence may have contributed to a climate of fear. If you take the reality of the situation, hundreds of thousands of ordinary people have received real information about abortion from Youth Defence and are and continue to be perfectly happy to do so. The notion that Youth Defence, in any way, contributed to such a climate is generated within political circles and, perhaps, by the media, but the very real fact that our work is in weekly contact with ordinary people who are perfectly happy to receive practical information about abortion from Youth Defence is proof, if anything, of the fact that we are representative of the vast majority of the Irish people.

Senator O'Meara: Thank you for your response.

Deputy McManus: Thank you for coming here today and waiting so patiently to be given a chance to make a presentation. I have two questions. The first one is in relation to the X case. You were very critical of the decision

in that case at the time. The issue was whether or not this girl should have had access to an abortion. Are you saying that, in your view, the girl in the X case should not have had access to an abortion?

Mr Barrett: We are saying essentially that the option of abortion was not to her benefit, that the court had a misreading of that and that given that it was an anonymous case, we do not know what the consequences of that abortion were for her psychologically. We know from the medical evidence that it is quite clear that it is not a method by which to prevent suicide. Since the court decided to give her an abortion on the grounds that she would otherwise be suicidal, that is quite extraordinary. They did not hear any medical evidence. Mr Fred Lowe, who spoke before the committee, I believe, said, 'I am not a medical person.' It would have been of great advantage to the Supreme Court in 1992 if he had opened his comments with the same line, 'I am not a medical person.' In the X case, as I said ....

Deputy J. O'Keeffe: Are you suggesting that ....

Deputy McGennis: Are you a psychologist?

Dr Ó Domhnaill: A psychiatrist.

Mr Barrett: We are not pretending to be the expert medical evidence. Mr Lowe's was the only medical evidence in that case.

Deputy McManus: To focus a little bit, I am asking you, as Youth Defence, was your position that the girl in the X case should have been prevented from accessing an abortion?

Dr Ó Domhnaill: We would certainly feel that the girl in the X case was not best served by the court deciding that it would be of greater benefit to her to have an abortion than were she to be disallowed from having an abortion. The court, if it had sought an expert medical opinion on it, would have been told that not only, as you know, does abortion increase the likelihood of suicide, but in a subset of people it increases it even further. The subset, to list the four, would be: previous psychiatric history, in other words, prior to the termination of the life of the unborn – that would include girls who were depressed or suicidal; younger women, which, of course, the girl in the X case was; those with poor social support; and those from cultural groups opposed to abortion. Certainly Ireland is a cultural group opposed to abortion. So they were not serving her very well.

Deputy McManus: To condense it, I take it what you are saying is that you think it would have been a better outcome for her to be prevented from having an abortion?

Mr Barrett: Certainly, as I said, because it was an anonymous case we have no opportunity of knowing exactly the psychological condition of that young woman today, but we do know, because of our close involvement, the psychological consequences for the young girl in the C case.

Deputy McManus: No, I'm sorry. That is not my question. I think Dr Ó Domhnaill has indicated that he feels it would ....

Mr Barrett: It is important to put on the record that the treatment that young girl received has had chronic psychological consequences for her.

Deputy McManus: No, I'm sorry. I am asking you one question.

Mr Barrett: I'm sure she doesn't matter to you. I mean, that's quite clear.

Deputy McManus: Sorry, Chairman ....

Chairman: I would like if that was withdrawn. You have a very strong motivation on this subject. You must understand we are here to listen and you are here to try to assist us. There is no point in engaging in what amounts to vulgar abuse of members of the committee.

Mr Barrett: The principle that was applied in the C case was the principle that was established in the X case. Since we cannot answer absolutely as to what the consequences were for Miss X, I think it is of relevance, since we can answer for the consequences for Miss C, that in fact that is extremely relevant to any answer as to what we would feel about whether she was ....

Chairman: Deputy McManus did not give you any opinion. What do you want to say about the C case for the purpose of the record?

Mr Barrett: The fact of the matter is that the girl in the C case has suffered enormous psychological trauma, which is directly related to the fact that she had an abortion. The manner in which the Eastern Health Board conducted that case leads any sensible, objective person to the conclusion that at least one organ of the State was deliberately pursuing a pro-abortion policy because the young girl herself had stated that she was not suicidal. The courts refused to allow a psychologist from the family – from her mother and father – to examine the girl on the question of her suicidal tendencies and took what I would say is deliberately misleading evidence because they desired a conclusion. And the consequences for her were enormous and very bad.

That's why we have this view that it was of no benefit to Miss C to have an abortion, it was of no benefit to Miss X to have an abortion and, in the instances similar to that in which we might frame a law for rape and incest, we can see that it is not of benefit to the women ... that, in fact, all it does is actually add a second assault. Again, the medical evidence, statistically speaking, back this up and our personal experience of it back it up as well. So the compassionate response we would have is that in those very difficult situations abortion is not of benefit and should not have been carried out.

Chairman: I think you have explained your position very, very clearly in relation to those cases and in relation to the matter generally. I want to clarify one thing to the committee, because it is an important issue and I want it

on the record. It relates to this issue of the courts. The rulings of the House are that members of the Judiciary are independent by virtue of the Constitution and they may neither be criticised nor have their rulings referred to in the House except on a substantive motion. I have taken the view, in relation to this committee, that, essentially the X and C cases are before us by way of substantive motion and I have permitted criticism of those cases on the basis of what is reported about them in the legal journals and law reports. I would not permit delving into the facts of those cases that does not derive from what is published in the authentic reports of those cases. I would not permit either criticisms of the judges which go beyond fair and free criticisms of court decisions. I just want to put that on the record for the purpose of explaining the approach I've taken on that issue.

Mr Barrett: Of course, but you'll understand that I can't pretend that I don't know what I do know.

Chairman: Well, you can confine what you want to say to what's published about those cases in the reports published about them. That's my ruling on that issue.

Mr Barrett: I understand the ruling.

Chairman: It is a very firm ruling and anything you have of your private knowledge is irrelevant in that context as it wasn't published about those court cases and can't be freely criticised. I, in fact, have departed somewhat from the practice because I could rule out all discussion on these cases but I think that would be an absurdity, given the issue that we have to address. But, I can't permit criticism of them or discussion of the facts of them beyond what is in the duly authenticated reports of those cases.

Are there any other questions before I conclude the session? I wish to conclude this session soon.

Senator Dardis: You've made several references about the importance of putting matters on the record. Would you accept that we are confronted by extraordinarily difficult and complex matters here and would you also accept that this committee takes its responsibilities extremely seriously, both to the Houses of the Oireachtas and to the Irish people, and that it will discharge its responsibilities to the very best of its ability in those interests?

Mr Barrett: We would expect that you would make the very best efforts to do so.

Senator Dardis: Do you accept that we are prepared to do that?

Mr Barrett: I have not seen, to be quite honest, any evidence that the committee has done anything other than seek to find a justification for the political opinions that they arrived at the committee ....

Senator Dardis: So, in other words, you don't accept that we are prepared to discharge those responsibilities?

Mr Barrett: I think that the committee, in its individual membership, arrived at this committee with a prearranged conclusion and proceeded to gather evidence for that prearranged conclusion.

Deputy J. O'Keeffe: I think ....

Senator Dardis: Sorry, I think in that context it is extremely important for us, as a committee, to say that we take these issues extremely importantly and that we will discharge our responsibilities because I think it is important that that would be on the record and that's the reason I say it.

Mr Barrett: Well, certainly the behaviour of the Minister for Health in attempting to manipulate the warrants in the ....

Chairman: That is not before us now.

Mr Barrett: Well, I think it shows the political attitude of the Government in this ....

Chairman: I'm sorry, I wish to speak. The committee has its own processes to carry out. We are not investigating what a Minister did, we are dealing with that Green Paper which is the result of that. As far as the procedures of the committee are concerned, they're open to the public and the public are free to criticise us as they please. That's the public's right: to evaluate what we do. The only point I would like to make is that there was no prearranged conclusion on the part of the members of this committee. In fact, we have very diverse opinions on this question and that's because we are elected by the people and we tend to reflect their opinions on the matter. That's inevitable, as Deputies.

You've the right to organise and contest elections yourselves and put forward your point of view. Up to now, you have restricted yourself, as I understand it, to engaging in symbolic protests to highlight public concern about this issue and that's something you're entitled to do, provided, of course, the protests are conducted within the law. If you wish to carry the matter further, you're quite free to contest parliamentary elections yourselves and make an appeal to the people.

Mr Barrett: I understand that. I was simply responding to Senator Dardis' question as to what we believed that the committee ....

Chairman: I do not know that ....

Senator Dardis: You have a very significant advantage over us in that we would be much more constrained by the rules in terms of what we could say than you have been constrained and I think you should recognise that in what the Chairman has allowed you say.

You criticised the Supreme Court with regard to what you perceived to be them determining a hierarchy of rights. In what you are suggesting to us, are you not also asking for a hierarchy of rights?

Mr Barrett: I don't understand the question. What I would understand is that the ... what we are proposing is that the equal right to life of mother and child be protected

and that that can be best protected by a complete prohibition on abortion. This is medically the case and it's legally possible. As for the question that you've asked, I don't really understand what you're trying to get at.

Senator Dardis: I think you do.

Chairman: Are there any other questions?

Deputy McGennis: I was told by a primary school teacher who had a group of young, very young primary school children in to visit during one of the days that our committee was meeting, and not either of the three witnesses who are here today but somebody was handing out anti-abortion literature which is absolutely their right to do but it was handed out to very, very young primary school children. I was asked, on behalf of that teacher, to bring to the committee's notice that this, in the view of the teacher, was extremely irresponsible and that she would have to deal with the issue in the classroom with a group of young people that she believed were far too young to have to deal with the issue. I'm not asking a question, I'm just putting it on the record.

Dr Ó Domhnaill: You're putting it on the record in the context of interviewing the members of Youth Defence.

Deputy McGennis: No, no, I'm not interviewing you – I'm asking if you have literature.

Dr Ó Domhnaill: We have it as a matter of policy that we do not distribute leaflets ....

Deputy McGennis: I can guarantee you that these were children ....

Dr Ó Domhnaill: .... to young children.

Deputy McGennis: .... primary school children. They were a group that I had in visiting the Dáil who were given literature ....

Dr Ó Domhnaill: It is a matter of policy that we do not ....

Deputy McGennis: .... going into the Dáil. I can tell you it's a fact ... your literature.

Chairman: On this issue, we've been talking about how to conduct this debate and it's a very important issue. That's one last point. Parliament is where people elect their representatives so, ideally, this is the best place to conduct this particular debate. You have your legal rights and I understand why you wish to exercise them. But, do you accept the point that we, as representatives of the people, have to make decisions in this matter?

Mr Barrett: Of course. But, at the end of the day, it is within both the power and the responsibility of the Dáil to finally decide what proposals shall be put into a referendum or not, as the case may be. All I'm saying is in that principle that the people are the masters of the State, is that I'm saying that you ought to be directed by what you perceive to be their will rather than what you perceive to be, perhaps, your own personal opinion.

Chairman: Very good. I call the session to a close and thank you for your assistance. We will suspend for two minutes.

SITTING SUSPENDED AT 1.29 PM AND RESUMED AT 1.32 PM.

Mr Richard Greene, Ms Anne Greene, Mr Phil Walsh and Mr Donal O'Driscoll

Chairman: We are now in public session. We're resuming our public session and I'd like to welcome Mr Richard Greene of Muintir na hÉireann Teoranta, Ms Anne Greene, Mr Phil Walsh and Mr Donal O'Driscoll to this meeting of the Joint Committee on the Constitution. I understand you're organised for political purposes and for that reason we were anxious to invite you to our meeting. The format of this meeting is that you may make a brief opening statement if you wish which will be followed by a question and answer session with the members. I want to draw your attention to the fact that while members of the committee have absolute privilege, this same privilege does not apply to you. I regret we are running behind time because of the three votes we had this morning and we are obliged to attend at these votes. Perhaps you would like to comment.

Mr R. Greene: Yes. First of all, I'd like to thank you, Mr Chairman, and members of the committee for having invited me to speak to you today. Our position, Muintir na hÉireann Páirtí Teo. submitted a detailed 27-page document to the interdepartmental working group on abortion in March 1998. This document is easily accessible on our Internet webpage and we have also offered to send an individual copy of that submission to any member of the all-party committee who would so wish. We submitted a one page statement to the All-Party Oireachtas Committee on the Constitution in November 1999. These two documents summarise our position in relation to abortion, that is, we reiterate our total opposition to the legalisation of abortion in Ireland. We also wish to state our view that the only way of satisfactorily securing protection for the unborn and good health for mothers is an absolute constitutional ban on abortion, the so-called Option 1.

Abortion is never necessary. There is nothing in the Green Paper to support unequivocally any assertion that abortion is necessary to save the life of a pregnant mother. What do we mean by abortion? Abortion must not be confused with the loss of a child as a result of treatment,

other than abortion, of the child's mother during pregnancy. If some refinement of the term is considered necessary to make this clear, then we hold that it can be done, if there is a will to do so.

Abortion is the direct and intentional killing of an unborn baby at any moment from conception up to and including birth. I say 'including birth' in order that the barbaric partial birth abortion method is included in the ban on abortion. In the event, which does happen, that an effort to abort results in a live baby, then of course it would be very wrong not to give every medical care necessary for the survival of the baby.

Dr Keane, Master of Holles Street hospital, said here on 3 May: 'Any time that there is a foetal heart present, by right, you cannot terminate your pregnancy...' The Chairman put it to him: 'But the current criterion, you say, is the heartbeat?', and Dr Keane replied: 'Yes, I mean, once the foetus is alive, *in utero*,...'. Now, we all know that an unborn baby's heart is beating at 21 days. Need I say more?

Regarding the mother, if the mother needs any medical care whatsoever, then such treatment as is required must be given, even if that treatment results in the unintentional and inadvertent death of her unborn baby despite all the efforts of the medical team. This situation does not involve abortion.

> The deliberate and intentional destruction of the unborn child is professional misconduct. 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. Refusal by a doctor to treat a woman with a serious illness because she is pregnant would be grounds for complaint and could be considered to be professional misconduct.

That is a quote from the Irish Medical Council guidelines. This, as you know, is and has been standard medical practice in Ireland. Professor Bonnar has said to you on the matter of the wording of Article 40.3.3o, '... if it is actually studied in its totality, it covers the situation'. I would refer you, in particular, to the evidence of Dr Clinch, Dr Conway and Professor O'Dwyer. The distinction between abortion and standard medical treatment must be clearly made. I don't propose to offer you a wording – I am quite sure that other pro-life groups will already have put forward to you a wording which will adequately protect the life both of the unborn baby and of her mother.

There is no such thing as restrictive abortion, nor is there any such thing as limited abortion. One only has to look at the situation in Britain where limited abortion was introduced in 1967 following the Bourne case. Today, the grounds for abortion in the UK are very wide and since 1967, five million unborn babies have been killed by abortion there. The vast majority of these five million unborn babies were killed for social reasons and we know that the Bourne case, as also with the Roe *v*. Wade case in the US, has been admitted to have been based on a false claim.

The degradation and exploitation of women and the terrible long-term effects implicit in these figures is truly staggering. In relation to abortion, we cannot say, as people do concerning the millions who were 'legally' killed in the holocaust, that we didn't know. We do know about the horrors of abortion and the horrors of the abortion industry worldwide. We have no excuse.

Regarding the X case, some of the discussion in this Chamber recently concerned the abortion of an unborn baby up to the time of birth. This, in fact, is provided for by the incomprehensible judgment in the X case. It is interesting to note that Dr McKenna, Master of the Rotunda Hospital, said of the young girl in the X case that when he was asked, 'Is this girl depressed?', he replied, 'No, she is upset, she is tearful, but so would I be...'

Yet, to my knowledge, no attention whatsoever has been given to this remarkable statement. Surely this undermines the entire case which gave rise to the X judgment. Also, it is interesting to note that very little, if any, media coverage was given to the evidence before your committee from Dr Sheehan on 9 May. A very important issue in his submission was the extremely low incidence of suicide in pregnant women whereas suicide is far more prevalent following an abortion.

Regarding other exceptional circumstances, in the horrific matter of rape and incest, the utmost genuine compassion and care, medical attention, support and love must be given to a woman or girl in this situation, but we must remember that an abortion of her unborn baby will never undo the rape. All the so-called hard cases amount to a very, very small percentage of those 5,000 women and girls who, according to reports, go annually to the UK to obtain an abortion. As we know, the standard of maternity care in Ireland is second to none. Indeed, UNICEF has stated that Ireland is the safest place in the world for a pregnant mother and her baby. It is safer in Ireland by a factor of four as against Britain or the US. In my opinion, it is unlikely that the position would be maintained were the culture of abortion to evade Irish medical practice. I am doubtful if the high standards we enjoy in other medical departments would be maintained either.

In October of last year an amazing photograph appeared in the *Irish Independent*. It showed the tiny hand of a 21 week unborn baby emerge from the mother's womb and curled around the finger of a surgeon. The surgeon was carrying out an operation to lessen the effects of spina bifida. That baby, Samuel, was born in December at 36 weeks and he is thriving. This was not a representative event but who would say that that baby should have been killed.

Reducing abortions – again, I would refer you back to the evidence of Dr Casey and a Ms O'Brien on 23 May when they put forward very positive and sensible ways in which numbers of Irish women and girls going to the UK for an abortion can be reduced drastically and safely. I would also urge all of you to read and study the article by Ms O'Brien which appeared in *The Irish Times* on 27 May. The availability of contraception does not reduce the abortion rate. In fact, the culture promoted by the availability of contraceptives is what leads ultimately to abortion in very many cases.

Political aspects – the foregoing outlines our position in regard to the taking of the unborn human life. There are four other points of a political nature I would like to mention. It seems to me from what is reported of these hearings to date that there is an extraordinary preoccupation with the justification for an abortion in extreme or rare cases and none at all for the 99.99% of cases. This has the consequence of giving the impression that abortion is an extraordinarily complex subject. This seems to me

to be leading to an endeavour by the media to convince the public that abortion cannot be dealt with by referendum and that it must be legalised, neither of which is correct.

While we in this country continue to arrange the culling of our population, a new report from the UN replacement migration is warning of the consequences of such policies. It foresees a demographic winter for the EU, the European Union, in which 13 million new immigrants per year will be needed. Retirement ages will have to increase, retirement and medical benefits will be cut, taxes on the reduced number of workers will be greatly increased in order to pay for the increased numbers of aged and elderly. These are the concerns that have been recently echoed by Romano Prodi, the President of the European Commission. It is sheer madness for us to be reducing our population in these circumstances.

Meanwhile, other elements in the EU and the UN are endeavouring to greatly increase the pressure on Ireland to legalise abortion and the Irish Government is behaving as a puppet in response. I have to emphasise that nothing is inevitable and that we do not have to bow to anyone. I am greatly heartened by the aiséirí of mná na hÉireann who have formed a new organisation, Neart, to resist the advances of anti-life and anti-family organisations and to recover the control of Ireland's own destiny.

I would like to quote one or two points from an article by Mary Ellen Synon in the *Sunday Independent* of 12 September last year. She asserts correctly, first of all, that each individual has the right to its own life. Secondly, that the life of the pre-born individual, and I quote, 'is no longer a matter of supposition. It is a matter of scientific fact'. Thirdly, that the fundamental duty of this Government and of every Government is to defend the right of each individual to his life, no matter what his age.

In launching the Green Paper the Government said it was seeking a broad consensus and wished to promote an understanding of all sides. The media has called for calm, reasonable discussion. I put it to you that we would not, should not, entertain a Government discussion paper on all possible options for the legalisation, say, of paedophilia or an understanding of all sides on the matter of incest. Is it not monstrous then that people are being invited to this very room at this very table for a calm, reasonable discussion on so called options for the killing of the unborn? Thank you, Chairman.

Chairman: That's the conclusion of your submission. We haven't encountered – níor casadh linn Neart fós. Do you accept there are very deep philosophical differences on this question entertained by large segments of humanity and, perhaps, in different proportions within this country?

Mr Greene: Mr Chairman, I would remind this committee that what you're being asked to do effectively – I really would remind you of your responsibilities because history will judge you as it judged certain members of another political party 60 years ago when they sat down at a famous conference, which was called the Wannsee Conference, and there were very distinguished individuals at that conference.

Chairman: Now hold on a second.

Mr Greene: Wait, no. I just want to say, well you'll hear the point.

Chairman: They weren't elected by anybody.

Mr Greene: They sat down to decide on actually how the Holocaust would be sold, how actually it would be carried out. For instance, look at the agenda. The agenda was for questions of selection, how was it due to be defined, possible exceptions. The very words that are used actually in order to try and introduce abortion worldwide. Now, Ireland is an exception in that in Europe we don't have legalised abortion. But everywhere that it has been introduced it has been introduced by what this committee has been deliberating and in many ways spent hours listening to, the exceptions, the very rare exceptions. Then our nearest neighbour is the classic example of that. In 1967 they said actually that abortion should be legal but in rare exceptional circumstances. The exceptional circumstances led to a holocaust of five million unborn babies being killed not for medical reasons but for social reasons.

What I'm putting to this committee is – be aware that you are not going to be used to in many ways introduce mass murder into this country because that's what I consider abortion to be. As I said again, the people at the Wannsee Conference in Berlin in 1942 when they were actually given the task of what was called the final solution – remember, look at the words. They didn't want to actually face the reality of what they were sitting down to do, of what they were sitting down to allow to happen in their country. They actually used nice words but, in fact, what they were discussing was mass murder.

I'm actually reminding this committee that what you have been discussing can potentially become mass murder because if you actually introduce, allow or recommend, say, legalisation of abortion in certain circumstances, the example of every other country where abortion is now practised, that's how it got in. It got in on not even 1% exceptional circumstances and that's how abortion was introduced into every other country where it's now operating.

Chairman: Very good. Can I say one thing, Mr Greene, before I close the session? The Wannsee Conference was a meeting of top ranking Nazis, a cabal group, in a fascist state which met, as you say, in the early 1940s and had an involvement in the preparation of one of the greatest acts of genocide we've seen this century. As far as this committee is concerned, it's a committee of the national Parliament. You're a citizen of this country, you've come here and I don't accept any comparison between this committee and a group set up by the Nazis in the 1940s. I'd remind you as a citizen, of your duties under the Constitution, of fidelity to the nation and loyalty to this State.

Mr Greene: Excuse me, Chairman, I didn't actually say that. I reminded this committee ....

Chairman: Very good.

Mr Greene: .... that individuals sat down 70 years ago to plan mass murder.

Chairman: That's fine.

Mr Greene: They didn't call it that. What I'm trying to say is I consider actually that legalising abortion in this country is letting mass murder into this country. I just wanted to remind the members of the committee that remember the consequences of what they're deliberating about and how history will eventually judge them. In the short term those people who sat down at that committee 70 years ago at the Wannsee Conference were powerful. They thought that nothing would stop them. They were at the height of their power and so on, but time and judgment came upon them, and we actually know what we think of the holocaust.

SITTING SUSPENDED AT 1.51 PM AND RESUMED AT 1.53 PM.

Chairman: Well, happily it did come upon that particular group. I just wish to make the point that, our deliberations have covered a very wide ground and have not been confined – perhaps you are relying on media reports – to consideration of exceptions but have considered in great detail the very substantial rate of abortion we have and the numbers who travel to England. If you look at the transcripts you will see that. I thank you for your assistance here today.

Mr Greene: Thank you, Chairman.

Dr Miriam Brady, Dr Catherine Bannon and Dr Máire Neasa Nic Gearailt

Chairman: I welcome the following representatives of Doctors for Life: Dr Miriam O'Grady, Dr Catherine Bannon and Dr Máire Neasa Nic Gearailt to this meeting of the Joint Committee on the Constitution, in connection with its consideration of the abortion issue. We received your submission, which is at page 315 of the brief book. It has been tabled before the Houses of the Oireachtas and circulated to the members.

The format of this meeting is that one of you may make a brief opening statement if you wish, which will be followed by a question and answer session with the members. I draw your attention to the fact that, while members of this committee have absolute privilege, the same privilege does not apply to you. Is there one of your number who would like to speak on your submission?

Dr Brady: Thank you for asking us here. We made a long submission, but we will cut it down as much as possible because we appreciate that you are running over time.

Doctors for Life is an *ad hoc* grouping of approximately 300 doctors from the specialities, who came together in the aftermath of the Supreme Court decision in the X case. Its aim is to provide solid, factual information on the medical issues arising in the abortion debate. To this end, it established a working group to research the various medical aspects of the abortion debate. The result of this research was published in November 1992. It covered maternal mortality and abortion trends, cancer and pregnancy, effects of cancer treatment on unborn children, heart disease and pregnancy, psychological effects of abortion, suicide in pregnancy and abortion and rape. This information was updated and submitted to the interdepartmental working group on abortion in 1998.

All the rest I will omit, except to say that Doctors for Life wish to record their opposition to the adoption of any of the options in the Green Paper, other than the first option.

Maybe I should introduce ourselves. First of all, I am not Dr O'Grady – my name is Brady.

Chairman: We had better correct the record.

Dr Brady: It is only a minor detail.

Chairman: It is very fundamental. You are Dr Miriam Brady?

Dr Brady: I am Dr Miriam Brady.

Chairman: You are referred to on the front of the submission.

Dr Brady: The other doctors are Dr Catherine Bannon and Dr Máire Neasa Nic Gearailt. Dr Nic Gearailt and I are GPs with other interests as well, although I am retired. Dr Bannon is a senior registrar in urology. My experiences are somewhat mixed. I have done general practice in rural areas and cities and towns in Ireland and England, both city and county. I have also done a great deal of obstetrics in Ireland and some in England and Nigeria. I have done a bit of public health and I have done the last 20 years in general practice in Cavan. Do you want to ask me questions?

Chairman: Would you agree that, apart from the very difficult constitutional question which we have to address, we have to do everything in our power to recommend measures that will reduce the actual rate of abortion which is already taking place?

Dr Brady: Yes.

Chairman: You would agree with that?

Dr Brady: Yes, absolutely.

Chairman: A number of suggestions have been made to us – more positive advertising on maternity itself, more encouragement for adoption and also, perhaps more controversially, widespread advertisement of post coital contraception. I think it is fair to say no one of these in isolation is it, but would you see taking them together as a set of measures which might serve to reduce the rate of abortion?

Dr Brady: I do not think it would be primary. It would

be tackling the main thing. I can give my own opinions, but I would prefer not to. Our remit was, as I said, to provide factual information on the medical issues.

Chairman: We have read those. We have read your submission and ....

Dr Nic Gearailt: I am sure we all agree we would all wish to see a reduction – and, in fact, elimination – of the need for abortion in anybody's perception. We don't wish to see ... I deal with these young girls very frequently coming into my surgery or, indeed, into the GUM clinic where I also work. Their problems are very real. There is absolutely no doubt about that. What you want is to provide them with the best medical care that you can provide. That is partly my opposition to abortion, in that it is not the best provision of medical care for these young girls. One of things that I think you have omitted in your suggestions for encouraging people not to opt for abortion, is a necessary education of the population on the consequences of abortion.

Chairman: I'm sorry – I suppose I was thinking just of the target group of mothers with children. That's accepted as well. I wasn't ruling that out. When I summarised the measures, I was only summarising them in the context of the target group.

Dr M. Nic Gearailt: I meet a lot of this target group, especially in the GUM clinic. In previous years, I worked with the Dublin Well Woman Centre, where I saw a lot of them as well. I see them in general practice, to a lesser degree – well, they are more diluted by the general population. One of the things that I have noted is the overwhelming lack of information they have on abortion. A lot of them just see it as a choice. They are absolutely oblivious to the impact that abortion can, and probably will, have on their lives. I think there has to be redress. I'd like to see it done. I do my part on an individual basis with my patients. But, I mean, I do feel I would love to see the Government and the Department of Health stepping in and educating themselves, perhaps first, and making available the information that is available worldwide on the impact of abortion.

Chairman: Dr Bannon, would you like to ....

Dr C. Bannon: I suppose the main comments that I ... my clinical experience in neurology would be limited in the context of this discussion, but it is present in that we would have a close relationship with the maternity hospitals and would have regular referral of, say, urological complications in pregnancy. And the main point, from hearing the previous submissions this morning, that I would like to bring across is that through our submission and through our clinical experience, that we feel that medical practice in Ireland is second to none in this area. That we very clearly understand when we are caring for both mother and child in a very difficult medical circumstance the difference between ending the pregnancy, whether it be before or at foetal viability, and the direct intentional harming of the unborn child, and that medical practice in Ireland is being practised in that context at the present time.

The result of the X case has resulted in a potential uncertainty in that regard, in that decisions may be made that we would not consider standard medical practice here as a result of your deliberations, or whatever, from this committee, but that .... Constant referral is being made to what the masters of the maternity hospitals said. I understand what they said. They did not say specifically that they intended to harm the unborn child. They said they needed to end the pregnancy. Now, albeit the pregnancies were at a point where the foetus was not viable, but it was not their intention to directly harm those unborn foetuses and, in that context, they may have used the term 'termination of pregnancy' and, therefore, created some confusion about it. But, in the end of the day, they did not say that they performed an induced abortion on those patients and, therefore, they conformed to standard medical practice. They conformed to what the Medical Council would agree with, what the IMO backed up as well. And I think that it would be very important for the committee to try and see a way that we can separate what some people are using as confusing terminology with what we understand is accepted and high class medical practice that we have available in this country, despite the lack of abortion available to us.

Also, taking into consideration that when we look at the figures of non-resident abortions in the UK, they do not correlate with patients that have been referred from here incognito with serious medical problems. The patients that we deal with here with serious medical problems are all accounted for in our maternity statistics and they are not the patients that are being referred to England for abortions. So, when you ask us about how to reduce the numbers of abortions in England, I would understand that as being the social aspect of the need of abortion.

Chairman: Yes.

Dr Nic Gearailt: Our remit here is to try and encourage and explain, but I think it is fully understood already that we consider that there is no medical circumstance where you can directly intentionally harm the unborn child to save the mother's life; that standard medical practice allows the ending of a pregnancy.

Chairman: Very good. I thank you for your submission and I will suspend the session. I would just like to thank you, doctors, for your representations, for your contribution and for your patience.

SITTING SUSPENDED AT 2.04 PM AND RESUMED AT 2.05 PM.

Dr Kevin Doran, Ms Julia Heffernan, Ms Mary Gallagher and Ms Ann Kennedy

Chairman: We are now in resumed public session. I welcome the following representatives of Life Pregnancy Care to this meeting of the Joint Committee on the Constitution, Dr Kevin Doran, chairman, Ms Julia Heffernan, Ms Mary Gallagher and Ms Ann Kennedy. We have received your presentation which has been circulated to the members and laid before the Houses of the Oireachtas. The format of this meeting is that you may make a brief ... one of you may make a brief opening statement elaborating your submission. This will be followed by a question and answer session with the members. I want to draw your attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you. Your submission is at page ....

Clerk to the Committee: It's separate.

Chairman: Oh, it's a separate submission. Has it in fact been tabled? In fact, it is not in the green book. It has been circulated and I propose that we do table it. I take it that is agreed by the members? Agreed. It will be tabled at the conclusion of the meeting. That is a technicality. Would you like to elaborate on your submission?

Ms J. Heffernan: I would like to, first of all, thank you for this opportunity to make this submission before you. I acknowledge that you have worked through lunch and have stayed late to hear us and I would like to thank you for that. So, thanks very much and I know you must be tired. I will just read my submission and I have a copy for members of the committee, if you wish, which we can circulate after.

First of all, I would just like to introduce us and tell you where we are coming from. We are all members of Life Pregnancy Care. To my right is Dr Kevin Doran, who teaches midwifery ethics and who has expertise in ethics. To my left is Mary Gallagher who's a member of Life in Letterkenny and who is a trained nurse and a trained midwife. To her left is Ann Kennedy who is the national administrator of Life in Ireland. I am Julie Heffernan, the national PRO for Life Pregnancy Care.

Life Pregnancy Care is a voluntary interdenominational organisation which was established in Ireland in 1981. We draw our support from people of all faiths and of none. We have centres in Cork, Dublin, Galway, Killybegs, Letterkenny, Tallaght and Thurles. Women counsellors, trained in all aspects of the work, offer care and counsel to women who find themselves in the dilemma of a crisis pregnancy. We also offer post-abortion counselling to women who experience emotional distress in the aftermath of abortion. All our services are free and confidential and we operate a health line from 9 am to 9 pm every day where a caller can have access to a counsellor for the cost of a local call.

We are aware of the distress and trauma that women suffer in unexpected pregnancy. An increasing number are opting for abortions as a solution. We are concerned that in every abortion a baby dies but we are also aware, through our work, that for many women the initial feelings of relief after abortion give way to feelings of guilt, regret, loss, depression and self-contempt. There is growing evidence that many women suffer post-abortion syndrome, that is, the severe and long-lasting depression experienced by women who have lost a baby through abortion. I draw the attention of the committee in particular to the work of Professor Patricia Casey in this regard.

However, many women suffer in silence for long periods of their lives because society does not acknowledge their hurt. The medical profession now recognises that women who suffer a miscarriage grieve for their babies. In abortion, however, the woman's grief is not acknowledged because the reality of her child's death is not acknowledged. She has been told that her problem would be solved so that she would be able to get on with her life as if nothing had happened but deep down the woman knows that she was expecting a baby and, indeed, this fact was borne out by the many interviewed in British abortion clinics for the women in crisis pregnancy study. Studies soon after an abortion may find that women feel relief and so claim that they suffer no adverse effect but medical journals are now coming filled with articles on the psychological effects of abortion. A review article in the *British Journal of Psychiatry* in 1992 states that approximately 10% of women who have an abortion will suffer marked, severe or persistent psychological or psychiatric disturbances. Studies are available from countries where abortion has been legal for decades which indicates that up to 10% suffer some complication – that's from the *Chinese Journal of Obstetrics and Gynaecology 1989*.

The Life counsellors who provide our network of pregnancy care services, and especially those who provide the post abortion counselling, know only too well what post abortion depression can do to women and, indeed, to men. They're hearing every day the anguished stories of guilt, grief, anger, loss of self-respect, sexual dysfunction and alcoholism which abortion so often leaves in its trail. It will often not be recognised for what it is when a woman suffering from depressive or similar situations presents to her busy GP. The anecdotal evidence obtained from our counselling work points towards long-term adverse psychological consequences following abortion developing some time after abortion rather than straight-away.

Women are often desperate by the time they come to Life. They have been recommended by another agency or some person. For many, it is seven or more years since the abortion. The woman engages in one to one counselling, sometimes for up to two years until she is ready to go on into group therapy. In the groups, two counsellors facilitate up to eight clients. It is interesting to note that in the last group there was three men and one grandmother. So we can see that the abortion has a ripple effect and affects not just the woman but many more people such as the woman's partner, other children, grandparents, the doctor and the nursing staff. There is no instant solution but we hope that they come out of the group having learned to be realistic and with new skills for living having grieved the loss in their lives and the loss of their child. They do not get over the loss but they can get through it healthily. We are aware that many women tell no one of their abortion experience and suffer in silence.

The women with whom Life counsellors deal choose abortion not for medical reasons but for social reasons.

These social reasons include lack of partner support, disruption of career or college, finance, housing, insecurity regarding the relationship, not ready to have a baby at this time and fear of parental upset. The women we see do not choose abortion for themselves but are pushed towards it by external circumstances. We in Life recognise the agonising situation a woman may find herself in because of an unplanned pregnancy. We do not feel the answer for either mother or child is abortion. The social reasons that compel women towards abortion should be tackled if we are serious about reducing the number of women having abortions. Abortion does not solve the social problems that impel women towards abortion.

There have also been a number of studies showing the link between induced abortion and breast cancer, the commonest form of cancer among women. In 1996, Dr Joel Brind, Professor of Epidemiology in Baruch College, City of New York University, published an analysis showing that 24 out of a total of 30 studies from around the world showed that induced abortion is a significant independent factor for breast cancer. In official guidelines published on 13 March last entitled 'The Care of Women requesting Induced Abortion', the Royal College of Obstetricians and Gynaecologists included the survey of literature on the physical and psychological effects of abortion on women and, for the first time, included a section on breast cancer risks. We suggest that the Department of Health take due regard of the consequences of abortion for women and put in place adequate resources to provide post abortion support and advertising its availability. Because of our work with women and because we respect human life at all stages, we recommend an absolute constitutional ban on abortion.

Chairman: Do you have a copy of that?

Ms Heffernan: I have a copy for you.

Chairman: In fact what I tabled was the e-mail you sent on 28 November. That would be of value to the staff. You used the phrase 'an absolute constitutional ban' but clearly we have to cover existing and dynamic medical practice that operates within the State. Do you accept that?

Ms Heffernan: We accept what the doctors are saying, what the medical experts are saying, that women are not suffering because of the lack of abortion, that they are getting proper medical treatment and certainly we would agree with that that a woman who is pregnant and whose life is in danger or who needs some form of medical treatment that she's entitled to that treatment even if the unhappy outcome is the death of the child. We see that as different from intervening and aborting.

Chairman: Yes, I understand. I think that's been very well put already this morning and summarised. We appreciate the nomenclature but, leaving aside that you want a complete ban on abortion, isn't that the position?

Ms Heffernan: That's the position, yes.

Deputy J. O'Keeffe Your looking for a complete ban on abortion does not preclude constitutional and legislative, or a constitutional and legislative, framework which allows for a continuation of the existing medical practice. Would that be correct?

Ms Heffernan: Yes.

Deputy J. O'Keeffe: So it's not an absolute ban on abortion. There was a lot of debate on definitions.

Ms Heffernan: I think you are down to definitions at that stage.

Deputy J. O'Keeffe: But, in practice, whatever happens, we must allow a continuation of existing medical practice.

Ms Heffernan: Maybe Dr Doran would like to say something.

Dr K. Doran: What I'd like to just say would be that our position would be that any procedure which is directed towards the deliberate taking of the life of an unborn – that that is the intention of the act – would be contrary to our ethos.

Deputy J. O'Keeffe: But the problem is that we have had evidence that in certain rare circumstances it is necessary to deliberately end the life of the unborn to save the life of the mother. This is the dichotomy.

Dr Doran: I wouldn't accept … you see if you ....

Deputy J. O'Keeffe: That is the medical evidence we have had.

Dr Doran: No, the point is the use of the word directly intended. Quite clearly the intention in say for instance the treatment of cervical cancer is the treatment of the mother, the intention is not the termination or the ending of the life of the child. May I say that I feel quite obviously that one of the big difficulties that you have in legislating is that you're trying to cater for the common good which includes both the good of the whole and the good of each individual person.

If you put it this way, doctors don't absolutely guarantee the health of their patients, they can't, but they do what is possible to save all the patients they're treating, either the mother or the child. Similarly, I think in the case of legislation, the State can't absolutely guarantee the security of any of its citizens and that applies not just to the area of abortion. But the State can absolutely guarantee to respect the fundamental rights of every individual, including the right to life, and I think that would exclude any legislation which, of its nature, would undermine that right. So there's a difference between the practicality or the practicability on the one hand and what legislation suggests.

Deputy J. O'Keeffe: We are into, of course, the whole area of motives and intent and effect. I think we're all agreed on ....

Dr Doran: It's a very difficult issue.

Deputy J. O'Keeffe: The end result will be … but you do understand and appreciate the complexity and the

difficulty we have in trying to find the necessary constitutional and legislative framework to cover the situation.

Dr Doran: Of course. We would rather be in our situation than in your situation.

Chairman: I thank you for your assistance. I take it there are no further questions. I thank you for your assistance. I actually read the submission which you made to us last November with great interest and I would like to thank you for your submission. If you would bear with us a moment. The minutes of today's meeting have been circulated to the Members and I propose that these minutes be agreed to, as amended, to provide for the publication of the submission dated 28 November 1999 from Life Pregnancy Care. Are the minutes, as amended, agreed? Agreed.

Before I adjourn the joint committee *sine die* I thank the members for their very faithful attendance at the proceedings. There has been a very large attendance for all of the sessions. You often read in newspaper articles about how Members of the Oireachtas are not in the Chamber and how there are televised versions of empty parliamentary debates. There has been a very full attendance at the joint committee throughout these hearings. Thank you for your assistance and your co-operation. I adjourn the Oireachtas Joint Committee on the Constitution sine die.

THE JOINT COMMITTEE ADJOURNED AT 2.22 PM SINE DIE.

WEDNESDAY, 5 JULY 2000, 9.30 AM
MEMBERS PRESENT:
DEPUTY B. DALY, T. ENRIGHT, D. McDOWELL, L. McMANUS, J. O'KEEFFE, SENATOR J. DARDIS, D. O'DONOVAN, F. O'DOWD.

DEPUTY B. LENIHAN IN THE CHAIR

Shaheen Ahmed, Sheikh Hussein Halawa, Ali Selim, Mr Arif Fitzsimons

Chairman: We are now in public session. I would like to welcome the following representatives of the Islamic faith in Ireland: Shaheen Ahmed, General Secretary, Sheikh Hussein Halawa, the chief representative of the faith in Ireland, Ali Selim, translator, and Mr Arif Fitzsimons who is a media and public relations adviser. I welcome you to this meeting of the Joint Committee on the Constitution in connection with our consideration of the abortion question. The format of this meeting is that one of you may make a brief opening statement elaborating your position if you wish and this will be followed by a question and answer session with the Members. I have to draw your attention to the fact that while Members of the committee have absolute privilege, this same privilege does not apply to you. I now invite one of you to make an opening statement.

Mr Fitzsimons: Good morning. I am going to give a brief introduction to the Islamic view of abortion. The basic view that Islam has to abortion is that it is forbidden and is a crime except if it is proven by medical experts that the mother's life is at threat. Firstly, I will explain the Islamic view of the embryo-foetus, then the general Islamic view of abortion and then the exception to this rule.

Islam means to submit to the guidance from the one and only God who is the creator and Lord of the Universe. Muslims believe that God knows what is best for us. What is Islam's view of the embryo and the foetus? Muslims believe that life begins at conception. This is illustrated in the Koran which Muslims believe is the word of God. 'Verily we have created man from a drop of mingled fluids of both male and female' – this is in the Koran, chapter 76, verse 2. 'Does man ever consider out of what substance God created him? Out of a drop of fluid he created him in which he determined his nature' – the Koran, chapter 80, verses 17 to 19. 'Man we did create from a quintessence of clay, then we placed him as a drop of sperm in a place of rest firmly fixed. Then we made the sperm into a leach like clot; then of that clot we made a foetal lump, like something chewed. Then we made out of that lump bones enclosed and we clothed the bones with flesh. Then we developed out of it another creature. So blessed be to Allah, the best to create' – Koran, chapter 23, verses 13 to 14. 'And we cause whom we will to rest in wombs for an appointed time. Then do we bring you out as babies' – Koran, chapter 22, verse 5.

From these verses we can see that the foetus is viewed as a human being in a formative stage. Thus, as the embryo-foetus is a human being it has, according to Islam, the right to protection by law. In Islam the embryo-foetus has the following divine rights: the right to life from conception, the right to good nutrition, the right to no harm, no smoke, no drink, no drugs or any harmful substances in pregnancy, lineage, i.e., rights to be attributed to his or her parents, burial – any stillborn or miscarried foetus is to be buried out of respect.

The Islamic view of abortion. In Islam all life is sacred. 'Do not kill or take human life which God has declared to be sacred', (Qur'an chapter 6: verse 151). There are two exceptions to this general rule. Firstly, a punishment in accordance with Islamic law or, secondly, in the case of a just war. The prohibition of killing of children is also specifically mentioned. 'Do not kill your children out of fear or poverty: it is We who shall provide sustenance for them as well as you. Killing them is certainly a great sin', (Qur'an chapter 17: verse 31). Islam encourages us to

marry and to procreate. No child is viewed as unwanted. All children are viewed as gifts from God.

bn Tammiyyah, a renowned Muslim jurist said, 'It is the consensus of the Muslim jurists that abortion is prohibited'. Imam Al Ghazalli, another renowned Muslim jurist said that it is a crime to disturb the fertilised egg of a human being and the crime becomes worse the further into pregnancy the disturbance takes place.

Dr Yusuf Al Qaradawi, chairman of the European council of fatwa and research, said that Muslim jurists insist on the payment of blood money if a baby is aborted alive and then dies, and a lesser amount if a baby is aborted dead.

Exceptions to the rule against abortion. Dr Yusuf Al Qaradawi says that Muslim jurists allow abortion on one condition i.e., 'the continuation of the pregnancy will result in the death of the mother', according to the Islamic jurisprudence principle of a lessor of two evils because 'the mother is the origin of the foetus, moreover she is established in life, with duties and responsibilities and she is also a pillar of a family. It would not be possible to sacrifice her life for the life of a foetus which has not yet acquired a personality and has no responsibilities or obligations to fulfil'.

In conclusion, Islam is against abortion with the exception of if the mother's life is threatened by the continuation of the pregnancy, which is proven by a specialist doctor.

Chairman: Thank you for that very clear-cut presentation. I take it you're speaking broadly within the Sunni tradition of Islam. Is that correct or would you say it is the consensus within Islam generally?

Sheikh Hussein Halawa: It is a consensus of Muslim opinion that the embryo should be safeguarded and should not be affected in anything that is against it unless there is harm that threatens the mother's life.

Senator Dardis: Thank you for your presentation and it is fairly clear. In terms of the threat to the life of the mother, how do you view suicide? Would you regard suicide as a real threat to the life of the mother? In other words, if someone said they were suicidal or there was evidence that they were suicidal would that allow a termination to take place within the Muslim context?

Sheikh Hussein Halawa: Generally Islam strictly forbids suicide. Even if someone is sick according to Islam he is not allowed to commit suicide.

Senator Dardis: What is the incidence generally of abortion within the Islamic community? Is abortion common within the Islamic community or is it something that very rarely happens?

Sheikh Hussein Halawa: The percentage of abortion among Muslims is very little and this is due to the fact that Islam considers the doctor who helps to do the abortion as a criminal. The Imam also mentioned that a woman went to the prophet Allah and she said to him that she committed adultery and she was carrying the baby at the time. The prophet did not inflict the Islamic penalty on her and said to her go back and come after the delivery.

Deputy McManus: First of all can I welcome you here and thank you for coming to us today to explain the view you have and your philosophy in relation to abortion. There are two areas that I would ask you to reply on. The first is in certain cases a foetus can be so abnormal that it has no chance of survival outside the womb. Some of the doctors who came here indicated that it would be better for the woman's health that an abortion be carried out because there was no chance of survival. Would you consider that as something that is acceptable or do you view it that you would insist that the woman carry through the pregnancy and deliver the child that has no chance of survival?

Sheikh Hussein Halawa: If the conception affects the mother in any bad sense or so abortion is allowed according to Islam, but if the baby or embryo is abnormal Islam does not allow abortion. The embryo should be given the chance to live and to be delivered and nobody knows, maybe in the future they will find a remedy for the case. Islam does not allow abortion if there is anything abnormal with the baby – the embryo.

Deputy McManus: Maybe if I could just explain a little further. I am not talking about a disability. I am talking about a particular condition where the baby is born without a brain – it is called anencephaly. So there is no chance, the baby may live for 24 hours, but there is no chance of life into the future.

Sheikh Hussein Halawa: If a doctor says that at most he will live 24 hours, he still has the right to live these 24 hours.

Deputy McManus: Thank you very much. There is one other question I would like to ask you. It is clear from your presentation that in the case of rape you don't believe that abortion is justified. But could I ask you, in terms of the child that is delivered as a result of a rape, is that child treated equally to all other children?

Sheikh Hussein Halawa: He is very much innocent and he is supposed to be treated equally and on the same footing as others. He has not committed any sin, so the baby is completely equal to other babies born. When he will grow up he will have the same rights and the same duties.

Deputy J. O'Keeffe: We welcome you here. I am sure you are probably the first delegation from a Muslim community in Ireland to appear before a parliamentary committee here. It is historic from that point of view. May I reiterate how welcome you are. I think probably the general public, as I, would probably like to know a little more about you. Are there very many of you in Ireland? How long are you here and is the community growing? That is the first question which is of more general interest.

The second question I want to raise is that we are a committee that's examining principally the provisions of our Constitution. We have been asked to look specifically at the issue of abortion. It's clear from your presentation that your community is very much against abortion, except as you say where the continuation of the pregnancy would result in the death of the mother. Have you given any

consideration as to whether we should have a provision in our Constitution in Ireland dealing with the issue of abortion or whether the issue should be dealt with under ordinary legislation?

Mr Ahmed: Thank you very much for inviting us here this morning. On your first question about our community, we are actually a growing community here in Ireland. The first Muslims arrived here in the 1950s when medical students were coming here to have their medical degrees. Many of them stayed on and other Muslims arrived here. At the moment I think there are about 16,000 or 17,000 Muslims. They're all spread over Ireland. You could say half of them are here in Dublin. Muslims comprise businessmen to professionals and, of course, there are now a small number of Muslim refugees coming here.

Sheikh Hussein Halawa: The Islamic community and Muslims wish that it would apply to all people. Also Islam prohibits abortion even for animals. The Muslims apply this for themselves and they wish it would apply for all people apart from their religion or whatever they believe in.

Deputy J. O'Keeffe: Did you want to focus in particular on the issue about the Constitution as to whether you feel there should be some provision in the Constitution of our country on this issue or whether it's a matter that should be dealt with in ordinary legislation? Perhaps you may not have examined this issue in particular.

Sheikh Hussein Halawa: We wish it would be in the Constitution.

Deputy J. O'Keeffe: The only question that you mentioned was that there was an exception to the rule against abortion generally in your faith where the continuation of the pregnancy would result in the death of the mother. But you said that has to be proven by a specialist. Do you have in mind any particular procedures? Would the specialist would make a decision and carry out whatever medical procedures are considered necessary? Do you feel that such proof would have to be furnished to some independent objective body or can you give us further assistance as to what you have in mind from the point of view of proof by a specialist where the exception is allowed?

Sheikh Hussein Halawa: If the expert proves that it will affect the mother, abortion is allowed according to Islam. If it is proved by an individual or by a group of people, as long as he is a specialist and he decides this will affect the mother abortion is allowed according to Islam.

Chairman: No further questions. I would like to thank the representatives of the Islamic faith in Ireland for attending here today, yourself Mr Ahmed and also your other representatives, assistants and translator. Your presence here was very much appreciated. As you know, under our Constitution the State honours and respects religion and that particular pledge is not restricted to the Christian religion. It does extend to other faiths as well. So thank you for your attendance.

SITTING SUSPENDED AT 10.20 AM AND RESUMED AT 11.05 AM.

Rt Rev. Harold C. Miller, Dr Michael R.N.Darling and Dr P.H.C. Trimble

Chairman: We are now in public session. I would like to welcome the following representatives of the Church of Ireland: the Right Reverend Harold C. Miller, Bishop of Down and Dromore; Dr Michael R. N. Darling, and Dr P. H. C. Trimble. I want to welcome you to this meeting of the Joint Committee on the Constitution. We have received a submission from the Church of Ireland which has been tabled before the Houses of the Oireachtas and can be found at page 379 of the brief book. That submission, in fact, was addressed to me as a document prepared by the Medical Ethics Working Group of the Role of the Church Committee in response to the Green Paper on Abortion. That response was considered by the full Role of the Church Committee and it was agreed by that committee to forward the response to this committee. The submission is at page 379 of the brief book and has been circulated to members. I understand you wish to make a brief opening statement elaborating on the submission and that will be followed by a question and answer session with the members. I have to draw your attention to the fact that while members of the committee have absolute privilege, this same privilege does not apply to you. I now ask Dr Miller to make his opening statement.

Dr Miller: First of all, this group of three people – the three of us – were chosen by the Standing Committee of the General Synod of the Church of Ireland at its June meeting to report on its behalf to the all-party committee of the Oireachas. The first thing I must tell you is that the submission by the Medical Ethics Working Group of the Role of the Church Committee which you have before you failed to be accepted by the General Synod in May. You may not realise how the Church of Ireland works but it is quite normal for committees to send in documents or responses to particular issues in their area. The group which has the over-arching authority in the Church of Ireland is the General Synod and in the course of debate where this particular report was an appendix to the Role of the Church Committee report a resolution was put forward that the Role of the Church Committee report be amended by the withdrawal of two appendices and that was passed by 166 votes to 164, suggesting that the Church of Ireland represents a diversity of opinions on certain aspects of the abortion issue. The three of us have been chosen to convey something of the spectrum of views which co-exist in the Church of Ireland. Indeed, Dr Michael Darling was on the medical ethics committee which drafted

and wrote the first report and Dr Peter Trimble was one of the respresentatives who spoke against the report at the General Synod.

However, not least in the light of an article in last Sunday's *Sunday Times* by Kevin Rafter, it is important to begin with areas in which all three of us here are agreed. These include the following – there may be others but we have listed the following to try and help you. First of all, we are agreed in expressing gratitude for the Green Paper and for the fair mined and helpful ways in which it disentangles, presents and focuses the major issues and the potential ways forward. Secondly, we reaffirm together the Lambeth Declaration on Abortion – at Lambeth every ten years all the bishops of the Anglican Communion meet – which remains as the essential and official stated position of the Church of Ireland. It reads as follows:

> 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 the violation of the personality of the mother) save at the dictate of strict and undeniable medical necessity.

This implies that there can be medical circumstances in which a termination of pregnancy is required.

Thirdly, we agree together on section 2 of the report before you when it says:

> From the Church of Ireland perspective the issue of abortion doesn't lend itself to the sort of clear definitions that law requires. However, we realise that such definitions have to be made and a clear way forward found.

The Green Paper itself has helped to clarify many issues in this process.

Fourthly, we accept the spirit of the second part of section 3 which says, 'Because of the complexity of the issue, we believe that it must be addressed by legislation rather than in the Constitution.'

It has been the official view of the Church of Ireland throughout the abortion debate that the constitutional way is not the best method of dealing with this issue. We would, therefore, say that the words at the conclusion of the Green Paper on page 172 are very close to the stated position of the Church of Ireland – I think it is the very last paragraph or the penultimate one. The review group, therefore, favours, as the only practical possibility at present, the introduction of legislation covering such matters as definitions, protection and appropriate medical intervention, certification of real and substantial risk to the life of the mother and a time limit on lawful termination of pregnancy. The suggestion of the medical ethics group that we put in place a legal structure within which abortion is illegal but exceptions are permitted is close to our own view.

Fifthly, we are agreed that the right to life itself is the most basic of human rights and that this applies to the life of the foetus in the womb. We are also agreed that one of the tasks of the Christian church is to protect the weakest and most vulnerable and that the unborn fall within these categories.

Sixthly, we are totally agreed in our opposition to abortion on demand. Seventhly, we are agreed that abortion should be permitted in situations where the continuance of the pregnancy represents a substantial medical risk to the life of the mother, even if in a few exceptional cases this requires direct rather than indirect abortion.

Eighth, we agree with the importance noted by the medical ethics group of a comprehensive programme of education but would wish to emphasise that this must include education in moral values.

Ninthly, we are agreed that in-depth pastoral care and ministry are necessary to help many women through the trauma of unwanted pregnancy and abortion and, although we believe most abortions to be wrong, we would emphasise the crucial importance of non-judgmental care in the process of healing and restoration.

The essential areas of disagreement among members of the Church of Ireland are the following: (a) whether it is appropriate, as was done in the report you have before you in the first bullet point, to define a lower limit below which abortion is not concerned. The sentence in the submission, 'We find merit in the UK's Human Fertilisation and Embryology Authority's use of the 14 day stage, a significant stage in the development of the embryo, and suggest that this should be the earliest stage for the legislation's concern' is unacceptable to many. Those who oppose the 14 day limit are often not prepared to label the IUCD and/or the morning after pill as contraceptive devices. They are also concerned that the 14 day limit has an arbitrary character and they may have strong views on life beginning at conception. Some may also wish to make the moral point that where we are uncertain about whether a life or an nascent life exists our approach should be an essentially conservative one. (b) In our areas of disagreement we are not in agreement about what constitutes an exception other than medical risk to the life of the mother. At the moment, that is the only agreed exception, though some would want to extend this to the risk of suicide where others would strongly oppose this extension.

The three areas of greatest disagreement in exceptions are (i) lethal or severe congenital abnormality in the foetus; (ii) pregnancy after incest and (iii) pregnancy after rape. Another area was also added in the submission and it is as follows: cases where 'the probable consequence of the pregnancy would be to render a woman a mental and physical wreck' – the Bourne judgment. This raises very difficult questions of interpretation for many and there would be genuine difficulties for many members of the Church of Ireland with any loophole that would allow the door to be open, which has been opened widely, for example, in England, where the vast majority of abortions are performed for social, economic or psychological reasons.

Having said that these are areas of debate and discussion among members of the Church of Ireland, this does not mean that every individual view among members of the Church of Ireland is to be considered as of equal moral weight. The official position of our church still remains an essentially conservative, but not a totally black and white one.

Senator O'Donovan: I welcome you here to this committee. I read your report some time ago. It was quite clear and succinct and I thought fairly well thought out. One of the difficulties I would face, as a member of the committee – and I have learned a lot since we initiated these proceedings, meeting various medical experts, etc. – is the definition of abortion. I wonder have you a particular view on it because we have heard of indirect

abortion – you mentioned it there – and direct abortion and there is the notion of termination of pregnancy and so on? Would it be helpful, or have your any opinion to offer, on how abortion should be defined? One of the medical experts, I am not sure which one, said when questioned on this, that any emptying of the uterus – I think those were the words he used – was in fact abortion and that something like a miscarriage would be deemed abortion. If we as a committee are somewhat confused, you can imagine the confusion the public would have, say, in the event of a further referendum. Do you feel that abortion should be clinically and legislatively defined as issue number one before we consider either a referendum or legislation or whichever combination you would see fit?

Dr Miller: If you are asking me, I think it is very important that it should be defined. My own wife had three miscarriages, which were labelled abortions. Of course they are officially abortions and, indeed, coming down on the train with Dr Peter Trimble we were just saying the Green Paper on Abortion.… The word 'abortion' is terribly confusing not only because of the question of whether it includes, for example, miscarriages but also because of the issue raised, on which we are not at one clearly in the Church of Ireland, the issue raised about the 14 day stage and the whole question of what you are dealing with before the 14 day stage. That has never, I think, been clearly defined, the moral and theological background or reasoning for the 14 day stage, in my view, hasn't been clearly stated and defined, even in the Warnock report, which claimed that it had, and I think that needs to be absolutely clear. Some of the reason this paper was found unacceptable by some is that the idea that under that stage it might be something other than quite abortion.

Senator O'Donovan: I wish to raise a point that I think you have pretty clearly answered and I don't want to labour on it. It is that some of the viewpoints that we have entertained in this committee basically look on abortion as a sort of a bad word, a taboo. It's like, you know, maybe some years ago when we were growing up the word 'sex', you dare not mention it. The reason I am anxious on this particular issue is that viewpoints have been put to us that in certain instances where medical intervention to save the life of the mother … that is not abortion. You don't call that abortion. I think it would be important to clear the air on this once and for all. Whether we go for legislation or for a referendum to make a constitutional amendment, I think it is absolutely critical that, for the public at large, the lay people who will be voting on it, this area would be cleared up.

Dr Miller: I would agree that a working definition is very important, not least because when people see the word 'abortion' they think they know what it is that we are talking about.

Chairman: Thank you. Deputy O'Keeffe.

Deputy J. O'Keeffe: You are very welcome. It is clear that there is a diversity of view within your church. May I congratulate you on the very healthy, open and transparent way in which you dealt with the issue and presented it here. There is a difference of view. I think that's possibly a reflection of the difference of view right throughout the country on some of the complex aspects of this very difficult issue. There seem to be some areas though where there's substantial agreement on the part of your Church. Essentially, do I take it that this could be summed up, in broad terms ... you're not really in favour of a further constitutional referendum? Would that be correct? All the different strands would agree on that particular point?

Dr Miller: Yes, I think, if I may .... I was living in Cork at the time of the 1992 referendum and personally voted for the first part of that referendum and was very disappointed when it didn't get through. But I think, with that history, that would generally be the case. The approach that the Church of Ireland would generally have taken, and I'm here speaking, as it were, officially rather than personally, would have been that the Constitution doesn't allow for the nuances that legislative reform allows for.

Deputy J. O'Keeffe: And a secondary ... of where there seems to be a broad area, again, of consensus is that you're very much in favour of an allocation of resources in a programme to deal with the non-legislative aspects, the education and counselling and so on. You'd be very much in favour of that. Am I right in that?

Dr Miller: Yes, and simply added the rider that the moral aspect of that is vitally important too.

Deputy J. O'Keeffe: How would you see the moral aspect of that being properly catered for if we recommended such a programme?

Dr Miller: I think there is an inclination to believe in the Western world of today that there is such a thing as neutrality within a kind of relatively secular environment and I don't believe that such a neutrality exists. So it would be very important, for example, that, for us as a Christian church, that any programme of education, at least for those who are under our care, would be something which takes into account Christian understanding of abortion and the issues associated with it and indeed contraception.

Deputy J. O'Keeffe: I suppose I should tell you that the previous delegation we had was from the Muslim community and .... Mind you, there isn't ... I didn't notice a huge difference of approach and that's ... what I would normally accept as being the Christian approach. So, I mean, we have to take it .... I merely mention it because they were here and we now have beyond the ... other than the Christian communities to consider.

Could I ask one other question? You mentioned that there was broad agreement in your Church on an exception, should be situations where the continuance of the pregnancy represents a substantial medical risk to the life of the mother. That's mentioned in the ethics group report and is acceptable, you say, generally. Has any consideration been given to a definition of what is a substantial medical risk? Has that aspect been teased out further? Would it have to be a proven risk that would likely result in the death of the mother? Or there is then the question of a substantial risk to the health of the mother – there is a scale here. Has that been looked at? Perhaps you might ....

Dr Miller: Can I ask Dr Darling to ....

Deputy J. O'Keeffe: Of course.

Dr Darling: Thank you, Mr Chairman. I welcome the opportunity of being here and I admire your patience. On that specific question, firstly, may I just state in answering that, where I come from and I am a practising obstetrician/gynaecologist here in Dublin but I'm also, I hope, a practising and active member of the Church of Ireland and my particular concern is along the medical grounds. I have other concerns but my particular concern would be along the medical grounds. There are occasions, albeit rare, but to my knowledge within this State in the last two and a half years on four occasions where it was felt by the medical information available by a consensus opinion that the appropriate management in the interests of the mother's life was termination of the pregnancy, was an abortion, and it was carried out within the State. And I know the cases.

Now, substantial risk is very difficult to define and you're quite right to hone in on it. The sort of information, and one of the cases I was personally involved in, was that the information available was that if we did not interfere with the pregnancy, the mother would have possibly about a 50% chance of dying before the pregnancy became viable and she could be delivered. Whereas, if the risk of interfering and of evacuating the uterus, removing the pregnancy, the risk of the mother dying was approximately 20% to 30%. Now, these are figures you can't actually justify because you don't know what's going to happen if you don't. The only way of finding out if she's going to die is not do anything or indeed do something to find out does she die then or not.

So, we don't know the answers, but the medical literature and the information that we have at the time of these clinical situations, we know that the pregnancy is exacerbating whatever the medical condition was and we know that if we remove the pregnancy, that condition will improve. The relative risks are weighed up. Substantive, in my mind, would be something over 50%. If you've got more than a 50% chance of dying, I'd call that substantial, but it's an arbitrary figure.

Deputy J. O'Keeffe: And then it would be very much up to the medical specialist to come to a view on that and consult then with the mother ....

Dr Darling: And her relatives.

Deputy J. O'Keeffe: Are we into the situation of ectopics and cancers and ....

Dr Darling: I will come onto that. There were cases I'm talking about are severe medical conditions affecting the mother where the pregnancy is otherwise normal but is exacerbating the clinical situation. In clinical practice, what has happened is that the combined wisdom of various ... and they'd be not just obstetricians, gynaecologists, there'd be haematologists, there'd be various sub-specialists, would give their opinion as to the clinical situation, the future prognosis, what would happen if we do interfere and what would happen if we don't interfere, and we would discuss this with the mother concerned and usually her partner and whoever is felt to be appropriate and a decision is then made.

The other situations, and that's really what the Senator was coming onto ... to me, the definition of abortion is very clear in that any removal of a pregnancy before viability is an abortion. I don't see any confusion in that. The top end of the spectrum – pregnancy is a spectrum – is viability and that varies. That may be 22, 24, 26 weeks – 28 weeks used to be the current idea, but with improved medical knowledge and techniques, that is getting smaller, getting less. The babies that can survive are getting smaller, 500g is thought to be the lower limit of viability. Now, babies less than that do survive and become healthy citizens. So, there is a spectrum, but anything that is pre-viable, which is approximately 24 weeks, and removed, any pregnancy would be, in my mind, an abortion. Call it a miscarriage if you wish, call it a termination, but it's an abortion.

The difficulty is, well, there are two difficulties. One is you can fudge the issue by talking about ectopic pregnancies, you can talk about double intent, a difficult cancer of the uterus. You remove the cancer but you're performing an abortion and that's been going on in this country always. The difficulty at the lower end of the spectrum, when does life, when does viability start or pre-viability start and that's a confusion. Again, I'm afraid, we never will know. The convenient thing for some is to fudge that also.

Some would say that as soon as the egg is fertilised by the sperm, there is the potential for life and that was, I think, correct. Now, we know that these eggs haven't implanted and, in fact, probably something greater than 60% of these eggs come away in the natural menstrual loss. So, the human species is the most inefficient procreator. So, we know that, at the early stage, that a huge natural wastage. People have tried to define 14 days and in the document to which I was party to, and I can explain my position there in a moment, we tried to suggest that it may be helpful to think of trying to define a lower limit.

You could define that from whenever the period is missed, but that isn't really rational. The actual time of conception would be 14 days prior to that, when the egg is fertilised. So any interference thereafter, in theory, if you're following that, is interfering with ... could be causing an abortion. Or you could talk about 14 days after the last menstrual period should have been which allows perhaps current practice which is the fitting of the IUCD post-coital contraception. So, in answer to the question, I think all this double effect is really fudging an abortion. It may make it more easily justifiable and, depending on your own personal attitude, may make it more comfortable, and your conscience may be eased, but I think the removal of any pregnancy would be an abortion.

Can I address just very briefly the document which the bishop did. I am a member of the Role of the Church committee ....

Deputy J. O'Keeffe: Before you address that, one last point. Perhaps the bishop might want to comment on it as well. Is there a consensus within the Church of Ireland in relation to what is know as the morning after pill and the IUCD? Is that regarded as acceptable or has that issue been addressed?

Rev. Dr Miller: I think it would be true to say that there is no consensus in the Church of Ireland on that subject.

Dr Darling: Just ....

Chairman: I would ask you and Dr Trimble to speak generally before we continue with the questions.

Dr Darling: I thought we said most of what we were ....

Chairman: I thought you were anxious to make one or two further points. Maybe you could develop them at this stage.

Dr Darling: I wanted to emphasise, as you may know, I was Master of the Rotunda Hospital and I know you have met the three current masters and they have put their views and I have spoken with them. We do come across clinical situations, which I was alluding to, where the current medical information is that in the interests of the mother, direct abortion is an appropriate management and, therefore, whatever conclusions your committee and the State decide, as a practising obstetrician we are a little bit uneasy as regards the current legislation. I am not a lawyer, but I do not think it has been tested. Although we are practising to the highest standards within a framework which we believe to be appropriate and correct, I am not sure if the courts would necessarily take that view if it were tested. I must emphasise that there are very few, I mean, as I say, I know of four cases. There are something less than 5,000 deliveries in this State per annum – this is over two and a half years – so we are talking about one in 30,000 or something like that, so it is not common but they do occur.

I sit on the Role of the Church committee and as one of the sub-committees on ethics we drew up what we understood was going to be a discussion document, which is now the one that you have. First, on a personal basis I would not disagree with anything that the bishop has said, that as a member of the Church of Ireland, the Christian way forward is along the lines outlined by the bishop, but as somebody involved in a social way and a medical way with lots of people who find themselves pregnant who, for various reasons do not wish to be, one has a social conscience and that is difficult to address. So, our document was to try and flesh this out a little bit further by trying to define what we meant by abortion and suggesting parameters that further legislation might follow. This then gained momentum and next thing it was up in front of the synod and you heard that there was not a little split, but there was a close vote. Many at the synod felt this was a positive contribution and they were comfortable with what we were trying to suggest, but there were as many, if not a few more, who were not comfortable with it which, I think, is a healthy reflection on the diversity within the Church of Ireland in that there is a great deal of agreement, as the bishop has already said, but there would be a spectrum of attitude, as I am sure there is within every church. That is really what I was trying to bring out.

Rev. Dr Miller: Could I add a rider, just for your clarification? It is important to notice that even though the vote was very close, this is not now the submission of the Church of Ireland to this working party. That is why we are having to step back. The three of us have been chosen to represent different angles, though not quite as different as they were presented in *The Sunday Times*, but we have been chosen to represent different angles on behalf of the standing committee and we have to step back slightly behind this document now to try to express to you some kind of consensus from ourselves, as three representatives, and some kind of expression of what the Church of Ireland has actually said previously on the subject. But this is not now what the Church of Ireland statement is.

Chairman: In fact, you had an opening statement and I assume you could hand us that.

Rev. Dr Miller: Yes.

Chairman: Because that is your position now, in effect.

Rev. Dr Miller: That is the position of the three of us representing the standing committee.

Chairman: That is your position as representing the standing committee and it identifies the areas of agreement and the areas of disagreement.

Rev. Dr Miller: That is right.

Chairman: Before I take any questions, Dr Trimble, do you wish to elaborate on that for us?

Dr Trimble: Dr Darling has said that his document, the Role of the Church document, came forward for discussion at the general synod and I was one of those who engaged in that discussion. There were a number of people who expressed reservations about aspects of the document. I would have to say that in the original submission to the interdepartmental working group by the Role of the Church committee, I was pleased that they affirmed the view of the Church of Ireland, upholding the sanctity of life before and after birth.

The issue of termination of pregnancy is clearly sensitive. It touches many people deeply and there is understandably a desire among church members to act out of concern for those in distress, as Dr Darling has expressed. We welcome the consideration that has been given to the difficult issue in the Green Paper.

The role of the church committee on medical ethics attempted to address the particular difficulties in a legislative approach and a situation which can appear unclear. Part of my concern is looking back to the UK experience, when in 1966 David Steele introduced his Private Members' Bill, which became law in 1967. The motivation behind that appears to have been intended to prevent death and misery from back street abortions and also to enable doctors to carry out abortions in hard cases without fear of prosecution. It came at a time when thalidomide was in the news and there were a large number of concerns. David Steele has stated that it was not the intention of the promoters of the Bill to leave a wide open door for abortion on request, but if we move on 30 years later, he is quoted as saying he did not think anyone foresaw what the numbers would be. The Act, as we know, allowed abortion to be performed in a number of defined situations.

Most abortions in England and Wales are carried out on the grounds that the continuance of the pregnancy would involve risks to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated. I, like other members of the General Synod of the Church of Ireland, was concerned that in framing the exceptions listed by the resubmission, that we would head into the same situation which exists in England and Wales and effectively end up with an open door.

Many would hold to the principle which has already been outlined by the Bishop of Down, that in the strongest terms, Christians reject the practice of induced abortion, which involves the killing of a life already conceived as well a violation of the personality of the mother, save at the dictate of strict and undeniable medical necessity. In their submission to the Green Paper, the committee describe abortion as never desirable and, at the most, the lesser of two evils. They then go on to attempt to define the situations in which abortion might be permissible

The first is situations where the continuance of the pregnancy represents a substantial, which is undefined, medical risk to the life of the mother. This appears to be open to wide interpretation. Then, abortion for lethal or severe, again undefined, congenital abnormality in the foetus. 'Severe' could cover a range of abnormalities, which are not necessarily incompatible with life. The detection of such abnormalities is itself not without the potential for physical and psychological complications. Even simple tests can have a profound effect on the mother's attitude to the pregnancy and can impair her acceptance of the developing baby. The more invasive tests can themselves result in the abortion of a normal foetus as a complication unintended of the test.

There are also wider implications. Abortion of abnormal individuals has an effect on society's perception of the disabled and, in particular, acceptance of disabled children. The detection of abnormality, and even the counselling process, puts pressure on the mother to make decisions regarding the continuation of her pregnancy. The process has even been described as giving rise to a situation where there is a duty to abort. So a process, an intervention which is designed to improve the position of the mother and give greater choice can perversely create a situation where she feels pressured to make a particular choice.

Pregnancy after incest and pregnancy after rape are understandably difficult and emotive situations, perhaps the most difficult in the list of exceptions, and some would argue that abortion in these cases is the lesser of two evils and the compassionate solution. However, going back to the principle outlined in the ... where the Church has previously stood, it denies the personhood and right to life of the foetus and it can itself re-traumatise the mother. Establishing the circumstances, that the pregnancy was due to rape, could clearly be very traumatic to the mother and presentation may be late because of her reluctance to come forward in these cases.

Cases where the probable consequence of the pregnancy would be to render the woman a mental or physical wreck is a term which, as we know, comes from the Bourne judgment of 1938. The first and most obvious point in this judgment is that the term 'mental wreck' does not easily translate to a diagnosis of a psychiatric condition and is open to wide interpretation and considering the evidence from several studies in the psychological sequelae of pregnancy and abortion, I cannot envisage a situation in my personal professional practice as a psychiatrist where I would recommend the termination of pregnancy on psychiatric grounds.

In his submission to the Rawlinson inquiry, Blacker reported 10% incidence of short to medium term psychological effects of abortion and the report of the same inquiry noted in its correspondence to questionnaires sent to people who had had termination an 87% of those responding reporting long-term emotional problems. As well as that, an article in the CMAJ has reported wide-ranging longer term emotional problems, including effects on the family following abortions.

On the final criterion for exception to the genuine case of threatened suicide, the assessment of suicide risk remains a major challenge in psychiatry with suicide accounting for 1% of deaths annually. Risk assessment involves identifying factors associated with suicide, careful mental state examination for signs of illness and the assessment of both the short and long-term risk.

Suicidal patients do not fit neatly into one type. They include those who are suffering from a major mental illness and those for whom self harm appears to be a function of their dissatisfaction with circumstances. It is important to note that despair is often a transient state and modern and effective treatments are available for psychiatric illness.

The Christian response to those who are having difficulty in this way with circumstances might better be to provide help. Studies have looked at this, at the suicide issue. One looked at admissions to hospital after suicide attempt after a miscarriage, induced abortion and normal delivery, and the risk was higher for miscarriage and abortion and the author commented that the risk of suicide after abortion might be a consequence of the procedure, and a study of suicides after pregnancy in Finland in 1987-94 noted that the suicide rate associated with birth was significantly lower and the rates associated with miscarriage and induced abortion were significantly higher than the population rate.

Coming back, as a final comment, Alec Bourne, the obstetrician involved in the Bourne case, from my reading is reported to have become increasingly concerned by what he saw as the abuse of psychiatry in the practice of certifying many pregnant women who were at risk of profound mental disturbance and opposed the 1967 Act, and also became founder member of SPUC. So, the Church response in this situation, I believe, has to be a compassionate one and should focus on the provision of help to those in difficulty through provision of crisis pregnancy advice, support, adoption services, care for the handicapped and in education.

Chairman: Deputy McManus.

Deputy McManus: First of all, can I welcome you here and thank you for coming here to make this presentation? I think it is very useful for us to have this kind of detailed information and I suppose the complexity of your presentation indicates the complexity of the issue itself.

I have to say I am very concerned at the fact that so few women have been involved in these presentations. Today, for example, eight times more men will be speaking here than women and yet it is the women who suffer the crisis pregnancies, who are the ones who have to live with the

after effects of rape and whose health and lives are threatened from time to time.

I would like to know if you feel .... You have come through the process of consultation, you have had a very narrow vote and, obviously, that is causing a certain amount of difficulty for you in terms of simplifying your position, but are you satisfied that the voices of women within your Church have been sufficiently listened to and in what way have you been able to enable women to make their position heard? And obviously there are differences .... And, you know, women as well .... I am not saying that there is any simple, straightforward view there but, for example, of the number of people who voted – it is over 300 people – roughly speaking, what proportion would be female?

Rev. Dr Miller: The light has just gone on there. I totally accept what you have just said and, indeed, it was an issue at the standing committee. The Church of Ireland actually in its governance does not have large numbers of women on the standing committee which is one of the reasons why there are two men here, but we are trying to represent positions as well, so it is quite difficult to get a small group to do this. But it was something that was recognised and, I think, you are absolutely right about that.

I could not tell you the percentage on the General Synod who are women. I would imagine something like a quarter, but that would be .... Would that be your perception?

Dr Darling: Something like that.

Rev. Dr Miller: I would imagine something like that. But certainly the Church of Ireland .... Let me put it like this – although we have women priests ... is still emerging from being a very male dominated Church.

Deputy McManus: Indeed, and you have some very eminent women priests and I would congratulate you for that.

Rev Dr Miller: And some other very eminent women too.

Deputy McManus: Could I just ask in relation to your consensus position, you have described it as conservative. As I understand from what you are saying, it is actually more conservative than the outcome of the Supreme Court decision in the X case, where suicide was interpreted by the Supreme Court as being a threat to the life of the mother. Are you saying to me then that the Church of Ireland position is that in the X case that girl should not have been given the right to travel to have an abortion?

Rev. Dr Miller: In relation to the X case, I think we have tried to convey a range of views. It would not necessarily be true to say that the Church of Ireland is committed – in fact, it is not committed – to one particular view, I think, of the X case. It did not oppose certainly the right to travel and it did not oppose the right to information. In fact, I think the Church of Ireland would stand with those two rights.

In relation to whether the Lambeth declaration can be widened, where you speak about, say, of 'the dictat of strict and undeniable medical necessity', the question of whether that can be widened to also include the risk of suicide is something that, I think, the members of the Church of Ireland and the General Synod would be, probably have very different opinions on.

Deputy McManus: In terms .... At the moment the constitutional position, as I understand it, is that suicide is, because of the Supreme Court interpretation, is included as ... within the terms of the constitution so that it would require a constitutional amendment to take that out of the equation. Now we have already had a constitutional referendum on that precise issue – it was the substantive issue in the previous referendum. What I'm getting from you is you're saying you really don't think it is worthwhile to have another referendum ... another constitutional referendum anyway. Is that right?

Rev. Dr Miller: Again I have to speak personally to a degree here. Speaking personally, I was very disappointed that the previous constitutional referendum did not succeed in that particular aspect. Whether there's a way of framing a new constitutional referendum which, somehow or other, takes that aspect out of it and allows for new legislation is a good question. I don't know the answer to that. We have looked through .... You have given seven potential ways forward and the original document which you received said we examined all seven options and while recognising the merit of some, none of them totally reflected the main body of opinion within the Church of Ireland.

I don't know who judged what the main body of opinion within the Church of Ireland was in that case but, on one level, it's not far from wrong. We've all looked at these seven options and the Church of Ireland does not come down in a black and white way either saying 'yes, a total constitutional ban on abortion we would be opposed to' just as we would be opposed at the other end on abortion being widened to cases where it was allowable ... being widened in option No. 7. I think something like option No. 4 might come a little bit closer where an attempt is made to put laws into place which would allow for very exceptional exceptions. But then the danger, as the Green Paper points out, is that that could lead itself to a legal case where the X case is held up as the result of the previous Supreme Court judgment in relation to the Constitution.

I don't think that we have a clear answer. We couldn't say we think one of these is the right way forward. The Church of Ireland has said right from the beginning that it felt that the Constitution was too blunt an instrument for such intricate dealings as the issues in relation to abortion. I think it would be true to say that we have always believed that abortion is essentially wrong, that we want it not to be legal but that there are very exceptional cases.

Deputy McManus: I'd just like to ask two more questions if I may. One relates back to this issue of suicide. We have received professional presentations here and I think it would be fair to say that while the general view is that suicide is less likely in a pregnant woman than in a woman who is not pregnant, that it still something that happens. It is rare but it does happen. Dr Trimble, you seem to be indicating that even in those rare circumstances it didn't

seem to be something you would accept, that even, for example, if there was clear clinical judgment being exercised where a psychiatrist or two psychiatrists, as has been suggested, felt that a woman was suicidal and that abortion would actually deal with her particular problem, you still feel that shouldn't be allowed. Is that right?

Dr Trimble: My difficulty with that situation is in the ability of clinicians to assess accurately the risk of suicide. There is a difference even between deliberate self-harm – non-fatal deliberate self-harm – and actual suicide risk. Quite often, patients presenting with ... or having made efforts to harm themselves, do not actually want to end their life but are seeking some other way of alleviating distress and it may be a sign of distress rather than a sign that they want to end their life. The hopelessness in true suicidal patients is usually a transient effect, a transient state, and if you come back to people who have been suicidal after they have recovered they will be glad that they have not taken their life.

I would worry that if suicide risk was taken as a criterion for termination of pregnancy that women already cornered in difficult circumstances may see threatened suicide or attempt at self-harm as a way to extricate themselves – and an unsatisfactory way, in the long-term – to extricate themselves from that situation. We may actually be providing them with a less good option from providing good care for psychiatric illness and good support for their plight. The difficulty is in the assessment of the suicide risk and in applying termination of pregnancy as a solution rather than looking to other ways of resolving the situation.

Deputy McManus: I appreciate medical judgment ... there's always a question of risk and having to make a decision one way or the other, but what you're saying is that you would rather take the risk that a woman commit suicide.

Dr Trimble: No. I would rather provide appropriate support for the woman to see them through the situation than provide what may appear to be a solution ... terminating the pregnancy, which, in effect, may not help the woman's plight and may lead her, when well, to look back with regret at what had happened and to be troubled psychologically with the consequences of an intervention that has, in fact, added to her difficulty rather than helped in the long term.

Deputy McManus: In effect, you're saying the X case should not have been allowed have an abortion.

Dr Trimble: I would have difficulty with abortion on the grounds of threatened suicide. I don't know the fine details of the case and I ....

Deputy McManus: Could I just ask my last question? I think there's a widespread concern at the idea of very freely available abortion as has developed in Britain and the fear that if any abortion is allowed – even though I take the point Dr Darling has made that there is already abortion in certain limited circumstances here – the floodgates would open. We had a presentation from Northern Ireland and I would ask if maybe you would give me your view on the fact that, in Northern Ireland, for quite some time now abortion has been available, probably on rather similar lines to the medical committee ethics working group's criteria, but, roughly speaking, that it's very heavy emphasis on the clinical judgment of the medical profession that is provided, hasn't opened the floodgates. In fact, I think in yesterday's *Irish Times* there was an indication that the number of Northern Ireland women is actually dropping whereas here it's actually increasing. In terms of what happens in Northern Ireland, abortion is provided in limited circumstances, targeting certain conditions and issues relating to health or, indeed, to foetal abnormality. Maybe you'd comment on that?

Dr Trimble: Abortion is available in defined circumstances in Northern Ireland. There are also people who would travel to England to obtain an abortion. It is a topic that is not widely and publicly discussed and ....

Deputy McManus: You won't not have that problem here.

Chairman: The Assembly voted not to have the discussion like this in recent weeks.

Dr Trimble: In some ways, that lack of public awareness of the abortions that do occur may be having an effect on numbers. However, the position in Northern Ireland is likely to ... there's likely to be pressure for change applying human rights law and even there's been talk of challenge on an equality basis, as to whether or not the legislation should be open. It may be that case law opens up further the gates for abortion in the North. In some ways I'm envious of your position where there is a constitutional safeguard for the unborn child, even though that has been tested by the X and C cases.

Deputy McManus: Thank you very much.

Senator Dardis: Thank you for your presentation and I suppose it's in the best traditions of your church that you have this accommodation of diversity of view. However, I need some clarification. Am I correct in assuming that the overwhelming consensus of the Synod would be that it should be by legislation and that the difference of opinion related to the so-called hard cases and how they would be dealt with?

Rev. Dr Miller: It's very hard to interpret this particular vote. The vote was not a vote on a motion put to the Synod in relation to abortion. The vote emerged out of a debate on the role of the church committee in which it became clear that some people were unhappy about two appendices, one on abortion and the other on withdrawal of artificial feeding and hydration. A proposal was put forward that the whole role of the church committee report should be not accepted by the Synod and I myself proposed an amendment which was that it should be accepted without these two appendices. In other words, when people were voting, they were not voting on a clear cut resolution about abortion. There was the abortion factor. There was also another appendix being removed about artificial feeding and hydration. In my view, and it's only a subjective view, there were three things running at the same time. One was that some people were unhappy about what the report said, ethically and morally. The

second one was that many people were concerned that, if the Church of Ireland withdrew these reports, we had nothing to say to you, and here was our submission gone. That was a genuine concern. The third one was that here was a committee that had worked hard and does work hard on a great number of issues, had presented all their material and it was a very rare thing to do to remove part of that. So, you couldn't say it was a vote simply, pure and simple, on abortion and you can't take from it that half the Church of Ireland is conservative on abortion and half liberal. It may well be that much more than half is conservative on abortion but that other things were running in their minds or that that was not the subject that was central to them in their vote, it was some of the other issues. So, to interpret that is actually quite difficult.

Senator Dardis: With regard to the substance of the debate when it covered the issue that's before us today, is it reasonable to say that the clear preference, as represented in the debate, would be one of saying it should be by legislation rather than by .....

Rev. Dr Miller: No the debate wasn't on that subject. What we have had to do since that particular situation, and I myself have gone through it with a fine-tooth comb, is we have had to go through all the other things that the Church of Ireland has said on this subject, either in the Synod or the standing committee or the role of the church committee or whatever, over the years, and over the years there has been a consistent feel right back to 1983 with the eighth amendment that amending the Constitution was not the best way to deal with the issue. Now, I would have to say, as Peter Trimble has pointed out, that nevertheless the Constitution has become a safeguard, in a funny kind of way and in a slightly indeterminate kind of way has become a safeguard because of Maastricht. I don't think there's strong feeling against there being anything in the Constitution but the overall feel is that we're dealing with very intricate and detailed issues and, when the 1983 amendment went wrong and was interpreted in quite the opposite way to what was expected, there was a certain amount of feeling in the Church of Ireland of 'we told you so'.

Senator Dardis: Is the core of the issue not that it is to devise a system whereby, in providing for the so-called hard cases, one doesn't allow optional abortion, so to speak?

Rev. Dr Miller: Yes, it is to devise – I think it would be to be true to say – a situation in which abortion is essentially illegal but that there are very very carefully controlled exceptions. Now, the agreed exception is where the life of the mother is at risk, and that has always been the position of the Church of Ireland, that where the life of the mother is at risk an abortion should be possible. Where there are agreed exceptional cases, and what those exceptional cases are, we're not clear about, but what we are clear about is that we do not want a situation like we have in England.

Senator Dardis: Just to return to Deputy McManus's point, about the Northern Ireland example, and we have had presentations describing how the system works in Northern Ireland, do you regard the system as it operates in Northern Ireland or is there something that we can draw conclusions from or that we can draw examples or that could be of benefit to us with regard to how the system actually operates as it stands in Northern Ireland?

Rev. Dr Miller: I wouldn't be an expert on that but what I would want to say is something like this: that the Church of Ireland is and has always been an all-Ireland church. So, whatever moral and theological conclusions we come to in relation to abortion should be applied both North and South, and there are many of us who are concerned about aspects of the northern situation at the moment as well as potential concerns about the situation here.

Senator Dardis: Perhaps Dr Trimble would comment on that aspect. I know you've already dealt with it.

Dr Trimble: I would agree with that and that the issue needs to be debated both North and South. We as a group representing the church need to be prepared for the next time a debate puts the focus on the church's opinion as it's likely to do in the North fairly soon. The case law which is applied, the Bourne judgment, actually the judgment, from my understanding, concluded that there was no essential difference between protecting the mother's life and protecting her health, so there is room for case law to broaden definitions, especially if those definitions aren't tightly defined at the outset.

Senator Dardis: Would you regard it as desirable that there would be a consistency between the position North and South of the Border, I mean, from a church point of view?

Rev. Dr Miller: Can I answer a question you haven't asked just before that one and say that it seems to me that the danger of the position in Northern Ireland, if we want to talk about that at the moment, is that the Assembly didn't even have to take a vote on the issue that they did not wish – nearly every party agreed which is pretty unique for Northern Ireland – but they did not want the 1967 Abortion Act extended to Northern Ireland. The danger is that they then think that everything is done, everything is dealt with. There are many areas in which it would be a great help to the Church of Ireland if we weren't living in two jurisdictions because there are two separate situations to be dealt with all the time. I would imagine that it would be – I'm just talking off the cuff and personally here – very helpful if there was an equivalency between the two situations.

Deputy McManus: May I just ask a supplementary to Dr Darling? As somebody who's obviously worked at the coal face, in a sense, and has to deal with issues as they arise in the medical context, would it be fair to say that there is a great comfort in the fact that, next door to us, there is a country that provides facilities and doctors to carry out safe abortions, where a doctor here is practising and comes across the hard cases, the anacephalic foetus, or where there is a serious risk to the health of the mother, whatever it is, that, in a sense, we can have very clear moral standards and that they can be safeguarded by the fact that, somewhere close by, the job will be done?

Dr Darling: This is fact. I tried to allude to it early on. There is an environment of hypocrisy in the South because, first of all, 6,000 girls don't come to us at all because they have gone to England, so that is not in our ambit and we can either be very concerned about that or we can disregard it and say, 'That's none of my business'. That's hypocrisy.

More particularly in the medical situation, yes, if we do have, and we do diagnose as in every other country, foetal abnormality etc., early in pregnancy and one of the options which many people feel should be available to a patient is the option of termination of that pregnancy. Now I speak as an obstetrician, if one hones in on the hat I am wearing today, which is an obstetrician but representing myself and I am an active member of the Church of Ireland, that may not be an option that I would necessarily put forward but when you're looking after the patient that is an option I think they should have. The comfort is there that if they wish to avail of the system in Northern Ireland, and they do, not many, but some do, it is there. The *status quo* and one of the options in the paper was the *status quo* – it works. It's a sort of system that sort of works for some and increasingly more. There are not that many people excluded from the system because of social status or wealth. In fact it tends to work relatively well but it is a double standard. We are not being honest with ourselves.

To go back to the Church of Ireland, I feel there is consensus within the church that while anti-abortion in a few carefully selected situations is appropriate and acceptable but then there are those also within the church who would like to see those exceptions extended perhaps in some ways. We are hearing various opinions today and I think probably the core opinion would be conservative as the bishop has stated. You will find a spectrum of opinion.

Deputy McManus: Thank you.

Dr Trimble: May I comment on that, Chairman?

Chairman: We are running short on time but certainly.

Dr Trimble: I find as a clinician that there is comfort in having legislation which protects the unborn baby as well and can back up clinical practice. I think it also protects women. If abortion is freely available and is seen as an easy alternative it's not difficult to envisage situations where a woman is shown practical options that she may take to get everybody out of a tight situation, like terminating a pregnancy, where it's inconvenient for others around or inconvenient for the State to provide support in what might be difficult social circumstances. I think there is comfort to be derived by having well framed legislation which protects both mother and child.

Deputy McManus: So you are in favour of legislation?

Dr Trimble: Yes.

Deputy McManus: Okay, thank you.

Chairman: One or two questions. Dr Darling, you are a member of the institute of obstetricians and gynaecologists I take it, and you participated in their consultation procedure?

Dr Darling: I did.

Chairman: I think they made it very clear that in current obstetrical practice rare complications can arise where therapeutic intervention is required at a stage in pregnancy where there would be little or no prospects of the survival of the baby due to extreme immaturity.

Dr Darling: Correct.

Chairman: I took part of what you said to refer to that and to the earlier comments we heard from the master.

Dr Darling: Correct.

Chairman: You expressed concerns about the principle of double effect. I take it from that you would be concerned that while it may be a workable moral principle or a principle connected with conscience, that it doesn't provide certainty for you as a medical practitioner at the coalface.

Dr Darling: That's right. It comes back to definition. To me whether you're removing a uterus because it's got a cancer in it and happens to have a baby as well, that's an abortion to me, regardless of how you classify it. The system works because it is accepted medical practice. Without going into the theological arguments I suppose I was trying to, in answer to a previous query, to say that in current practice in my definition, abortion does occur, not frequently but it does occur for very strong medical reasons.

Chairman: And you referred to these three or four cases in recent years and I take it that, as was indicated to us by the masters, that these related to Eisenmenger's type syndrome?

Dr Darling: There was one Eisenmenger's, two, I think a thing called HELLP, which is a liver failure situation, and another condition, hydatidiform mole. They are there to be scrutinised.

Chairman: And I think you can speak for everyone in this respect, it's correct to say the Church of Ireland is anxious to see that all those kind of cases are covered as medical intervention and are recognised and accepted.

Dr Darling: Yes, exactly. I think whatever these deliberations, whatever legal framework emerges from these deliberations, the Church of Ireland wishes that this should be allowed.

Chairman: Yes, so that in so far as there is a consensus between you, it is not that different from the consensus which the institute of obstetricians and gynaecologists arrived at.

Dr Darling: No, I'm just trying to .... No, that's right.

Chairman: But there are divergent views on other issues of course and I accept that.

Dr Darling: Yes. I think the church's view would not be that dissimilar to what was put forward by the institute.

Chairman: And then of course the wider questions were canvassed at length and I do not want to go back into them but the question of the Constitution. I suppose it's fair to say that when the 1983 referendum was proposed the Church of Ireland took the view that the Constitution was not the appropriate instrument for this issue and that, as you say, the complexities of the issue require detailed legislative treatment. On the other hand, we do have to operate in two jurisdictions in Ireland and of course in this jurisdiction. Parliament is sovereign in Northern Ireland but in this part of Ireland the people ultimately make decisions on questions of public interest, so that is the constitutional system. Would it be a fair refinement of your position to say that while the Constitution should state general principles, the details should be settled by legislation?

Rev. Dr Miller: That would certainly be a fair refinement of my position and I don't think that would be very far from the Church of Ireland's position.

Chairman: Thank you very much.

SITTING SUSPENDED AT 12.17 PM AND RESUMED AT 12.20 PM.

Rev. Dr Trevor Morrow and Rev Norman Cameron

Chairman: We are now in public session. I would like to welcome the following representatives of the Presbyterian Church in Ireland: the Reverend Dr Trevor Morrow, Moderator, and the Reverend Norman Cameron, convenor of the social issues and resources committee. I welcome them to this meeting of the Joint Committee on the Constitution. My apologies to you – we were delayed on the previous submission. We have received your presentation which has been circulated to the Members. The format of this meeting is that you may make a brief opening statement to elaborate your position and this will be followed by a question and answer session with the Members. I have to draw your attention to the fact that while Members of the committee have absolute privilege, the same privilege does not apply to you. I now invite you to make your opening statement. Before I do so I would like to say that you have an opening statement prepared – isn't that the position?

Rev. Dr Morrow: Yes, we have.

Chairman: I suppose I should circulate that to the Members. I don't know that we can take it as read, or ... Will we table it before the Houses so it becomes part of the record? If you wish we can table this before the Houses of the Oireachtas so it forms part of the record and that would absolve you of the need to read through the whole lot of it. Or would you prefer to elaborate on it?

Rev. Dr Morrow: I think it might be easier because we might make little asides or references that are not actually in the content of that.

Chairman: Yes, well if you want to elaborate on the submission. Thank you.

Rev. Dr Morrow: Well, can I thank you first of all? It is an honour for us to come and do this. I will just explain our roles. I am Moderator of the Presbyterian Church in Ireland. A Moderator literally moderates – he chairs. He has no episcopal authority, but I am meant to be able to articulate to some extent the opinions of the general assembly of the Presbyterian Church. Norman Cameron is the convenor of the social issues and resources of the board of social witness of our church and that is why we are here to fulfil those roles.

We want to thank you for this opportunity to make an oral submission and to answer questions on this important subject, but can we do two things briefly in our introductory submission today? We want to first outline the context of our written submission and the theological and ethical stance of the Presbyterian Church. Second we want to give a little more on the reasoning behind our favoured option, which is option 5 in the Green Paper.

The Presbyterian Church is a broad church, a democratic church and at heart a conservative church. It includes a wide range of opinion and it can sometimes be difficult to assess what exactly our membership thinks upon an issue unless the issue has been debated fully at presbytery or general assembly level. If you like you can ask me later on the niceties of how Presbyterians exercise government – as to what those actually are – but the major body for making decisions for us is the general assembly – it is the equivalent of the house of bishops or the general synod of the Church of Ireland.

This issue of abortion was last dealt with by report and full discussion at our general assembly in the early 1980s. A report presented by our national and international problems committee in 1981, while strongly urging protection of the life of the unborn, considered that there might be areas where the termination of pregnancy is permissible. These included where it was necessary to save the life of the mother and in cases outlined in your own Green Paper's option 7. This report was noted by the assembly and sent down to presbyteries for comment. Presbytery responses to the report were mixed. In 1982, in a full debate on the matters raised, a number of resolutions were passed. In one, the general assembly declared their opposition to abortion on demand for purely social reasons or as a means of birth control. A resolution attempting to get support for abortion in the hard cases of rape or gross abnormality detected in the foetus was defeated and replaced with a resolution stating that in exceptional cases where medical abortion might be necessary the most stringent safeguards should be provided to prevent abuse. A third resolution was passed that year stating that much

greater emphasis should be placed on the provision of adequate care by church and State for those with unwanted pregnancies and for the infants when they are born. As we have stated in our written submission, while there would be an openness to consider option 7 among some of our membership, a more conservative position would probably have majority support – probably option 4 or 5 of the Green Paper.

Since that time there has been a report from a committee on ethical issues to our general assembly in 1993 on life before birth, a copy of which we have supplied today for your information. This summarises well our current church's thinking. It again reinforces our theological stance which is that human life is sacred and uniquely valuable, we are made in the image of God, human life begins at conception, the taking of human life can only be considered in the most extreme cases. Again, the 1992 report acknowledges the hard cases of rape, incest, foetal abnormality, and indicates that some Presbyterians would consider an abortion in such cases. As against this it seems clear that – we are quoting – 'significant numbers of Presbyterians are convinced by the arguments for the absolute rights of the unborn. For them the practical decisions are clear even if they are demanding and traumatic. In faith they believe that our God will provide the grace which is sufficient for those who willingly except their burden as a labour of love.'

As a church we wish to reiterate the call to compassion and grace and for more of an emphasis to be placed upon appropriate care, support and counselling for those faced with an unwanted pregnancy. There is also growing evidence of emotional trauma caused to women who have abortions. In Northern Ireland there is a growing network of advice and support agencies which offer realistic and caring alternatives to abortion and support for the woman through her pregnancy. We would encourage this in the Republic.

I am going to ask Norman now if he would like to present the rest of the oral submission.

Rev. Cameron: Can I just make one or two comments about the options in the Green Paper? In our written submission we have very briefly stated objections to options 1 to 3, 6 and 7, and our comments are made in the light of general assembly debate and resolutions passed especially in the early '80s – 1982 and '83. We do not believe that our church's position has changed substantially since that time, but we do not know for sure as we've not had a recent debate at presbytery or general assembly level. The committee will be interested to know that in 1982 the following resolution was passed by our general assembly – that the general assembly is firmly opposed to indiscriminate abortion but does not believe it is wise to insert a clause banning abortion into the Constitution of the Irish Republic. The State's regulations of this and other matters affecting morals should be a matter for legislation by the Dáil and the Senate and not for definition in the Constitution. A government committee made representations in these terms to the Republic's Government when the eighth amendment to the Constitution was being debated. This position was reaffirmed the following year – 1983.

Thus, as a church we have not chosen option 1 as our assembly has indicated that a constitutional ban is inappropriate. Likewise, option 7 has been debated by our assembly in 1982 and while it has some support it was ultimately defeated. We would feel that option 4 or 5, while not ideal – and we would emphasise that – are the best way, preferably option 5. We do have a concern that no psychiatric evidence was received in the X case. Nevertheless, we do agree with the principle that abortion should be permissible to save the life of the mother and where there is a clear and substantial risk of suicide. We believe that such cases are very rare. I quoted a statistic there from a parliamentary answer in 1992 – .004% of the 3.6 million abortions were carried out to save the life of the mother. We also believe the suicide risk is very low, indeed pregnancy is protective against suicide but we do believe that in rare cases it can still occur.

We prefer option 5 in that it provides a legal framework to assess abortion. It seeks to establish in legislation what appears to be the current position in the Republic. It is stricter than the R v. Bourne case. As a church we have not agitated for a change of the R. v. Bourne position in the North of Ireland. Therefore logically we feel our church will accept a position stricter than R. v. Bourne, meaning the X case.

In closing, can we say that if option 5 were adopted as a way forward it is on the understanding that very tight controls and safeguards would be put in place in assessing the risk to the life of the mother. We believe, as we have said, that abortions to save the life of the mother and abortion to avert suicide are very rare. In the event of such an option being accepted and it being shown after, say, three years that abortions are more numerous than we would have expected on these grounds, perhaps there should be a process of review built into legislation to prevent a situation of abortion on demand developing. If such a review could be built into the process it may reassure those who fear that legislative change will be a licence to abort unwanted children. While by no means ideal, option 5, we suggest, represents a compromise in a world of moral imperfection where we all fall short of the ideal and the glory of God.

That is our oral introduction.

Senator O'Donovan: First of all, I would like to welcome you here. I have just one question on the preferred option of 4 or 5 on the legislature. Being devil's advocate on this issue, how can we trust the legislature having regard to the rather diverse way things have developed since the legislation came in in Great Britain in 1965 or 1966? In legislation, without any tie in with the Constitution, how can we guarantee the public that firstly we bring it in in very strict terms? Some people say the law is an ass and we can drive a horse and carriage through legislation, how can we bring in a guarantee that legislation over the next decade would not be watered down or diluted? Would it not be more appropriate to have a constitutional change allowing for legislation with very strict parameters?

Rev. Cameron: It would be good to have a twin track approach. I think for many of us we have an underlying fear that any legislative change is going to open the door to perhaps abortion on demand. I feel that in the Presbyterian Church, as it has discussed this, there is a sympathy for the hard cases and, as a church, we want to show compassion for the hard cases but in line with that

there is also the real fear that even to legislate for the hard cases will open the door too much as has been the experience in England and Wales. It's obviously up to the legislators whether they can find a framework that is tight enough. I suspect they will not be able to but it is up to the lawyers to try to find that legal framework that will be tight and strict enough and maybe it will require constitutional backup and maybe that is the advantage of having a twin track approach but we felt that the Constitution was a bit too blunt an instrument and it should at least be backed up with laws that were a bit more detailed to allow for the exceptions that there will be. It was too restrictive – a constitutional ban on its own. Thank you.

Deputy McManus: Thank you very much for coming here today and presenting what is a very clear and concise presentation. I do not have many questions but there are two I would like to ask. One relates to an area which you did not deal with here but I am sure is of concern to you, the very large numbers of young women who are travelling to Britain at the moment, mainly in secret, without having any great knowledge of their circumstances. Have you looked at developing your view in relation to crisis pregnancies in relation to sexual responsibility and do you have any proposals as to how the Government could actually make some practical measures work?

Rev. Cameron: I think in the North of Ireland we are aware of an increasing number of agencies as the Moderator referred to here, supporting those who have unwanted pregnancies. We are providing counsel, support, care and saying there are alternatives to abortion. As a Presbyterian Church we have not any initiative in that line. Any initiative we have would be mainly on the educational side through our youth department and we feel we are living in a culture today which we can only expect to have more and more unwanted pregnancies because of the culture, the media, the whole line of sex outside marriage almost being encouraged and obviously the Christian viewpoint is there should be a faithfulness within marriage and sex preferably kept for the marriage bond. But unless that is a line that Government sells we will continue to have unwanted pregnancies, we will continue to have 5,000 seeking abortions going to England or wherever. It sounds trite or simplistic to say no sex outside marriage but that is the message that must be put forward in a loving and gracious way and the reasons why it is the right message. That would be our Presbyterian Church's stance on that. We feel that is the best thing to do to prevent unwanted pregnancy and abortion. If people don't listen to it, fine, but at least we have said time and again this is the message and it needs to be heard. Unfortunately today people do not like that message and there is a cost. There are always consequences of our actions and we would like that to come across very strongly. I don't know if the Moderator wants to ....

Rev. Dr Morrow: I don't think it is possible for any Government to legislate to prevent people having sex before marriage, during marriage or after marriage. It is just not possible. The realities are that this is something that will happen. What is required, I think, and what can happen in society and I think the churches have a role to create a society where, when people make choices we may not approve of, that those people are affirmed and loved and not stigmatised. I think often, both North and South, because of the conservative moral nature of our society, many of these people have felt it necessary to go secretly because they felt they would not be accepted and would be rejected. I think the churches have a role in affirming and embracing those who are struggling in some of these areas. We would not go down – I think, we would of course feel it is important and necessary for information to be made available to those so the choices could be made. We would not have a difficulty with that even though in practice we would hold strongly to the desire that abortion should not take place but we feel it is at times necessary for such information to be communicated to those if they are struggling and suffering.

Senator Dardis: We had a presentation earlier from one of the consultants in the Royal Victoria Hospital and we have also explored this area a little with the Church of Ireland and the practice there being in Northern Ireland that it is medical ethics that decide the issue, within the context of the law obviously. Do you think that there are any lessons we can learn or any parallels that can be drawn with regard to the situation in the North and the South? Is there any merit or anything we can draw from their experience that could be a help here?

Rev. Dr Morrow: You're a Northerner, Rev. Cameron.

Rev. Cameron: I suppose in the North there is very limited abortion available. We're still under the Offences Against the Person Act ... combine partly born. Our feeling would be that that seems to have kept the abortion level to a minimum, but we also have the feeling that abortions are taking place which are illegal. An example perhaps might be a Downs' syndrome case where we feel abortions are more readily available for that today than they would have been. But there is a kind of a culture of it being suppressed in secrecy. We're not quite sure what's going on. So although there is a level of abortion allowed that we feel, happy is the wrong term, but we feel that it allows for the extreme cases. We feel that even there the door has been pushed wider and wider each year. I suppose we would take the line that option 5 is even stricter than what is happening and, therefore, we would be satisfied with that position. We have not agitated to change it in the North. We certainly wouldn't want to see it any broader than that. I don't know whether that helps.

Senator Dardis: It does, yes. I am sure you would agree that it's a very major task to frame the wording that covers the so-called hard cases without at the same time opening the possibility which we all would not wish to open of indiscriminate abortion on demand. I suppose we're back to what happened in the United Kingdom.

Rev. Dr Morrow: I think it's probably fair to say that what I would describe as the absolutist position is the easiest to present, defend and advocate. But to hold as we would do as a church on the sanctity of human life, recognising that in social judgment you're faced with situations where you're confronted with two evils. Now within the reformed faith, which we represent, we recognise circumstances where you have two evils and

you have to choose one of them. We feel it is appropriate, therefore, that a Government representing not just majority but minority opinion legislate in such a way that that is at least a possibility. On the one hand, you're seeking to preserve and recognise the sanctity of life, which I think the Constitution does, but, on the other, give the option for circumstances, no matter how difficult it might be in terms of legislation, when you will have to make very, very difficult choices. The X case shattered some people's illusions that what was in the Constitution would make any such possibility out of the question. But, in fact, as far as I can see it, and I personally spoke in favour of that constitutional change and I supported it on the basis that it honoured the sanctity of life, but it did not exclude the possibility that in certain extreme circumstances a termination of life might be necessary.

Chairman: There are no further questions. In fact, I was just about to put the question you answered by anticipating it, that is, the role of the Constitution in these matters. In a sense you're in difficulty in that you're in two jurisdictions here and, of course, the Northern Ireland Parliament is the supreme authority, whereas in this jurisdiction the people are the ultimate authority. So I take it you wouldn't view it as unreasonable that there is a statement of general principle about this matter in the Constitution but that because the Constitution is a blunt instrument, the details in this area must be dealt with in legislation.

Rev. Dr Morrow: There was great debate within our Church when the referendum was being discussed and voted on. There were many who believed even by adding what is there at present was a rather blunt instrument. That was not my own personal opinion and I feel what has happened in the X case has justified that. It has established a clear principle of the sanctity of life, yet recognising that in certain circumstances the termination of life is possible. What I feel, therefore, is the responsibility of the legislators is to put in place those circumstances in such a way as to ensure that the Constitution is preserved and yet recognising the difficult cases.

Chairman: I thank you very much for your submission and wish you well in your term of office as Moderator. I am sure we are very proud in the committee that a member of our State as well as a constituent of my own is occupying the office this year.

Rev. Dr Morrow: The first time in 37 years.

Chairman: The last person was, I think, a card carrying member of the Fianna Fáil organisation, unlike yourself.

Rev. Dr Morrow: Is that an invitation?

Chairman: It is not. Thank you very much for your assistance today.

SITTING SUSPENDED AT 12.46 PM AND RESUMED AT 2.30 PM.

Mr Robert Cochran and Rev. Des Bain

Chairman: We are now in public session. I would like to welcome the following representatives of the Methodist Church in Ireland: Mr Robert Cochran, Secretary and Convenor, Methodist Church in Ireland, and the Reverend Des Bain. I welcome you to this meeting of the Joint Committee on the Constitution. We have received your submission which has been circulated to the members. The submission from the Council on Social Responsibility can be found at page 383 of the brief book.

The format of this meeting is that one of you may make a brief opening statement elaborating on the submission, if you wish, and that will be followed by a question and answer session with the members. I have to draw your attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you. I now invite you to make your statement.

Mr Cochran: Thank you, Chairman. We appreciate the opportunity to meet with the committee today and elaborate on our submission. May I introduce my colleague? Reverend Desmond Bain is a senior ordained member in the Methodist Church. His current responsibility takes him throughout the country and he has, therefore, a very good sense of Methodist thinking throughout the country. Prior to that he served in Dublin in what we call our Dublin Central Mission where, among other things, they are well known for running a variety of sheltered accommodation and special care units for the elderly. I had hoped, Chairman, to have some other members present, including some medically qualified members of our Council, but, unfortunately, a lot of people are on holiday this week.

I think it might be useful, Chairman, if I outline briefly some of the context from which we are coming and the particular perspective of the Methodist Church which may differ from other Churches or groups you are meeting.

Chairman: Before you do that, I take it that the Council on Social Responsibility is the body which deals with public affairs in the Methodist Church in Ireland.

Mr Cochran: Yes, I was going to explain that.

Chairman: Very good. I thought you were passing over the question and I wanted to ask it.

Mr Cochran: No. We are, of course, the smallest of the four main Churches in Ireland. We are, like all the other Churches, an all-Ireland body and all our institutions are all-Ireland in nature. We have, I think, as a Church, a strong tradition of involvement with and concern for social issues as well as, more specifically, theological issues. We believe that there is a requirement on us to have a social responsibility as part of our faith and, hence, in fact the name of our Council.

Our Church's overall governing body, as it were, is our annual conference which is composed of equal numbers of lay and ministerial members. Decisions of the conference are, therefore, the official opinion of our Church. We, of course, in common with the other Protestant Churches, do put a lot of stress on the right, in fact, the obligation of individuals to form their own view on all matters, both religious and social.

Our conference has created a number of standing bodies to, particularly, advise it on certain matters and our council, the Council on Social Responsibility, is the body which acts, firstly, as it were, as a think-tank on social, ethical, political and economic issues, reflecting on them and reporting to our conference, as we think appropriate, from time to time. We also, of course, represent the Methodist view out to other bodies, such as this opportunity today.

We have about 50 members in our council, North and South, lay and clerical members. In fact, this is the norm in our Church, to have both lay and clerical members in all our institutions, roughly equal numbers of male and female and structured in such a way as to be geographically representative of the country and also with people appointed with a particular interest and expertise.

As a nuance on the fact that we are an all-Ireland body, I might mention that, because of the differences in the two jurisdictions on the island, that part of the council which is based in the Republic operates separately for issues specific to the Republic. In fact, I am the Secretary and Convenor for the subsection of our council, so I help to co-ordinate our concerns on issues specifically to do with this part of the island. I hope that is useful, Chairman, in setting the context of our council and where we fit into our structures.

In concluding, perhaps I will highlight very briefly the key points we made in our submission which, I think, are three. Firstly, we strongly believe that the matter of abortion should be dealt with by ordinary legislation not by constitutional change. Secondly, we are not in favour of easy or widespread abortion. In fact, we are not generally in favour of it at all, but we do believe that there are a certain limited number of special circumstances, generally medical circumstances, where, if I might use the cliché, it is the lesser of two evils. Associated with this is our strong belief that the right to the mother's life and well being must take precedence, if that choice has to be made. Thirdly, we feel strongly that much more attention ought to have been given to the social and personal circumstances which lead women to seek abortion. It would have been more profitable, in our view, if more attention had been addressed to that rather than to, what seems to us at times, to be endless angonising about precise formulation of words for a constitutional amendment. Those are my remarks, Chairman. I am happy to answer questions. Thank you.

Chairman: Thank you. Rev. Bain, do you want to add to that?

Rev. Bain: I am happy to stand by what Mr Cochran has said.

Chairman: Thank you. Any questions? Deputy O'Keeffe.

Deputy J. O'Keeffe: Thank you very much for coming. We are getting a very broad spectrum of opinion at our hearings, not least from the Churches today.

I gather that your advice to us would be not to in fact have a further constitutional amendment. Would you clarify a little further why you actually recommended opposing the amendment on what was loosely termed the substantive issue, the third issue, other than on travel and information, in 1992?

Mr Cochran: On the first point, we have in Ireland, we believe, a very good system of layers of legislation. The Constitution is the right mechanism for broad parameters of social policy. Legislation is the right mechanism, in our view, for filling in the details in particular circumstances. It may be that in issues like this there is also a need for delegated legislation, in some form, to deal with the particular circumstances of individual cases. That is something we can move on to.

We think that the emphasis on constitutional change is, therefore, dealing with things in a way that the system was never designed to deal with. That was not what the Constitution, in our view, was ever intended to do. To try and make it deal with detailed issues is, in fact, a distortion of the purpose of it and it does not work very well. In fact, the evidence, since we have passed certain referendums reinforces that view – that it doesn't work very well in terms of the X and C cases for example.

Our tradition and our legal system are to use legislation for that. That is our general approach. I might add that this approach is not a view just in relation to abortion. We have taken the same view in relation to other issues that have come up, for example, the divorce referendum. We have taken exactly the same view that the Constitution was not the way to deal with that. It was a legislative matter. So that is the consistent view on that.

On your second point, our approach to that was based on this general principle that I've just outlined. When we looked at the specific referenda, the first one we opposed completely on the basis that we believed it was the wrong thing to do. The second one, we had to look at it, given the circumstances which were in existence at the time of the more recent referendum. It was a difficult circumstance for us to be in because we were in a position that we believed was not optimal anyway. The approach we took seemed to be the better way of dealing with it at the time, given that we would have preferred a purely legislative way of dealing with this, in that, the X case effectively moved some way towards our position which, as I stressed earlier, is not a position of easy access to abortion. By taking the particular view we did, in terms of recommending a rejection of the so-called substantive issue but recommending an acceptance of the travel and information issues, was most consistent with our general approach. It was a difficult one to formulate a way of dealing with it because we were in a position that we didn't think was ideal. I hope that clarifies it.

Deputy J. O'Keeffe: Indeed yes. I gather from what you have to say, and indeed from reading your submission, that you believe that whatever decisions emerge from the constitutional legislative point of view it is not really going to affect the vast majority of people who go to England for abortions anyhow – now running at 6,000 a year from

the Republic – and that you feel the primary focus should be on establishing a programme fully resourced to encourage preventative measures and to deal with post-abortion counselling.

Mr Cochran: Precisely. That is a real tragedy of this, in our view, the fact that so many women feel the need for abortions. We would much prefer that attention be given to dealing with that, in so far as one can, rather than, as I said earlier, worrying abut precise formulations of constitutional referenda which are not going to change that position. No matter what we do in the Constitution, it will not change that position of people seeking abortions. That is the issue that needs to be dealt with. As you say, with more widespread contraceptive advice and contraceptive availability and counselling, both pre- and post-counselling, and so on ....

Deputy J. O'Keeffe: I suppose many pople would suggest we are getting to the core of the abortion issue. If one is genuinely trying to prevent abortion or reduce the number of abortions, that, in fact, your suggestion is that the primary focus... that would actually work and that the primary focus should be on such programmes fully resourced.

Mr Cochran: I am not sure that anything will stop it, being realistic, but at least one hopefully will reduce it somewhat and minimise it or at least ....

Deputy J. O'Keeffe: Prevent the increase of it.

Mr Cochran: .... prevent the increase of it and that would be a success. If one can reduce it substantially, that would be even better. The 6,000 represents 6,000 different stories with different circumstances and it is very hard to know what are the circumstances in each case and what would have worked had it been in place. It is very difficult to know. I don't know of any research which has even sought to identify what are the issues. That might help if that was in place.

Deputy J. O'Keeffe: Are you pretty convinced that if the emphasis, as it were, switched to that aspect, and if you had such programmes in place, in effect, it would result in reducing the rate of abortion or preventing its increase or minimising the rate of its increase?

Mr Cochran: I would hope so, yes, certainly, if there was a culture which maximised use of contraception where sexual activity took place. I mean that would seem logical to reduce the likelihood of people seeking abortion. The more there is counselling and information on these, one would hope that it would minimise those seeking abortions.

Deputy J. O'Keeffe: On that issue there are different views as to what type of programme would be most appropriate and one that would just totally focus on easier access to and availability of contraceptives would be too confined, but that is another issue.

On the legislative side, essentially I would gather from your submission, in so far as any of the options match your provision, option 7 would be the one.

Mr Cochran: An aspect of option 7 not the totality of it.

Deputy J. O'Keeffe: Yes. I take your point that you don't favour easy or liberal abortion, but, essentially, you favour the availability of abortion in certain restrictive cases, including rape and incest. When the 1967 Act was being introduced in the UK, I understand that the view of the promoters at the time, including David Steele, was that it would only be available in quite a restrictive sense, but, yet, we can see what has transpired in the meantime. Do you really believe it's possible to open the door along, even very narrowly, along the lines you suggest without the same result ensuing here where it would ultimately just lead onto virtually, if not abortion on demand, abortion for social reasons?

Mr Cochran: No, I don't see that as obvious at all. I think legislation is obviously a function of those who are in the Legislature and particularly on the Government party at any point in time. They, in turn, are, presumably in a democracy, representative of the wider population. Given that at present, and I think for the foreseeable future, there will not be widespread support in Ireland for easy access to abortion and, therefore, that will reflect itself in the legislative approach.

I think that what happened in the UK perhaps reflects a different public opinion and the public at large which, therefore, led the Legislature there to take a different view. I think it's a function of the society. It's not automatic that if you do one thing, another thing will happen. So, you know, I have trust in the Irish people basically and, through them, parliamentarians.

Deputy J. O'Keeffe: Thanks very much.

Chairman: It's nice to hear that. Senator Dardis.

Senator Dardis: Perhaps you might sort of use the pulpits next Sunday to explain that to your congregation.

Thank you for your submission and the other thing I would have to say is that the written document you sent us has the great benefit of a total clarity about it which is not something that is evident in all of the submissions that we have received. But leading on from the debate about the insertion of an amendment to the Constitution and the legislative aspect, can you see any merit in the argument which says that there should be perhaps a combination of those two, that you state a general principle within the Constitution, then you define it in law?

Mr Cochran: We had a general principle in our Constitution before we started this process. Was that not sufficient support for life?

Senator Dardis: But then you ....

Mr Cochran: Did we need anything more specific than that?

Senator Dardis: Then you also say that you wouldn't revert to the pre-1983 situation or that you wouldn't favour a reversion to that on the basis that the 1861 Act is not adequate to deal with present day circumstances.

Mr Cochran: To revert to the pre-'83 position and do nothing more I think would not be a particularly good scenario. If one could turn the clock back to pre-1983 and then put in appropriate legislation, that would be the best position from our point of view. Now, maybe one would say that, given what has happened, that is a hypothetical situation which is not possible to achieve and, therefore, we have to work it from where we are now. That's, I mean, I think we can discuss that.

Senator Dardis: I'm sure you can appreciate the practical difficulty from our point of view.

Mr Cochran: Yes.

Senator Dardis: We could set out with the intention, which was the intention of the constitutional amendment, and wind up, as in the case of the constitutional amendment, with a totally unpredictable outcome, which is not something that we would wish. So, in other words, we're back to this idea of opening the door ever so slightly, that it would allow unforeseen widening of the door even within the context of the legislation as framed. So, I think we accept your point that it is more easily dealt with in that way.

Mr Cochran: Well, I think what we're saying is that our approach is perhaps similar to the judgment in the X case but slightly wider in that we would perhaps see a number of other rare grounds as well as the risk of suicide where it would be permitted, and it is a question of permitting rather than encouraging. Our whole approach is on that line.

If one was to put in place legislation now which fully implemented the X judgment in legislation, I'm not sure, I'm not a constitutional lawyer, I'm not sure whether you could go beyond the X case within the present legal structure and add in a few more analogous grounds. I'll leave that to the judgment of legal experts. But, as I said earlier, our view is that ... if a choice has to be made, and hopefully this is a rare case, but if a choice has to be made, the mother's health and life and well-being must be given a higher priority. Hopefully, that choice is a very rare choice to be made but certainly the advice of our medical expert is that it is a real issue from time to time and, in looking through the submissions, I think some of your medical submissions have indicated that as well.

Senator Dardis: So, we come on then to the specific cases which you talk about and where you would say that abortion was permissible. You don't mention suicide in that list of cases. Would you like to comment on that aspect of it?

Mr Cochran: Well, if one is protecting the life of the mother, it seems to me that suicide is one aspect of that. If there is risk, as you say, of grave injury to the physical or mental health of the mother, I mean, I think it is subsumed within those two issues. But, to restrict it to only the case of suicide seems to us to be a little too narrow. There may be other circumstances where the life or risk of grave injury to the health or well-being of the mother, other issues could arise, not just the case of suicide.

Senator Dardis: Yes, but the other issues, I mean, I take it you mean the other issues are all cases that are medically verifiable.

Mr Cochran: Yes.

Senator Dardis: Whereas this one is somewhat into the area of subjectivity, even from a professional assessment point of view.

Mr Cochran: That is true, but a lot of the medical ... may be subjective judgments too. A clinician makes a judgment at a point in time of the position. Whether the final outcome confirms that or not, I mean, they still have to make their best judgment at that time.

Senator Dardis: The other point which the ... where you have discussed with the Church of Ireland and the Presbyterians is the difference between the North and the South. Now, I appreciate that your committee is dealing with the legislation and the Constitution that you have before you, but do you think there are any lessons to be learned from the situation in the North, in other words, in the way that they have dealt with the matter? That it is medical ethics within the law and it seems to ....

We've had a submission from a consultant at the Royal Victoria Hospital who has told us about the practice there whereby people are referred from hospitals around the province, that there's a sort of three man panel that makes an assessment that is not directional but people are left to make their choices. I mean, do you think that there are any examples north of the Border that you can think of that would be of benefit to us?

Mr Cochran: I personally am not sufficiently aware of the details of the situation in order to comment in any detail on that but, as you have outlined it, I think it is not that far from what we are arguing in that, within certain parameters, that it may well be something that could be left to the clinical and ethical judgment of clinical practitioners within certain parameters. Obviously, there need to be safeguards there but I don't see that that is too difficult. As you've outlined it, the North is taking one approach to such safeguards. We might take a different approach but, yes, there would have to be safeguards, but I would think that something along that line might be a possibility. Des, do you have any comment on the Northern position?

Rev. Bain: I have little or no knowledge of the Northern situation. I would venture to presume that the situation as it exists in the North is one with which our church, whilst we can't say is happy with, nevertheless, they have taken the position that this is acceptable in the circumstances, but I would be very reticent to make any further comment beyond that. Nevertheless, they have taken the position that this is acceptable in the circumstances, but I would be very reticent to make any further comment beyond that.

Senator Dardis: Of course, we should also record the contribution that one of your church made when he was here, the late Gordon Wilson, who I was privileged to be in the Seanad with, and he informed a lot of our views on

the North in general, not in regard to this aspect, but otherwise. The other point, perhaps it is for Rev. Bain, do you have any sort of formal pastoral or structure of support for people who have had abortions, or is it just casual one to one?

Rev. Bain: Again, Sir, I can only speak from limited personal experience. As you rightly say, it is very much on a one to one basis. As Mr Cochran has pointed out, the Methodist Church in Ireland is a small church, and so ordained ministers who have responsibility for parishes or circuits tend to know the members of their church very well, so that when a crisis such as this arises, providing it has been brought to attention, then it would be dealt with very much on a one to one basis with the pastor and he or she may seek to refer people in that crisis situation to others of whom he or she is aware. My own experience is very limited and I do know that, as with people everywhere, there are those who would seek to deal with this quietly without it being brought to anyone's attention.

Senator Dardis: The final question is, the other churches have outlined their attitude to the morning after pill, IUCD and so on. Can you tell us you position on that?

Mr Cochran: I do not think we have directly addressed this in our considerations, so I do not think we have any firm view.

Rev. Bain: I think that it is possibly fair to say that there is no method of contraception which our church has formally condemned or said is not acceptable. I think that is as far as we could go.

Mr Cochran: Perhaps a comment that I make in our submission might also be relevant to this and that is that we tend not to see the issue of the unborn as an issue of trying to define a particular point at which that person is given the full dignity of a human being, but rather that it is an evolving process, which it is medically, but we believe ethically is also an evolving process, so it is a continuum from the point of conception to the point of birth. Obviously, at the point of birth a person has the full dignity of a human being.

We try to see it as a process and, therefore, as a continuum. It is not a question of before some arbitrary point where one situation applies and another applies to another situation. That is a more difficult situation to manage, possibly, this sense of a continuum, but it is the way we look at it. In relation to, for example, the morning after pill, it would be seen in that context, that is it at a very early stage, it is at the very early part of that process and one could argue that it is more a contraceptive method than an abortion method at that stage.

Chairman: Of course, different constitutional arrangements apply in different parts of Ireland and in Northern Ireland you have parliamentary sovereignty. Parliament can legislate, but in this part of Ireland the people are sovereign through the Constitution and it is their right to decide matters of national policy in referendum, as they brought in the Constitution in the first place. I accept your point that it is most undesirable that detailed matters should not be regulated by legislation, as indeed they are on many subjects under the Constitution, whether it is citizenship or personal freedom, or what may be. But, in relation to the statement of fundamental principles, on an issue of life and death, such as this, it does not seem exceptionable that it should be dealt with in the Constitution.

Mr Cochran: Yes, I see the point you are making, Chairman, except in so far as that it tries to define something which I think the medical profession has difficulty defining, and certainly, as I said earlier, from an ethical point of view I think it is difficult to define because of this sense of a continuous process, an evolving process and how do you define a sense of evolving and progressively increasing rights, how do you define that in constitutional terms? You have a better chance of doing it in legislative terms. As I said in answer to an earlier question, I think there was, we did have a right to life in our Constitution and I think that could have been built on in legislation to support that in particular ways and we would have perhaps avoided the difficulties about trying to formulate, to define something which is almost indefinable in a very precise way.

Chairman: But a speaker from Northern Ireland this morning, who was representing, I think, the standing committee of the Church of Ireland made the point that there is some consideration being given to the extension of the United Kingdom 1967 Act to Northern Ireland and that he would welcome the facility of a referendum as a device that allows popular consultation on that issue. So, I am taking very much on board what you say in terms of working definitions and hard cases and that the legislative approach is preferable. But the fact remains that given the depth of opinion on this question, perhaps recourse to the people is necessary from time to time to obtain a clear judgment.

Mr Cochran: Yes, certainly I think the facility of a referendum is a very valuable element of our system here, of our democracy and I am not for one minute suggesting that that would be something we would not want to wish. Perhaps I think you are implying, Chairman, that if there was legislation being proposed that the approval to proceed with that legislation might be sought from the people, so it would not be a referendum on a constitutional change, but a referendum to proceed because of the particular sensitivities with a particular piece of legislation. We partially did that in relation to the divorce situation. I know there was a constitutional change as well, but there was also a draft Bill put before the people and they were told this is what we will implement if you give the approval. Yes, maybe the referendum in that context might be valuable, to give an endorsement to a particular legislative course of action.

Chairman: I do agree with you that it is very important that we are clear on the details of this matter and I think that is really the thrust of your criticism about the exclusively constitutional approach. I was just trying to get that out of you, if you like.

Well then on the detail, the first ground, you say, is where the mother's life is at risk and you are advised by experienced obstetricians that this does arise as a real

issue in modern obstetric practice, contrary to the views expressed in some quarters. We have heard evidence on that, indeed.

Mr Cochran: Well yes, I see that in the other submissions you have got, Chairman.

Chairman: And, of course, as a matter of general principle, that issue is left open in the Constitution at present, the present constitutional arrangement allows that issue to be considered because of the reference to the equal right to life of the mother.

Mr Cochran: Yes, unfortunately this is where I would welcome the views of my colleagues who are here with me, but my understanding, Chairman, is that the phrase 'the equal right to life of the mother' and the unborn infant does cause some difficulties for medical people because we would take the view, as I said earlier, if a choice has to be made that the mother's life would be given a higher priority, not to eliminate any rights for the foetus, but that there is a prioritisation of rights here.

Chairman: So, can I take it from that what you would be saying there is that while the constitutional provision simply leaves it as an open issue at present, you would like to see more legislative detail clarifying that and making it clear that maternal help and maternal life is the priority in maternity hospitals.

Mr Cochran: Yes.

Chairman: Well the other grounds then, the grave injury to the physical or mental health of the mother, the rape, incest, gross abnormality of the foetus, of course, they are not open to us under the present constitutional referendum arrangement. We would have to have a fresh referendum to empower us to consider them, is that not the position really?

Mr Cochran: Not being a legal expert, that is my understanding, unless there is an argument to be made that it is implicit in the X judgment to say that certain circumstances are of sufficient severity to allow it, but we will leave the experts to argue that issue.

Chairman: That is true, but even on the fact of it, the X case seems to be constructed on the threat to the life from the probability of suicide.

Mr Cochran: Yes.

Chairman: That is what led to the, that is what brought it within the present constitutional position. Just taking the first ground you listed there, the first extra ground, where there is a risk of grave injury to the physical or mental health of the mother, that is not very different from the expression used in the 1967 Act in the United Kingdom.

Mr Cochran: Yes, I accept that.

Chairman: And yet you make the case that cultural differences will ensure that we will not have the same result.

Mr Cochran: Well I am stating to you a general principle that we believe should apply. Now obviously to put that in detailed ... I am not attempting to draft a law here in this statement ... one could clearly have to ensure that that was adequately validated and substantiated in some appropriate way. I recognise there is a concern in some quarters that if you allow such a clause to be implemented that it becomes the beginning of a progressive loosening of the law and Deputy O'Keeffe, I think, touched on this earlier, this concern. So, it would need to be properly qualified, but you can do that sort of qualification in legislation in a way that you can not do in the Constitution.

Chairman: No, I agree, but you referred earlier to cultural differences as a reason why it might not happen. If we brought in a provision such as this here, it would not be the same as in the United Kingdom but yet are there that many cultural differences when you look at the considerable rate of abortion that already exists here?

Mr Cochran: Well let me put it another way around. I think the reason it happened in England was because the people, collectively in some sense, wanted it to happen. If the people in Ireland wanted it to happen, yes, then it might happen, but then if there is a clear expression or public wish for that to happen, is that a problem – which is a separate issue from whether we would be happy with it or not?

Chairman: Yes, no, I appreciate that, but I am just putting the question of cultural difference to you because you raised it. If the cultural differences are not that wide, surely the introduction of a provision like this will lead to the same conclusion, that you will have widespread abortion available here.

Mr Cochran: I recognise that as a concern but I do not believe it will happen.

Chairman: Thank you very much for assisting us here today. We very much appreciated your views and your thought out position, and I will suspend the session until 3.20 pm.

Mr Cochran: Thank you, Chairman.

SITTING SUSPENDED AT 3.12 PM AND RESUMED AT 3.20 PM.

Very Reverend Chief Rabbi Gavin Broder

Chairman: We are in public session. I would like to welcome, as the representative of the Jewish community in Ireland, the Very Reverend Chief Rabbi Gavin Broder. You are welcome to this meeting of the Joint Committee on the Constitution. The format of this meeting is that you can make a statement elaborating your position and this will be followed by a question and answer session with the members. I have to draw your attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you. And I now invite you to make your opening statement.

Rabbi Broder: Thank you very much, Mr Chairman. Much of Jewish law is based not so much on public opinion but rather on the text that we have and the way that they're interpreted by the commentators. Whichever subject we have, no matter how up to date and modern it may seem, we, nevertheless, look to our text to try to find clarification and source material, whether direct or by inference to try and help us explain the particular issue.

The subject of abortion is one which has, certainly of recent times, become of more interest and a number of the great rabbis have looked into the subject to try and get an understanding and inferences from the Bible and other Jewish material to express the view on abortion. I know that today this is not necessarily the case ... where the idea of women's rights and the arguments about it being the woman herself and her body and, therefore, she has the claim to be able to do as she chooses while the physicians are turning around and saying this is their field, they've got the legislature modifications, they should be given the discretionary power to do what they want. This isn't the Jewish view. Judgment, in such a case, obviously is based on medical evidence. However, we feel it's something which is clearly of a moral nature and, therefore, it needs moral judgment, not a medical one.

If you like I can give you some brief outlines ... if you'd like I can take you back to some of the sources which we use as inferences for this particular subject. Regarding abortion itself, we don't find direct reference in the Bible only an indirect one – one by implication. The Bible tells us, in the Book of Exodus, chapter 21, that if two men strive and hurt a woman who is standing nearby with child so that the fruits depart – she loses the child – and no harm follows – in other words, she remains wholesome, she may be injured but she does not die – then the man is fined. We have come to understand from here that there's no capital guilt involved ... there has been a child, there has been, if you like, by inference, an abortion but the attacker merely pays compensation for the loss.

Similarly we find, also in Exodus, where it says he that smites a man so that he dies, shall surely be put to death. Once again, the inference is a man – somebody, a man or a child, that's been born, not something which is within the womb. There is another famous case which is brought, not in the Bible but in the Talmud itself and quoted by the greatest of the rabbis in the 12th century and earlier, which says that if a woman is in hard travail during pregnancy and her life cannot be otherwise saved, then one is entitled to cut up the child within the womb and extract it member by member because her life comes before that of the child. In other words, this is a case of a pursuer ... if somebody is attacking you, you have the right to defend yourself. In this instance, the child within the mother's womb is the pursuer, it's attacking the mother, therefore, one has the right to look after the mother and forsake the child.

So, we have here clear cases, if you like, if only by implication, that the child can be aborted. We don't take any significance of it as a person. Nevertheless, there are a number of sources which seem to contradict this and that tell us and reveal that the soul of the foetus, nevertheless, has significance. One of the main laws that we have is the keeping of the Sabbath – we may not violate it in any way whatsoever. Nevertheless, if there's any slight question regarding saving the unborn foetus, then one may desecrate the Sabbath.

There's another inference which tells us whoever sheds man's blood by man, his blood shall be shed, which some commentators understand to mean whoever sheds the blood of man in man, his blood shall be shed – referring, of course, to the foetus. So, we, therefore, see an indication from the Talmud itself that only if it's hazardous to the mother may one abort. Otherwise, although it is not murder, nevertheless, from other sources we see that it remains a grave offence.

Our belief is that an offence which is not entailing statutory punishment is not necessarily an anomaly. Something might be wrong, but you might not have that punishment. I'm thinking perhaps in terms ... I am not sure if I'm borne out completely correctly , if a person is crossing the road at a red light – the red man is showing – and he decides to cross, I'm sure it is an offence. It certainly is dangerous, but he is not going to be penalised. For all that I know, in some countries that person may be. Certainly, within Jewish law, the same applies ... that something can be an offence even though there's no statutory punishment and the same would apply in these particular cases. It is wrong to abort unless the definitive case of ... it is hazardous to the mother. Otherwise, it is something which, nevertheless, remains a moral offence. From that particular scenario, we build out and try to understand the different circumstances that the woman ... that the family find themselves within and see ... try and find out whether abortion would be applicable or possible in those particular circumstances.

Chairman: That concludes your opening ....

Rabbi Broder: That's the overall picture. I don't know whether you wanted me to get into the specifics, which I'm sure you've spoken of a number of times.

Chairman: Does the Jewish Representative Council here in Ireland or yourself have a view to convey on civil legislation, as to what we, as legislators, should do in this area?

Rabbi Broder: I don't think that it is within a Jewish perspective to legislate for others. We've our own legislature, we have our own laws with our own moral conduct and ethics. We can convey that to others, you know, they can look at the entire picture and make their decision on

it ... not necessarily in this case, different laws would apply. You know, we would have one law which we would be strict about but we wouldn't impose it on anybody else. An individual is entitled to be strict on himself without imposing it on somebody else, if that answers the question.

Chairman: It does.

Rabbi Broder: I'm quite happy to give you our picture, from moral and ethical and from the different points of, you know, psychological considerations ... cases of rape, of adultery and so on, if you wish.

Chairman: Are there any questions?

Deputy J. O'Keeffe: It's a very clear perspective that, as you say, within your own religion you establish your own rules, but you don't insist on applying those rules to others.

Rabbi Broder: Correct.

Deputy J. O'Keeffe: As a constitutional committee of the Parliament, we are in a slightly different situation in that whatever we recommend, if it's adopted, will apply to everybody, including yourself and your people. So, perhaps we might explore that little bit. You mentioned, in brief, that abortion isn't acceptable unless it's ... there's a situation which is hazardous to the mother. Would that sum up ....

Rabbi Broder: That was a generalisation. We expand from there how would you define something which is hazardous to the mother? I have a very, perhaps, extreme example, not my own example, an example which was recorded in the Talmud which was redacted in the 3rd and 4th centuries, in the extreme case of ... the mother was in fear of death, if the child wasn't aborted. It is an extreme case. The modern commentators today look at it and say well, perhaps, there are other considerations which would also be considered as hazardous to the mother too. Perhaps in the sense of illness or general social welfare.

Deputy J. O'Keeffe: From our point of view, even taking a question of what's hazardous to the mother as being the starting point, there's a recommendation in the Green Paper, one of the options is an absolute blanket ban on abortion. Depending on how you define abortion, some people, including medical experts, have suggested that that would preclude the termination of pregnancy in cases where they would feel justified to save the life of the mother, using your words, in another way where it's necessary because the condition is hazardous to the mother. Would you be concerned if such a provision were introduced into the Constitution?

Rabbi Broder: An absolute ban?

Deputy J. O'Keeffe: Yes.

Rabbi Broder: Within Jewish belief, there are certain circumstances where it would be allowed. An absolute ban could, perforce, be taking away a certain right and, in fact, a mandatory right, that a woman might have under certain circumstances for abortion.

Deputy J. O'Keeffe: So, it wouldn't be acceptable is the answer.

Rabbi Broder: No.

Deputy J. O'Keeffe: Moving to the other side, the sort of issues that have been ... the concrete questions that have been focused on in our deliberations include, do you allow, whether through the Constitution or by legislation, abortion, whether in the danger of suicide on the part of the pregnant mother and, on from there, where the pregnancy is as a result of rape or incest. Have you any reflections on those situations? What would be the position in your religion on those particular issues?

Rabbi Broder: They are different circumstances. The case you mentioned of suicide, that is something which most authorities would consider something just obviously hazardous to the mother's health. Some wouldn't go so far as to suggest that it had to be a case of suicidal .... If it had other facts, perhaps extreme pain, deafness, possibly resulting in another serious illness, that would fall under the same category. Now that's with regard to the illness. Now, that is something which would have to be medically proven, and she would have to have some history or some psychological condition or some mental condition which would have a past record. That would then be a legitimate request for abortion and, perhaps, like I said, mandatory in those cases.

Deputy J. O'Keeffe: Even if they were not life-threatening?

Rabbi Broder: Even if it was only possibly life-threatening. It doesn't have to be proven to be life-threatening, certainly, if there is a great possibility that that could ensue.

Deputy J. O'Keeffe: If it were clear that they were probably of some danger to the health of the mother but not a life-threatening nature ....

Rabbi Broder: That would also be sufficient in the case of deafness, as we mentioned.

Deputy J. O'Keeffe: And then could you lead on from there to the other ....

Rabbi Broder: The other cases are slightly different. The case of rape, although unfortunate circumstances, unless it leads to the condition we just mentioned of serious mental or psychological problems, that wouldn't be a reason for abortion because, like in the secondary set of cases, there is an entitlement for the child to have his life. In such a situation, we would say that it would be the burden of the assailant or society to protect and to look after the child and the mother as best as possible, but it's not a reason to forfeit the child.

Deputy J. O'Keeffe: And the same would apply in incest.

Rabbi Broder: The same would apply in incest and adultery and any illegitimate birth because that child still

is a living being and has to be given every accord to be able to move forward. The reason that has been propounded for this is that, by legitimising – not by legitimising – but by giving a complete open reason for abortion in a case such as that of an illegitimate child of incest or adultery, that would somewhat open up a floodgate of abortion. Jewish belief is rather that, if you have a strict set of moral conduct, then it is better to keep that moral conduct with a most severe consequence, of the illegitimate child, for instance, rather than to reduce the severity and make it more open to everybody else.

Deputy J. O'Keeffe: Could I just ask one other question? Maybe you mightn't be able to answer it. You have indicated a view which would suggest that abortion is only acceptable in the Jewish faith in very limited circumstances. Essentially, where the condition is hazardous to the mother would be the broad heading. Is that view then part of the cultural ethos of the members of your faith? In other words, is that acceptable to the broad mass of numbers of your faith or is it more honoured in the breach than the observance?

Rabbi Broder: You ask a difficult question. There are a number of different opinions and authorities, but I think the majority would go along with what I've said, and that would apply to deformed children as well, which wasn't mentioned.

Deputy J. O'Keeffe: I see.

Senator Dardis: Thank you for your presentation, Chief Rabbi. My question actually is almost the same as Deputy O'Keeffe's. Is there a uniformity of opinion across Judaism, say, from ultra-orthodox to the liberal side, if I may use that, and how would it be represented at the extremes?

Rabbi Broder: I don't think that there would be much divergence between what we would term orthodox and, for want of a better term, ultra-orthodox.

Senator Dardis: I apologise for using those terms.

Rabbi Broder: No, we all do because there is no other way of describing it. The authorities of whom I speak when I say there are opinions, and there are quite a few people, these are world renowned authorities, people that are highly respected for the position which they hold by the majority of people. For the other side of the spectrum, I don't know.

Senator Dardis: But would the ultra-orthodox, to use that term, would it be a much more restrictive view than the one that you're representing here or would it be very similar?

Rabbi Broder: It would be very similar because life is precious. It works almost sometimes in an inverse proportion that we seem to believe that, if somebody's ultra-orthodox, therefore, he's more strict by nature of the ultra-orthodox name which we're giving to him. I don't think that necessarily is true in all circumstances and I think this is one where it wouldn't apply. If I can add as well, there's an extra dimension to it and that is depending at which time of the pregnancy we would be talking about. Certainly within the first 40 days, there is a greater tendency to be more lenient.

Senator Dardis: Forty?

Rabbi Broder: Forty days.

Senator Dardis: Fourteen or 40?

Rabbi Broder: 40.

Senator Dardis: The other thing is probably the reverse side of the coin. Is there any evidence of differences between .... There are big cultural differences between countries and obviously some countries are much more restrictive than others. Is there much evidence of differences within those countries within the Jewish community? In other words, does there tend to be uniformity across societies, even if there is a very liberal regime within a society or a very conservative regime within a society?

Rabbi Broder: It tends to be uniform. Certainly within the authorities of whom I speak, we're talking probably between possibly five or six in the world. These are people that are world-renowned and are men of great stature and accepted by the majority of people.

Chairman: No further questions. I thank the Chief Rabbi for your presentation today. I will suspend the sitting until 4.30 pm when the next witnesses will take their place before the committee.

SITTING SUSPENDED AT 3.30 PM AND RESUMED AT 4.32 PM.

Most Rev. Desmond Connell, Most Rev. Laurence Ryan, Dr Ciaran Craven, Rev. Paul Tighe and Ms Ann Power

Chairman: We are now in public session. I would like to welcome the following representatives of the Irish Catholic Bishops' Conference, the Most Rev. Desmond Connell, Archbishop of Dublin, the Most Rev. Laurence Ryan, Bishop of Kildare and Leighlin, Dr Ciaran Craven, barrister-at-law, lecturer in jurisprudence and philosophy and the Rev. Paul Tighe, lecturer in moral theology. You are welcome to this meeting of the Joint Committee on the Constitution. We have received a submission from the Episcopal Conference which is at page 269 of the brief book. That has been tabled before the Houses of the Oireachtas and circulated to the members.

The format of this meeting is that you may make an opening statement elaborating on the submission if you wish and that will be followed by a question and answer session with the Members. I have to draw your attention to the fact that while Members of the committee have absolute privilege you do not. Absolute privilege does not apply to you. I now invite you to make your opening statement.

Most Rev. Dr Connell (Archbishop of Dublin)**:** Thank you very much, Chairman. I wish in the first place to express our deep appreciation of your great courtesy in receiving us. Thank you, Chairman, and the members of the committee.

The Chairman has already referred to the submission that we have made and the possibility of our making a brief statement on that to be followed by questions so I would, with your permission, Chairman, invite the Bishop of Kildare and Leighlin, Dr Ryan, to present this brief statement.

Most Rev. Dr Ryan (Bishop of Kildare and Leighlin)**:** Mr Chairman, I join with the Archbishop of Dublin in thanking you for inviting us to this oral hearing. I would like, in the light of the Green Paper, to develop some of the key points which were contained in our written submission. The Irish Bishops' Conference believes that it is essential to ensure that legal order adequately protects the right to life of the unborn. That is the principal focus of our submission. However, it has to be recognised that reliance on the law alone will not be sufficient to protect such a right. We need to ensure as a society that our no to the legislation of abortion is matched by a compassionate and caring yes to those who find themselves faced with difficult circumstances. We need to ensure that those who feel abortion represents the only way out of crisis pregnancy or a difficult situation are offered a truly life giving choice. In this context, we would like to recognise the work done by agencies such as CURA and LIFE. They offer support and understanding to those for whom the prospect of the birth of a child creates difficulties which they feel unable to face.

The genuineness of our conviction as a society about the right to life of the unborn child must be matched by our willingness to give this support. We deeply regret that so many Irish women feel compelled by circumstances to believe that they have no alternative to abortion when faced with pregnancy. We believe, as a matter of justice and in the interests of equality, that everybody has the right not to have his or her life treated as a means to an end and that such a right should be enshrined in the Constitution and that the direct and intentional taking of a human life should be prohibited.

It is singularly appropriate that such a basic value should be stated clearly in the document which establishes our legal and political system. The need for such a clear statement of principle or value is rendered even more urgent by the fact that the Supreme Court interpreted the existing constitutional wording in a manner that does not offer full and meaningful protection to the right to life of the unborn child. We believe that the principle enunciated by the Supreme Court in the X case is seriously flawed. If that judgment is allowed to stand as an authoritative statement of Irish law and, further, if that principle were to be enacted into legislation in this jurisdiction, then we would be confronted with well meaning but erroneous law reform. This would be to deal with difficult situations by abandoning the fundamental principle that every human life is of value in itself.

Having studied and reflected on the Green Paper the Bishops' Conference remains of the view that the best option is that of seeking a constitutional prohibition on direct and intentional abortion. We believe that what is required is a constitutional amendment that would protect the right to life of the unborn child while recognising that an expectant mother who is ill must receive such medical treatment as is necessary even when that treatment has a side effect that puts her unborn child at risk.

Our view in this matter is shaped by a conviction that each human life is of unique value, that its dignity and worth must be respected. This conviction is at the heart of Catholic moral teaching but it is not unique to the Catholic tradition. At its most basic, respect for the worth and dignity of every human being requires that we respect his or her right to life since this is the most fundamental of all rights and, without it, other rights are rendered meaningless. We believe that if any legal or political system is to be truly just it must seek to uphold this fundamental right. The violation of this right is an injustice. It is gravely wrong to directly and intentionally take an innocent human life, born or unborn, irrespective of its stage of development. Every human life is unique and irreplaceable. No one should be treated as if his or her life were of less value than that of any other. Any statement of moral principles about how human beings should treat one another and any just legal system must be based on a recognition of the dignity common to all.

The life of the mother is precious and unique but also the life of the child in the mother's womb is equally precious and unique. Both lives are equally entitled to be treated as ends in themselves and to be protected from unjust attack. This is the consistent teaching of the Catholic Church. Concern for the life of the mother must go hand in hand with concern for her unborn child.

Obstetric practice in Ireland has an outstanding record of success in caring for the lives of mothers and their babies. The excellence of maternal care in this country indicates that recourse to direct and intentional abortion is not necessary to save the lives of mothers and the absence of abortion does not endanger their lives.

At this point I would like to correct an error in the submission from the Irish Episcopal Conference. On page 272 of the first interim report, in the fourth line from the bottom of the page, in the paragraph headed 'Abortion is Unnecessary', the two words 'per cent' were inserted by an administrative error and should be deleted. The sentence should read, 'According to the report, Irish maternal mortality rate is only two per 100,000'.

Sometimes the death of an unborn child may be an unsought and unwelcome side-effect of medical treatment that is necessary for a mother who is ill. In those sad and tragic circumstances, the death of the child has not been chosen and is not the purpose of the treatment.

Finally, the Bishops' Conference believes that it is possible to formulate a constitutional amendment so that the right to life of the unborn child will be adequately protected.

Deputy J. O'Keeffe: Thank you very much indeed. I take it that you're quite firmly behind option 1 in the Green Paper, an absolute Constitution ban on abortion. Would that be a correct summary of your position?

Dr Connell: We would have to say that the way in which it is put in the Green Paper would perhaps create some difficulty depending upon how one understands abortion. If you say an absolute ban on abortion, it may include indirect as well as direct abortion. So we were unable to say that we would endorse No. 1 but quite certainly what we believe No. 1 intends is what we would wish.

Deputy J. O'Keeffe: That leads us on to an area of great difficulty as far as we are concerned. That is the definition of what is abortion. We have had quite a number of definitions, including medical definitions, and some of the main medical definitions would appear to suggest that any termination of pregnancy for any reason could be, strictly speaking, classified as an abortion, including miscarriages. Do you appreciate our difficulty from that point of view and have you any views to offer in relation to that particular difficulty?

Dr Connell: Yes, we appreciate the difficulty about the ambiguities there. Perhaps, Fr Tighe, our moral theologian would be able to clarify the matter for us.

Rev. Fr Tighe: I think there is a real difficulty in terms of the first option when it speaks of the ban on abortion because abortion, as the evidence from the previous submission shows, can cover simply spontaneous miscarriage. It can also be used to talk about any death that occurs as a result of medical treatment. Within the Catholic tradition we would always have distinguished between a direct abortion and an indirect abortion – a direct abortion being an abortion which happens where there is a direct and intentional killing of the unborn child. I suppose that distinction is rooted in our general distinctions. It's not confined to the Catholic tradition. You'll find it in medical ethics. You'll find it also in law at times that general distinction between a direct and indirect consequence of one's actions. I think that's where it's rooted.

Deputy J. O'Keeffe: That leads us on to another area that causes some concern, that is, how we deal with the medical evidence which we have had. I am sure you have read about it or had the opportunity of going through the transcripts. We had evidence in particular from the Masters of the main maternity hospitals in Dublin. It was clear from that evidence that in current medical practices there are cases, quite rare, that arise every year where termination of pregnancy is necessary to save the life of the mother. How would you react to that situation? You accept that as being ....

Rev. Fr Tighe: I accept the evidence that I think was offered by Dr Keane, the Master of Holles Street hospital, who spoke about this case. I think it was HELLP syndrome where the child had to be delivered at 18 weeks very remote from term. I suppose it's a development of a problem that has faced medical practitioners in a number cases, also in the pre-eclampsia case, where the only treatment that's available which will save the life of the mother is to deliver the baby, to end the pregnancy earlier than one normally would. Normally one wouldn't want to deliver a baby before term because of the risks to the child. However, in this situation you're treating the mother and the only way you can treat the mother is by delivering the child. You can foresee the risks to the child in the HELLP case, the certainty of the death of the child eventually. But I think your prime dominant intention is to deliver a baby and to save the life of the mother through that treatment. The death of the child is not your intention.

Deputy J. O'Keeffe: Yes. It is clear from the evidence we had that doctors didn't refer to delivery of a child to be honest. The question of delivery at such an early age doesn't give rise to any possibility of the right to life of the child. They use the words 'termination of pregnancy' in certain circumstances being necessary.

Rev. Fr Tighe: I think the words 'termination of pregnancy' probably have an ambiguity about them. I think 'termination of pregnancy' means ending the pregnancy, bringing the pregnancy to an end, which one does in a variety of situations. I think in the particular situation the way the pregnancy is being ended, the child is being delivered, not by any means at the optimum moment, not at the time one would want to do it, but at the only time in which there is still that possibility of saving the life of the mother. It is also in a situation where if the doctor were not to act, the consequence would be the death both of the child and of the mother.

Deputy J. O'Keeffe: Leading on from there, you appreciate the difficulty of people like myself who wouldn't want to put anything into either the Constitution or law which would restrict the medical practice of saving where it was necessary to save the life of the mother. From that point of view, do you appreciate the problems of option 1, the total ban on abortion?

Rev. Fr Tighe: I suppose part of our difficulty was with the terminology of option 1 talking simply about a ban on abortion, that it didn't make any distinction between the different types of abortion. I would have thought if something that would call for a prohibition on direct abortion, or maybe on direct and intentional taking of innocent life, to avoid the term abortion itself which is in the context perhaps ambiguous.

Deputy J. O'Keeffe: Just to complete that point from my perspective. We've had a multiplicity of processes as to wording, as to a kind of wording that would cover this situation. Have your group given any thought as to what, taking into account all the facts that are now known to us, might be an appropriate wording to cover the view you're presenting?

Dr Connell: That would not be .... We are not experts in the framing of law. We felt it would not be appropriate for us to attempt to do that. I think there are people who are putting forward such suggestions, but we feel it would be inappropriate for us to do that.

Deputy J. O'Keeffe: The difficulty, to be honest, Archbishop, is not that we are lacking suggestions, the difficulty,

to some degree, is that we have had so many suggestions that some of them directly conflict, one with the other.

Dr Connell: A good reason for not looking for another one, isn't it?

Deputy J. O'Keeffe: Fair point. Thank you.

Deputy McDowell: I am not sure that it is a fair point because the argument is proactively being made that an amendment should be put into the Constitution. I would suggest to you, gentlemen, that there is an onus on those who are making that argument to suggest, firstly, that it is possible to formulate an amendment which reflects your views and, secondly, that it is one that would be likely to be upheld by the courts.

Rev. Fr Tighe: I think our reluctance in coming forward with any specific wording is that the wording or the drafting of any constitutional provision requires great expertise in terms of parliamentary draftsmen or women, which we don't have. However, I think the general principle one would want to ensure ... one would be some statement of the principle of the value of human life. A second would be a prohibition on the direct and intentional taking of life. Maybe then some qualification would be necessary to save necessary medical treatment where it's foreseeable that the child might die, but where that is a side-effect and not the direct result of the action.

Deputy McDowell: I think it's clear what the Roman Catholic Church's view is, that life starts at the moment of conception and any deliberate taking of life thereafter is wrong. I think I understand that to be the case, but it doesn't necessarily follow that the Supreme Court, either now or at some stage in the future, mightn't, for example, interpret the phrase that you use, 'the taking of life', to mean the taking of life that is viable at 12 weeks, 15 weeks, 18 weeks pregnancy, or something like that. That's really our difficulty in transposing a moral certainty into a law that is not likely to be challenged in some form or fashion or not likely to be interpreted in the fashion that at this stage might appear improbable.

Rev. Fr Tighe: I think that's why ....

Deputy McDowell: What I am really asking is that isn't it best left to medical practice.

Rev. Fr Tighe: I think you can't simply leave something to medical practice. You can't ....

Deputy McDowell: Why not? Hasn't it served us well so far?

Rev. Fr Tighe: I think medical practice has served us well, very well. I think also it's important that a constitution would make a statement about something as basic as the right to life and the value of life.

Deputy McDowell: Why?

Rev. Fr Tighe: Because I think a constitution, in many ways, is going to set the parameters for all your legal system, for all your political decision-making. I think, in that context, it has an important regulatory role and something that defends a right as important as the right to life is, I think, very essential in it. Secondly, I think your constitution, in addition to its regulatory role, has an educative role. It's a statement about the values that are fundamental to this society. I think, for those reasons, it's important. I think, of all the type of provisions one would want to put into a constitution, a clear statement of one's fundamental values is essential.

Deputy McDowell: The difficulty I have, and I know some other members of the committee have as well, is that much of the debate in public about this issue seems to be premised on the assumption that we don't have abortion in Ireland. In fact, Irish women have abortion available to them. It simply requires that they go to Britain, or elsewhere for that matter, so I am really wondering what any constitutional amendment can possibly hope to achieve. It is certain to produce a divisive debate, but it is very unlikely to reduce the number of people going to England for an abortion. To that extent, what possible positive purpose does it serve?

Rev. Fr Tighe: I think it's unfair to say that it won't save any lives. I think it guarantees that best medical practice will continue to be protected and will continue to be guided by a clear constitutional statement. There is the broader concern, of course, about the now 6,000 people who are travelling to Britain. I think, in the context of where ....

Deputy McDowell: With respect, Father, that is the issue, isn't it?

Rev. Fr Tighe: That is an important ....

Deputy McDowell: What we are addressing here is not some abstract academic legal issue; it's actually the very fact that this year 5,000 or 6,000 Irish women will have abortions.

Rev. Fr Tighe: I think we are starting ....

Deputy McDowell: That's not going to be affected by the Constitution one way or the other.

Rev. Fr Tighe: I think, as a first step ... today we are looking ... this is the all-party on the Constitution looking at the issue of abortion and I think, therefore, it's first step is to get the constitutional provision right. As we said in our opening statement, that is only the first step. There is also the need for us, as a society, to reflect on what we can do to reduce the number of people travelling to Britain for abortion. In that context, a clear statement in the Constitution of the value of human life enables, empowers the people to take that seriously and to get involved in that further debate.

Deputy McDowell: I won't labour the point excessively, Chairman, but just to put it to you, perhaps more clearly, once again ... what do you believe can be achieved in terms of the abortion problem which we clearly have in this country by amending the Constitution?

Dr Craven: I think, first of all, any debate about a major social issue will inevitably raise divisions. I think that's the very nature of political debate. I think it's fair to say that every time a general election is called, for instance, that could also be considered to be divisive, so the mere fact that people may have different views and may vote on one side or the other, I don't think, is necessarily a reason for not actually seeking to pursue what, at the end of the day, is really a fundamental value.

As Fr Tighe has said, the Constitution sets out the basic values which we, as a people and as a society, subscribe to. Obviously, the right to life is the fundamental right without which, as, I think, the courts have said on numerous occasions previously, no other right can be enjoyed. As Bishop Ryan has said in his statement, it appears to be an entirely suitable place in which to make such a statement about a fundamental value, but no one here is suggesting, as, I think, Fr Tighe has also indicated, that that is enough. It is certainly necessary, but I don't think anyone would maintain that it is sufficient in itself.

I think Bishop Ryan in his statement has also referred to the work being done by a number of agencies, particularly Cura and Life, in the field of assisting women and, indeed, fathers in situations where they feel that they are left with no other choice. That's a positive demonstration of the kind of things that can be done. As, I think, Fr Tighe has also correctly pointed out, the primary focus of the discussion here this afternoon – no one is suggesting that it should be the sole focus – is upon the constitutional arrangements upon the legal order. I think Fr Tighe is correct when he says that the Constitution does have an educative value, it does make a statement about the kind of people we are and the kind of society which we would like to be in the future. I think it does define the kind of society which we want for both ourselves and our children in the future.

Deputy McDowell: So, its aspirational, is it?

Dr Craven: It's not aspirational. As I say, it is necessary, but of itself it is not sufficient and there is a great deal more which has to be done. I think it is the first step, but I don't think we could reasonably assert that it is all that requires to be done.

Deputy McDowell: Thank you, Chairman.

Chairman: I think another member of your delegation has arrived, so I want at this stage to welcome Ms Ann Power, barrister-at-law and lecturer in jurisprudence and philosophy ... at what institution?

Ms Power: I teach philosophy at All Hallows and I teach jurisprudence at the Honourable Society, King's Inns.

Chairman: I didn't actually ask Reverend Tighe either to outline where he taught.

Rev. Fr Tighe: Mater Dei Institute of Education.

Chairman: Very good. Thank you.

(INTERRUPTIONS.)

Dr Craven: Strictly speaking, it's in medical law, rather than in jurisprudence.

Chairman: Sorry, Dr Craven, in where?

Dr Craven: In Trinity College.

Senator Dardis: Thank you for your presentation. If Deputy McManus was here, she would have to say she was glad that a lady had arrived because she has been consistently critical of the fact that it's men who are exclusively discussing things particularly to do with women.

I want to pursue the argument that Deputy McDowell has raised. If we accept the Constitution as the document which sets out the basic rights, that it enunciates principles and then we say that the prevention of the direct and intentional taking of human life is part of the constitutional provision, we are now getting to the point where there is a lot of detail entering into the constitutional provision. Would you accept the proposition that, in addition to the enunciation of the principle, it would be required to reinforce that by legislation?

Dr Craven: I think that's a fair comment and I think Mr Justice McCarthy in the X case drew particular attention to the absence of any legislative interventions following the passing of the Eighth Amendment in 1983. I think that, perhaps, it might be said that, the actual form of words which any proposed constitutional amendment might actually take is probably less important than the fact that it ought to incorporate the view of the Bishops' Conference, the very principle that Fr Tighe was speaking about a short while previously. In so far as a further legislative effect requires to be given to such principles, that would appear to be from a legal point of view eminently sensible.

Senator Dardis: Would you think that that might minimise the subsequent possiblity of a challenge through the courts or something like the X case cropping up again were that to be done, in other words, were a legislative supplement to be added on?

Dr Craven: Of course, all legislation has to be interpreted in the light of the Constitution taken as a whole. Certainly when it comes to a judicial interpretation of the Constitution, it would be foolish of anyone to predict or to state that at any point in time in the future a court could not take a particular meaning from either a legislative provision or, indeed, from a constitutional amendment that perhaps had not been in the contemplation of those who proposed it in the first instance. I think that is simply a manifestation of the nature of the legal process and the nature of the process of a judicial interpretation.

Senator Dardis: The other question I suppose is possibly addressed to Fr Tighe. It's to do with developments in theology. To what extent has the theology changed as a result of the advances in science? In other words, if I asked you the question 25 years ago as to when life began, you might give me a different answer to what you would give me now.

Rev. Fr Tighe: Yes, I think the church's position on the beginning of life is quite nuanced and quite interesting. It says that the strict scientific philosophical question about when life begins may be subject to evaluation, but it says the arguments that argue that life begins at the moment of conception are the most convincing arguments. The arguments say that from the moment of conception there is a new life come into being which is not reducible to the life of the mother and which has within it the act of potentially to develop into a human person. The more we learn from genetics, the more that becomes clear. In that context, the church statement says from the first moment of conception that new human being has the right to be treated as a human person and has the right to have its life protected. So obviously the certainty and the conviction of the church's teaching in the area have been strengthened by the emerging scientific knowledge.

Senator Dardis: There is a reference on page 273 of the document we have. It is in your written submission that was made in November last. It is to do with pregnancy from incest and rape. The concluding sentence of the first paragraph states, because it is an act of violence the victim has the right to seek medical help with a view to preventing conception. Could you elaborate on that for me?

Ms Power: 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. At the end of the day, this is a terrible thing that has happened to a woman. I think the Church and, indeed, every member of society, every member of the human race, would have a moral obligation to endorse and 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 non-ovulant, 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 possiblity 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. Having said we cannot destroy the life of one human being because no life can be used as a means towards an end, I think, concomitant with that is the duty to support both lives and not just during the pregnancy but, indeed, during the growth and adolescence of the child. So, I think, the duty is on all of us to remember that if we are calling for protection of life and respect for life in all of its stages, that is matched with a real sense of compassion and support. Particularly in these days when economics are going so well, there is a duty on the State to provide resources to protect both lives and to support those lives.

Where it is a question of preventing ovulation actually taking place, preventing fertilisation taking place, I don't think there would be a difficulty in those circumstances, but where we can know that we are dealing with two lives, then that is what we are dealing with and, in those circumstances, the duty is towards both people.

Senator Dardis: I wouldn't detect much difference between your proposition on the prohibition of the direct taking of human life and what the other Christian Churches have said to us, indeed, what the non-Christian Churches have said to us, but one of the things that has arisen with the Church of Ireland, the Presbyterians and the Methodists is the sort of all-Ireland dimension. I realise that your sees are in the South, but have you any observations to make as to anything we might usefully learn from practice in Northern Ireland? Our understanding from what was presented to us by the Royal Victoria Hospital was that there was a referral system from smaller hopsitals to the largest hospitals, that there was a consultation process but that no direction was given. In the particular difficult cases, which are on the margin, coming back to the indirect effect, is there anything in current Northern Ireland practice, or that you are aware of, that might be of benefit to us in terms of our consideration of the question?

Dr Connell: I couldn't say that I'm aware of anything such as you are suggesting. There is one point though, for example, the issue of the 6,000 women who travel to Britain, which is a very serious problem, they in fact could not be accommodated in this country without a very radical change in our law because the vast majority would be making use of the extremely liberal law that exists in Britain and unless we were to bring our law into ....

Senator Dardis: Northern Ireland is different ....

Dr Connell: Just a moment, I'm getting on to Northern Ireland. Northern Ireland is at present struggling to resist the imposition of that extremely liberal law in Britain in Northern Ireland. It seems to me that if we here in this part of the country move in a liberal direction, we will be creating an embarrassment for Northern Ireland. That's the only reflection that I would offer. I don't know how important you may regard it, but it does seem to me that what we do down here does have or could have its impact on Northern Ireland. Other aspects of this question might perhaps be taken up by some of the others.

Dr Craven: I think even within Northern Ireland there are differences in practice. As I understand the situation, the practice east of the Bann would be quite different, say, to practice west of the Bann. I also understand the situation to be that there has been a number of decisions, which I think were referred to in the evidence of Dr Lamki from the Royal Victoria Maternity Hospital in Belfast where judicial sanction was given to abortion in certain circumstances. It's a completely different legal regime. It is almost operating in the post-Bourne, the post-1939 environment. I am sure the Chairman and members of the committee are well aware of the direction of the trial judge in those particular circumstances. Even operating in a post-Bourne kind of environment, still I think, as the Archbishop has said, it still would appear to require a fairly radical shift in terms of practice here. I am not at all convinced that practices are very significantly different, certainly in terms of core obstetric practice, although I think it is fair to say that certainly in respect of some of the cases to which I think you might have been referring, they would take a different approach. To the extent to which that is influenced by what's happening in Britain, I wouldn't be

competent to offer an opinion other than to observe that there are certain differences. As to whether or not that is a regime which ought to be introduced here, given that, as I say, it does represent a post-Bourne kind of legal regime, I think it is fair to say that it doesn't come within the statement of principle that Fr Tighe has already enunciated.

Chairman: Deputy Enright.

Deputy Enright: Thank you, Chairman. I would like to join with the other speakers in saying that we are pleased to have the opportunity of meeting all of you ladies and gentlemen here this evening to discuss these matters.

In the last two lines of Dr Ryan's opening statement he says that finally the Bishops' Conference believes it is possible to formulate a constitutional amendment so that the right to life of the unborn child will be adequately protected. In some of the earlier hearings here, Dr Keane was present and he was replying to questions about how the existing regulations affect the medical profession. I will quote the following from what he said:

> **Dr Keane:** In answer to your question, we feel if medical practitioners in this country are governed by the Medical Council, and we do feel somewhat exposed in the field of obstetrics and gynaecology, that we are not protected for these already mentioned rare cases because, technically, any form of termination of pregnancy or abortion is against the law of this country and, therefore, despite the serious considerations that are given to these individual cases, the technical termination of pregnancy that we occasionally and very rarely, thankfully, have to perform, we are technically on the wrong side of the law in doing so and we feel exposed in that area. The proposed amendment to the Constitution in 1992, I think, was trying to effectively tackle this situation. I mean, it actually stated, as you know, that it shall be unlawful to terminate the life of an unborn child unless such termination is necessary to save the life as distinct from the health of the mother.

He goes on further later in response to the question I asked and stated:

> Our own Medical Council is essentially siding with the views of the Constitution that termination of pregnancy for whatever reason is illegal and it is also of considerable number of medical people respect their views where they say or feel there is no indication where a termination of pregnancy is required to save the life of the woman. As I say, currently the Medical Council, and I haven't read the specifics of their guidelines to us recently, would side on the fact that termination of pregnancy is illegal.

In other words, direct abortion ... I believe everybody present in the room this afternoon would be against the direct termination of pregnancy. However, it's the indirect termination of pregnancy – and Dr Keane and some of the other masters of the hospitals, really believe they're on the wrong side of the law when in fact it's an indirect termination of pregnancy that's actually happening.

Now, on the question of placing that in a constitutional amendment, Dr Connell mentioned and Deputy O'Keeffe mentioned about the numbers of likely such amendments that would be put forward. Is it really possible … you know, you're lecturing in different specific areas of jurisprudence and moral theology … is it really practical and is it possible to devise such a wording? We spent some time at it, I know, for the last number of years. There's been a vast array of the best brains in Ireland trying to come up with a form of wording. Is it realistic?

Ms Power: I think it is. I think the law is quite capable of accommodating the direct and indirect distinction, notwithstanding the suggestions to the contrary. There is a notion in law called oblique intention and if I could demonstrate in very simple terms, if I plant a bomb on a boat and I intend to kill only one person but another person is there, the law will not exonerate me when the following morning I'm charged with the murder of both and I say, 'well, I'm sorry, I only intended to kill one'. I had the oblique intention of killing the other person.

Similarly, if my primary intention is to do good, is to save a life and to protect the value, the basic value of human life, but, if as a consequence, an unsought and regrettable consequence, a life is lost or damage is caused, then I'm not going to be fixed criminally with any damage. Again, if I could give you the instance. If two people are drowning and I'm attempting to save both of them, my primary intention is to preserve life. It's to do good. If, as I'm taking them to shore, I had to release the hand of one person, because I know we're all going down, and I release the hand of that person but get to shore with one survivor, the law will not come in on me tomorrow morning and say, 'I'm sorry, but, you know, you could see that that person was going to die by releasing that person's hand'. So, in the first instance I gave you, the concept of oblique intention is there in the law. I think the law is more than capable of accommodating that. In the second, there was no intention. The primary intention was to do good, no intention to do harm. I think the guidelines of the Medical Council reflect the fact that doctors realise there is a difference between primary intention, where the only act is to take a life, and, of course, some may argue good consequences may follow, and indirect intention or indirect abortion where the only act is to protect a life, is to save life but regrettably a life is lost. If I could just cite from those guidelines

> The deliberate and intentional destruction of the unborn child is professional misconduct. 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. Refusal by a doctor to treat a woman with a serious illness because she is pregnant would be grounds for complaint and could be considered to be professional misconduct.

Doctors are capable of recognising the distinction. I don't think it's too difficult for legal draftspersons to accommodate that distinction as well.

Deputy Enright: Okay, thanks very much, but that's referring to the actual law and I think that there are a lot of people believe that if we as a committee go down the field ... go down the road of recommending legislation, that there might be a danger that … or consequences, however well intentioned, might have the opposite effect to our good intentions in trying to legislate. People are very concerned over what legislation brought about in other jurisdictions.

It's in regard to the Constitution itself, to get a wording in the Constitution to ensure that the master or whatever

gynaecologist is involved, that he's endeavouring to save both lives. He realises that both lives will be lost as you gave an example of the drowning, both lives will be lost in this instance and it's then he wants to decide that he's going to try and save the life of the mother. Nevertheless, there is a life going to be lost as well. It's to get a wording of that, to try and get that into our Constitution as distinct from law. You know, I think from the ... are you referring specifically to the Constitution now when you're speaking about law or are you referring to legislation or the Constitution?

Ms Power: I think the Constitution is the fundamental legal document upon which our State, upon which our legal system is based, and I think that should reflect the general principle which you yourself have … you have acknowledged that, at the end of the day, I think there are very few people who would deliberately endorse the direct and intentional taking of life. I think it's not beyond the bounds … I mean, I don't think it's reasonable or fair to expect us to come up with a wording here and now, but I think it's not beyond the bounds of legal draftspersons in drafting the terms of a wording to incorporate that distinction.

Deputy Enright: Deputy O'Keeffe mentioned about it … we tried it before. Can I just say this to you? I remember being at our own parliamentary party meetings and I'd say this, we actually had quite a number of good constitutional brains in our party at the time. There was the late Professor John Kelly, we were getting advices from Attorneys General, Peter Sutherland, the Attorney General. You know, we had discussions with all of the different churches and people, other groups as well, other organisations, and, well, the wording that was finally arrived at, the different wordings ....

Ms Power: And the wording was fine and I must say, I think, many commentators would argue that the real difficulty was not with the wording but was in fact with the interpretation of that wording. The wording is quite clear, equal means equal. But I think the jurisprudence of the Supreme Court in the X case didn't reflect the equality that was actually afforded to both lives. I think the fundamental flaw may in fact be in the philosophical underpinnings of the judgment rather than in the wording.

Deputy Enright: Can I just say this? Life is terminated indirectly … the Offences Against the Person Act is quite straightforward, you know, it regards the taking of life … some of the masters in the hospitals, the way medical practice is … if in fact somebody decides to lodge a complaint against one of the masters, one of the hospitals, whose … there's a baby lost because of … to try and save the life of the mother and, in fact, the father decides later to take an action and it's up to a private individual to take an action as well, as you're aware. At the present time, that doctor could find himself at risk legally.

Dr Craven: I can well understand the concerns which the masters have expressed although I would have to say that it's not for me to be offering legal advice to the master of the National Maternity Hospital. I think it's also fair to say as well, that when you've more than one lawyer in a room, of course you're bound to get several different opinions and, in fact, if you don't get several different opinions ....

Deputy Enright: That can happen to doctors too.

Dr Craven: If you do not get several different opinions you have a row. The problem which Deputy Enright has averted to has arisen in Britain within the context of the criminal law, but at the other end of life, certain doctors have been charged with the unlawful killing of patients who were ostensibly or allegedly terminally ill. Certainly, in the most widely reported of those cases, which was the case of The Crown *v.* Cox, Dr Cox was a consultant in a hospital in Winchester and he caused the death of one of his patients by giving her a lethal injection. The actual charge of the trial judge to the jury in that particular case is a model exposition of the principles that Fr Tighe was referring to earlier on.

To follow up on what Ms Power was saying, the principles are actually quite clear and it seems to me that if a crown court trial judge in Winchester is capable of formulating a set of words which a jury is capable of understanding and then, notwithstanding a large number of lawyers in a room, it is not beyond the bounds of possibility for a parliamentary draftsman to formulate a similar set of words to be incorporated into a constitutional amendment.

Deputy J. O'Keeffe: In one sentence?

Dr Craven: I do not think we should be caught up on the length. I think one of the criticism of the eighth amendment, and I would endorse what Ms Power has said in respect of that, was that one attempted to enshrine a principle in what I think was 120 words. I do not think much should be caught up on the length or the brevity of it. I think certainly the essence of constitutional drafting is to set out broad principles and to do it as tersely as possible, but I do not think anyone could reasonably object to having whatever length of an amendment was actually required to effect the principle that Fr Tighe was talking about earlier on.

Deputy J. O'Keeffe: Do you not accept that if you are comparing it to a charge to a jury, and in particular if you are incorporating things like *mens rea* and intent, a charge to a jury could go on for half an hour or an hour, it could go on to pages and pages, so it is hardly a fair comparison to a paragraph or a sentence in the Constitution.

Dr Craven: Indeed, I think you are correct, many charges do go for such an extraordinary length of time, but the essence of this particular charge was that it was actually completed within one paragraph. I am not particularly caught up on the particular formulation, I just offer that as an example of the manner in which it is possible to do so.

Ms Power: If I could just come in and say that at the end of the day, certainty is not something that is easily attainable. One very eminent jurist said just because we cannot have certainty, or to say that because we cannot have certainty, we might as well abandon the proceedings

altogether is somewhat akin to saying that because we cannot have a perfectly sterile environment we should conduct surgery in the sewer.

I think at the end of the day it is all about intention. Is the primary intention of this society to say to every mother who finds herself pregnant, your child is welcome and you are not obliged by socio-economic reasons or by any other reasons to leave the jurisdiction. I think at the end of the day we may not be able to come up with an absolutely perfect guarantee, but we do have a duty to do that which we can to reflect the value of life and to reflect the fact that ours is a society that says to every mother your child is welcome.

Most Rev. Dr Ryan: Something strikes me about Deputy Enright's question, which I think is a very valid one. I am not a constitutional lawyer or a lawyer of any sort, nor am I a draftsman, but it seems to me that a document which states acceptance of human rights should state the acceptance of the fundamental human right, namely the right to life. I would put the proposition that the Constitution should acknowledge the right to life of every human being from the moment of conception and then say that no law will be enacted which would permit the direct and intentional taking of human life at any stage of its development and then legislation could spell that out.

Chairman: I just want to clarify that if I may. Are you saying that if we recognised in the Constitution the general principle that all human life must be respected and protected from conception to natural death ....

Most Rev. Dr Ryan: Okay ....

Chairman: Is that the general principle?

Most Rev. Dr Ryan: That is the general principle of it. I am not going on the wording because ....

Deputy Enright: Yes, but as a general principle.

Most Rev. Dr Ryan: Yes.

Chairman: You then want to say that that necessarily entails a prohibition on the taking, on the deliberate intentional taking of life, whether by way of abortion, induced abortion in the case of the unborn, or homicide in the case of a born, living person. Are you then saying in relation to medical procedures, where they are essential to safeguard the life of the mother, that that can be left to legislation?

Most Rev. Dr Ryan: If the Constitution prohibits the direct and intentional destruction of human life at any stage of its development, then I think the medical cases we are talking about would be covered there and legislation could specify it more precisely if necessary.

Chairman: On your own terms we are in one of those difficult areas because there was such a thing as a just war once upon a time in moral theology and self defence has always to be recognised. If you are talking in the context of abortion, am I to take it, without characterising for moral and legal purposes or forcing you to a pre-judgment there, that in terms of the evidence we heard from the masters, you have the HELLP syndrome and the Eisenmenger syndrome, where very substantial, quantifiable levels of risk to the security of life of the expectant mother can be demonstrated. That is what I took from the masters' evidence. Are you saying that legislation can permit intervention and necessary treatment in such instances?

Most Rev. Dr Ryan: I think it could. What I am concerned about is the fundamental principle, which I think should be enshrined in the Constitution.

Chairman: What you are concerned about is the direct targeting of unborn life. Is that a fair summary of your position? I do not want to misrepresent you in any way.

Most Rev. Dr Ryan: That is it, yes.

Deputy J. O'Keeffe: You received the Sutherland proposal. It is not too far away from you.

Most Rev. Dr Ryan: My recollection of that was that it stated a law forbidding abortion would not be deemed to be contrary to the Constitution. It did not say that a law permitting abortion would be deemed to be contrary to the Constitution.

Deputy J. O'Keeffe: That is not 100 miles away from that formulation.

Dr Craven: I take on board what the Chairman has said to Bishop Ryan, I think perhaps for the avoidance of doubt or for the avoidance of possible subsequent ambiguity, a statement of principle to the effect also that the provision in respect of the prohibition on the direct and intentional taking of human life would not affect necessary medical treatment in circumstances where the death occurred as a consequence of, I am sorry, as a side effect rather, of such treatment. In so far as the Constitution would represent a broad statement of principle, it seems to me that would be appropriate, as I say, for the avoidance of subsequent doubt that such an assertion might also be made in it.

Chairman: I am sorry, I realise there are other members who wish to take questions, but I just want to finish this. There is the distinction, though, in jurisprudence between a matter of fundamental principle, which would be put into a Constitution, and legislation, which is a matter of detail. Now, I can appreciate on your side of the argument you are anxious that that safeguard of popular control should always be there in the Constitution. But, having said that, there must be some discretion given to the Legislature in this area, because it is clear from the evidence we have heard that matters of very great detail and medical complexity arise which the vary nature of a constitutional instrument is not capable of addressing because they are not matters of general principle, they are matters of detail.

Dr Craven: But I would respectfully submit that they are capable of setting out, if you like, the very broad parameters that the subsequent legislation, if necessary, might be required to flesh out.

Senator O'Dowd: This is a very important debate. I have two comments to make and perhaps you would like to make a comment on the observations that I make. One is that we already had a very important debate many years ago on a constitutional referendum. We voted for it, we passed it, nobody anticipated the decision of the Supreme Court on it. If we go down the constitutional route again there is no guarantee that there will be any less or any greater clarity and, in fact, it might, in my view, there is a fear that it might actually open up rather than close down the issue of abortion.

Could I just say that the Institute of Obstetricians and Gynaecologists, when they wrote to us, they made the distinction we have all been talking about when they said in paragraph two of their submission: 'We consider that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example for social reasons, and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother.' And I think that, it is certainly my view that, you know, that latter part, that is where I would like the situation, that we would not have any change in the second part of that sentence. In other words, that where there is an unavoidable situation, that we try and save the mother and if the baby dies indirectly as a result of that, we accept that. But when you say – and I respect what you say – that you cannot assist us perhaps in the wording of a proposed amendment, you know, I would like you to think about that again and perhaps to come back or to think very seriously about it because if we end up in the present situation again or if it is worse, you know, that is what I am worried about really, basically. And if you have views on that, I would be happy to hear them.

Dr Connell: I will try to make a brief comment on that, Senator. We are not in a completely neutral position at the moment. At the moment we have the eighth amendment together with the interpretation of the Supreme Court in the X case. Now the interpretation of the Supreme Court in the X case is possibly to be interpreted as making widely available abortion and we do need to tighten up on that. Unfortunately, we are not in the happy position that would have been, let us say, in 1982, before the 1983 amendment was passed. We are now in the position where we have '83 together with the interpretation of the Supreme Court.

If I might, Chairman, refer to the other submission, that was presented before the Green Paper was put together, by Bishop Murray and myself, we went into that ... I do not think it would be in the ....

Chairman: No.

Dr Connell: But it would be in your archives.

Chairman: It is not, in fact. You might forward it to us because the Department of Health did not forward their documentation to us. We would appreciate it if you forwarded it to us.

Dr Connell: I would be delighted to send it out to you. I do not think I have it with me, in fact, no.

I would also like to say – I do not know whether this is the appropriate moment – I would also like to say that I am aware of a certain manner of conducting a campaign in this whole area where aggressive tactics are used and I would wish to assure the Members of the Oireachtas that they have no support from the Episcopal Conference.

Deputy Enright: Thank you. I express a warm word of appreciation. We felt you would not be doing it anyway. They would not be doing that anyway.

Dr Connell: I have spoken ....

Deputy Enright: It is good to hear it said.

Dr Connell: I have already spoken on that. I have made a public statement on that and I wish to reiterate it.

Deputy Enright: Thank you very much.

Chairman: Senator O'Dowd, have you completed?

Senator O'Dowd: I am happy ... there are no other comments.

Deputy Daly: Bishop Ryan mentioned caring – yes – for the people in difficult circumstances and maybe somebody on the panel would clear my mind about an issue where suicide and a real danger to both lives is involved. What is your attitude on this?

Dr Ryan: Well my attitude is that every effort should be made to save the mother who is – if she is – threatening suicide, that psychiatric help and all of that should be used to help her but to directly take away the life of the unborn child for that stated purpose, that should not be permitted.

Dr Craven: I think the committee has already heard significant medical evidence, not alone from the obstetricians but, indeed, also from certain eminent psychiatrists, particularly those who specialise in liaison psychiatry and I think it would be clear to members of the committee that the preponderance of evidence, in terms of the international medical literature, would be to the effect that, first of all, suicide is a rare event and, secondly, that suicide in pregnancy is even a rarer event still which is very very difficult to predict.

I do not think I am doing an injustice to the evidence which has already been adduced before the committee if I were to say that there is no empirical evidence in the international medical literature to the effect that an abortion is necessary in terms of treating a pregnant woman who expresses suicidal ideation, but not being an expert in the area I would not be competent to comment beyond simply summarising the evidence which, I think, has been adduced before the committee already.

Chairman: Are there any further questions?

Deputy McDowell: If I can just address briefly one of the difficult cases, if I can use that horrible phrase, and that is a case where ... of rape or incest. Am I correctly understanding Roman Catholic Church teaching when I say that this is not a matter on which you regard the exercise of conscience as being appropriate, that a woman

who has been raped cannot morally decide that she wants to have an abortion?

Rev. Fr Tighe: I think the Church's teaching in that area would be to say that to abort in those circumstances is wrong.

Deputy McDowell: And it is not appropriate that an individual should be allowed to exercise their conscience.

Rev. Fr Tighe: In terms of making the right decision. But even if the person was following their conscience convinced that it was right, what in fact they are doing would objectively be wrong.

Deputy McDowell: So it is, in that sense, a matter of right and wrong.

Rev. Fr Tighe: It is a matter of right and wrong.

Deputy McDowell: Would you not agree with me though that very many women and, indeed, parents of a woman or a child that has been raped would take a different view?

Rev. Fr Tighe: Of course, and I would accept too that in many circumstances there may be situations where a person chooses to abort in situations like that, where they are sincerely and genuinely convinced that that is the best or only option open to them. What I would say is that they are mistaken, that it is wrong, but I would also say that sincerity of conscience may excuse them from any personal moral culpability or fault, and it is very clear in *Evangelium Vitae*. The Pope's document speaking about this whole area, makes it clear that in many circumstances rtion may do so without fully knowing the wrongness that is involved, may do so without real freedom, and therefore it is not our business to be condemning the individuals but it is important to say that it is the wrong choice.

Deputy McDowell: So, am I getting this right, so you are saying, did I get that phrase correct, that they are free of moral culpability or fault?

Rev. Fr Tighe: They may be.

Deputy McDowell: But nonetheless you are suggesting that they should be legally deemed to be guilty of a serious crime.

Rev. Fr Tighe: Yes. The same way that somebody killed a person outside, convinced it was the right thing, convinced in conscience it was their moral obligation to kill that person. That, for all our ... misguided and all as I would judge it, that sincerity might excuse them at the level of conscience of their own culpability but it would not excuse them at the level of law. We would still say they did something wrong; they took a life.

Deputy McDowell: You see, my difficulty here is, as a politician not as a moral theologian or, for that matter, a philosopher or a Church person, is that while obviously the Church may have a teaching with which a significant minority, I would suggest, of the Church's flock does not agree, politicians are in a slightly more dodgy territory. You know, I think we do have some responsibility to reflect the fact that, I would think, a large percentage – perhaps a majority – of women take the view that they would not stop somebody from having an abortion. They may think personally that abortion is not right but they do not feel it is appropriate to intervene to stop a woman who has been raped from having an abortion, and do you see that difficulty?

Ms Power: I see the difficulty but, I mean, lots of women, lots of people may feel they have no right to interfere in another person's life and that ....

Deputy McDowell: Do you want to criminalise a woman has just been raped herself?

Ms Power: I can appreciate that difficulty but, as Fr Tighe was saying, at the end of the day we are asked ... it is the State that must, that is expected to basically come up with its position in relation to this and at the end of the day if something is wrong, ...

Deputy McDowell: But aren't you suggesting that the State should reflect the moral certainty of Roman Catholic Church teaching ....

Ms Power: No, I am saying the State should reflect ....

Deputy McDowell: .... in its Constitution?

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 imposed by the Constitution at this point, is it?

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.

Deputy J. O'Keeffe: Can I just clarify two issues? What's known as the 'morning after' pill ... I don't think this has been specifically covered. What would be the view of the Catholic Church in relation to that and do you suggest that we should put in place either constitutional or legislative procedures which would prohibit the morning after pill?

Ms Power: I thought we actually addressed it in the question that was raised earlier in relation to a non-ovulant. If medication is prescribed and its intention or its purpose is to prevent fertilisation taking place, well in those circumstances we are not dealing with ....

Deputy J. O'Keeffe: Is it the intent on the part of the doctor prescribing or the intent on the part of the woman?

Ms Power: If the purpose for which it is taken is to actually act as an abortifacient, then, in those circumstances, because we have two lives in being, I think it wouldn't be reasonable to allow one of them to be disregarded. But, if ovulation hasn't actually taken place – I think, perhaps Ciaran could assist us here – if ovulation hasn't taken place, no damage is being done to a life, no life is being destroyed.

Deputy J. O'Keeffe: Let's, say, take the practical example, and following up from the point raised by Deputy McDowell, some girl is raped and she's brought for medical attention and she's prescribed the morning after pill. What's the view of the Catholic Church in relation to that? I understand it's common medical practice, to be honest, but would you feel that our constitutional provisions should (a) permit it or (b) prohibit it?

Dr Craven: I think, Deputy O'Keeffe, it's already a matter of settled statute law. I think section 10 of the Health (Family Planning) Act, 1979, specifically prohibits the importation, sale and distribution of abortifacients. So, in so far are abortifacients are concerned, and I'm not sure it's a matter which is properly before the committee this afternoon, the issue of abortifacients is already a settled matter, it seems to me, of statute law in that regard. But, I think Fr Tighe might have something further to say ....

Deputy J. O'Keeffe: Does that mean you are suggesting that it is not ... that it is illegal at the moment? Is that what you're saying?

Dr Craven: My understanding of section 10 of the Act of 1979 – it deals specifically with the importation, sale and distribution of abortifacients ....

Deputy J. O'Keeffe: And you're classifying ... are you classifying the morning after pill as an abortifacient?

Dr Craven: No, what I'm saying is ... in such circumstances, if it were to be classified as an abortifacient or if the so-called inter-uterine device were also to be classified, that that's a matter which is already considered in the statute law.

Deputy J. O'Keeffe: To leave the situation, are you suggesting that it should be dealt with? I'm not quite clear on the response, I must say. Perhaps ....

Rev. Fr Tighe: Just in terms of ... you asked about the church's position in the administration of the morning after pill after rape. In 1986, the British and Irish bishops' bioactive committee looked precisely at this issue and it examined the main form of morning after pill that was commonly administered in those circumstances. It said that that morning after pill could be effective in two ways: it could be effective by preventing conception occurring or it could also be effective by acting as an abortifacient by prevent implantation. It said that if, in the circumstances of rape, where an act of violence has been done and

there is no obligation on a person to conceive, if the morning after pill could be taken with a safe expectation that it were likely to be effective as a contraceptive, then it was morally licit to do so – even if you could see that there was that risk, that side-effect, that it could actually act as an abortifacient if the person were already pregnant. But if it were prudent in the circumstances to judge that it was being administered as a contraceptive measure, then that would be morally licit.

Deputy J. O'Keeffe: Is that only in the case of rape?

Rev. Fr Tighe: That is in the case of rape, yes. They spoke about the case of rape. Obviously, one of the issues there that might be slightly different .... We're talking ... it's a moral document, it doesn't have to get into the issue of kind of technical defining rape but it says in the case of rape.

Deputy J. O'Keeffe: But our concern, of course, then would be as to how we would deal with such a situation either under the Constitution or under the law.

Rev. Fr Tighe: I think the Constitution probably has to stay at the level of general principle. I think in the eighth amendment there was a thing there 'as far as practicable to vindicate' and there may be a practicability issue there, but I think the Constitution has to state the principles.

Deputy J. O'Keeffe: The other issue that I just wanted a view from you on was the question of preventative measures being mentioned. There are 6,000 women and girls who go to the UK. Many of us feel there should be a very strongly financed, resourced programme of measures to deal with crisis pregnancies and that would include preventative measures. It's been suggested by a number of people that such preventative measures should include an emphasis on widespread availability and access to contraception ... contraceptive devices. Would your group have any view on that proposal?

Ms Power: I suppose just that it hasn't worked in other jurisdictions. That's the only point I think we would make. But, having said that, I would see it as part of a much wider package, you know, resources, education – primarily education – and I think the committee has already heard other people's ....

Deputy J. O'Keeffe: Yes, but I'm talking about in the context of a wide programme of education and counselling and so on. As part of such a programme, the suggestion is that there should be widespread access to and availability of contraception, that this would help in discouraging crisis pregnancies.

Dr Craven: I think it's fair to say that the issue of what are known as crisis pregnancies is very much a human problem and, accordingly, it requires human solutions. I think it remains to be seen ... I think the evidence indicates that it's not amenable to, I think, what might be called a quick technological fix. I think that what is required is more than perhaps might have been suggested. I think that Ms Power has already pointed out that the ... the importance of education, particularly in terms of sexuality education within a relationship context, which is not value-free but rather value-founded. As to whether or not it is amenable to a technological fix which, I suppose to a certain extent ... in fact widespread access and availability to contraceptives could be characterised as ... I think, as Ms Power has also said, it really hasn't proven itself to have been successful in other jurisdictions, and most notably in Britain. I think really what's here are human solutions to a very human problem.

Chairman: If I could refer just for a minute to human legislation, you've taken your stand on the moral teaching and on the reflection of conscience on the data of experience as it presents itself. You haven't taken your stand on revealed religion today. Is that a fair summary of your submission?

Most Rev. Connell: I don't think we separate them. I do believe that what we are presenting is a reasonable position, but we certainly are not hiding the fact that we are bishops.

Chairman: No, that is clear.

Deputy Enright: You have not been known to hide it up to now.

Most Rev. Connell: It is not possible for a bishop to think other than in episcopal terms, shall we say.

Chairman: If I could come back to human legislative terms and the question that was posed about what the Institute of Obstetricians joint commmittee for family planning described as post-coital contraception, does the human legislator have a discretion in relation to the period up to implantation, the first 72 hours there? You see, the moral teaching is clear that life from conception is absolutely deserving of equal respect, but if you introduce a consideration of praciticability, then you might argue that the Legislature has to have a discretion for 72 hours at least on pure grounds of practicability and the existing practices that take place in the country. Have you any comment to offer on that?

Dr Craven: I don't think any more can be said other than that there must be a broad statement of principle covering the circumstances. I am subject to correction on this but, my understanding has always been that the interval between fertilisation and implantation was in the region of 11 days, but I don't think anyone would be suggesting that, between the point of fertilisation, whenever that may occur and in whatever place it may occur, given that these are all of necessity uncertain and unknown quatntities, but I don't think it could be said that any statement of principle could be regarded as, in effect, a free fire zone between fertilisation and implantation. I don't think that an unborn, as a subject of constitutional rights, only acquires those rights at the point of implantation.

Chairman: Now you're interpreting legislation here. You're not just giving a moral teaching. You are interpreting legislation when you gave that interpretation there. I'm coming back to another question which is, can the Legislature of itself not have some discretion in that area on grounds of practicability and proporationality?

Dr Craven: Within the broad parameters of the statement of principle as set out bearing in mind the consideration that Fr Tighe alluded to earlier on, I think there's a world of a difference between positively asserting something and then saying that, within a certain area, there are no pracitcable steps which we can take.

Chairman: But, for example, we heard evidence on various steps that can be taken to try and reduce the rate of abortion and that is a central concern of this committee apart from the substantive question which we spent a long time discussing today. Now, a wide variety of measures have been recommended to us. The suggestion has been made, and it seems to have considerable merit, that encouraging chastity among young persons is a positive value and encouraging young persons to postpone sexual experiences for as long as possible. Equally, the case has been made that availability to preventive contraception is very important. Equally, the case has been made that positive advertising about motherhood is very important and this has been attempted in some states, in the United States. Equally, it has been suggested from Northern Ireland, of all places, that there is some evidence that widespread availability of post-coital contraception and its widespread advertising does, in fact, reduce the rate of abortion thereafter, if I can put it as neutrally as I can. So, these are all considerations which we, as legislators have to reflect on in formulating a response to this particular problem. That's the point I'm making to you, that we have to balance different matters in human legislation. You can have an ideal abstract principle, but we still have to translate it in practical terms into a workable response to the position as we see it. Would you accept that statement?

Dr Craven: I accept the broad statement which the Chairman makes. I'm not in a position to comment on the success or otherwise of various programmes in the North of Ireland.

Chairman: No, I am not asking you ....

Dr Craven: Yes, I accept that.

Most Rev. Connell: Chairman, could I simply say, and you referred to the relationship between the approach of reason and the approach, shall we say, of the faith, I would like to say that we place this whole issue firmly within the context of our concern for justice, just as the bishops have spoken out on a whole variety of areas where justice is concerned. We regard this as the most basic issue in justice, but the bishops have constantly spoken out on various other aspects of justice. Whereas what we have to say is certainly, it seems to me, very much enlightened by what our faith has to say, we are dealing with these issues also as matters that are accessible to human reason.

Chairman: I raise something Fr Tighe mentioned about direct and indirect effect. Of course, you made the point that there's a distinction between morality and legislation. It may be morally necessary for legislation to prohibit certain acts for the good of society as a whole whereas, in moral terms, the person may be morally innocent or guiltless in terms of particular acts which are committed. But, can I just say in relation to the principle of double effect, a problem I have with it is that, to me, it belongs primarily to the world of morality rather than jurisprudence because it judges conduct in terms of intention whereas the lawyer in court has to judge conduct on the basis of an inferred intention. The conduct is proven and then you infer an intention from it. So it is, in my submission, and perhaps Ms Power might like to address it, a difficult principle to introduce on the plane of, say, working criminal legislation.

Rev. Fr Tighe: Without any expertise in the area of criminal law, I would just like to say that, I think the distinction, if you were to say, if you were to collapse the distinction and you were to say that everything you could foresee would happen because of your actions, that then you were liable or responsible for all those consequences, then I think life at some level becomes unworkable, because every time I sit into my car, it is at some level remotely foreseeable that I could have an accident and I could hurt somebody, but in driving my car I am not intentionally, at least I hope I'm not intentionally, setting out to damage or harm somebody. So, I don't think you can collapse the distinction completely. I also think the distinction, when you get to very detailed applications, can be tricky enough, but I do think as to the distinction it holds, it has an importance. I was impressed recently, I don't have the text and I think it would have been helpful ... John Keown, a lecturer in law at Cambridge, spoke on this area talking about the end of life and he quoted from the Attorney General in Britain who had used the distinction, speaking in the House of Lords precisely on this area, and it doesn't seem to be something that is inaccessible to the legal mind in that context.

Ms Power: Again I would just endorse what Fr Tighe has said. I think, again, the first principle is that we don't destroy or damage a basic value, a value that is self-evident to every person in this room by virtue of our own continuance in existence, I think that is the first requirement, that a basic value is not destroyed and that our Constitution reflects that. Thereafter, we cannot just permit a basic value to be destroyed, even though good consequences may flow from it. I think once we go down that road, we're into the road of relativism, we're into the road of consequentialism, and who knows where that could stop.

Chairman: Are there any further questions? I'd like to thank the representatives of the episcopal conference for addressing us today. The next meeting of the Joint Committee will be on Wednesday, 12 July, at 9.30 am in room G24. Thank you.

Most Rev. Connell: Allow me to express our gratitude for your very patient and courteous hearing. We will be, perhaps, a little less apprehensive of meeting the Members of the Oireachtas in future.

Chairman: Thank you very much.

THE JOINT COMMITTEE ADJOURNED AT 6 PM.

WEDNEDAY, 12 JULY 2000, 9.60 AM.
MEMBERS PRESENT:
DEPUTY J. ELLIS, J. O'KEEFFE, SENATOR M. FINNERAN, D. O'DONOVAN.

DEPUTY B. LENIHAN IN THE CHAIR

Ms Rosemarie Rowley

Chairman: I would like to welcome Ms Rosemarie Rowley to this meeting of the Joint Committee on the Constitution. Ms Rowley, you sent us a written submission which I have examined. I think you have an updated submission today.

Ms Rosemarie Rowley: Yes. The first submission I sent was a general look, from a philosophical point of view, at some of the questions surrounding abortion legislation. The document I sent you last evening was written on invitation to speak to the committee. It's quite long. What I am going to do is read a bit from it here and there. I have given you all copies. What it is actually is a particular examination of some questions in relation to ideology, experience and whether this would have a bearing on exclusion and on looking at … For example, the debate in Ireland tends to be very polarised, as you are all aware, so I was just looking at it from a different point of view.

Chairman: Yes. You have written quite a lot about this subject down the years, I think.

Ms Rowley: Yes. I have tried to get a hearing because I think it is very important that people realise what's involved and that women especially understand that short-term solutions simply do not work. I am very much for women and for women's health. I always have been a feminist. If you read my submission, you will see that I draw a line between republicanism and feminism as being egalitarian and how in Pearse and all that we look to models from outside who have made a passionate identification with the suffering of the Irish people and came to Ireland. You will trace the same movement in feminism, that certain women who had their formative experience outside the culture came to Ireland with a passionate identification with Irish women who were suffering from passive socialisation. What happened was that they actually put abortion on the agenda as a priority. I am just looking at it in relation to how it has developed as an ideology over the years.

Chairman: I have looked at your submission this morning as well and I see that you are analysing the nature of the ideology that they are promoting ....

Ms Rowley: That's right.

Chairman: .... a pro-abortion approach, a pro-abortion culture in Ireland ....

Ms Rowley: Yes.

Chairman: .... but we are a committee on the Constitution. Is there any practical proposal you wanted to submit to us about that?

Ms Rowley: It's like any question of freedom of information. For example, there has been a lot of talk about how the United Nations wants Ireland to accede to certain questions about freedom of information in relation to abortion. What I would like to know is why in practice … the abortion practice has shown that there is a high failure rate in contraceptives, detailed by Colin Francome. There are also a lot of studies done of post-abortion syndrome, which follows after an abortion. I would like that information included if we are going to have … in other words, the best decision anyone can make has to include all the information.

From that point of view, I think there has been a certain tendency of the ideology to ignore or suppress the information simply because it doesn't fit in with the picture, the received wisdom. When you have a goal you tend to ignore the evidence as you go along. This is a feature of all ideology, that as you go along, as things appear, you tend to ignore them because in a way they are sort of contradicting your thesis. The thesis in feminism is that abortion is a goal for women and that it helps women. I am saying that if you look at the experience and if you look at the way it has been handled, in fact it's actually anti-woman.

As I said, the ideology can be looked at in a particular way, as the ideology was looked at in Russia. What actually happens is that a predetermined objective determines the way you look at people, including men or including babies, and deprives them of a certain kind of personality; in other words, they lose the quality of personality in the name of justice for women or justice for the wider cause, which originally had very good reasons, but it just went a little bit too far. In depriving the baby of personality and in depriving men of personality, what we are doing actually is legislating for the destruction of life.

That's why I think ideology is very important. I actually wrote about the pain of that kind of reductionism in one of my books called *The Sea of Affliction*. That's why I am interested in why I was excluded from the general … for example, there has been a huge interest in women's writing. I have been writing since the sixties. I have had token inclusion now and then, but I think it's interesting that I was excluded on the grounds, perhaps, that they didn't want to hear what I was saying.

Chairman: Have you looked at the Green Paper?

Ms Rowley: Yes, I have.

Chairman: Have you any comments on it?

Ms Rowley: In relation to rape, there is a definite question of necessity arising out of rape. For example, if you look at the Offences Against the Person Act, 1861, it does

actually talk about unlawful, so the law can be actually interpreted in some cases of necessity as a defence and, therefore, lawful, if we look at the case of rape, but the difficulty is that it has been used. Legislation for rape causes a difficulty, there are two difficulties involved, first of all, it opens the door for millions of abortionists. For every one baby you can justify, there are millions of abortions. The second thing I would like to say is that there are two things … looking at the evidence now about rape … because the feminist ideology favours abortion, it tends to disregard the evidence of such things as post-abortion distress or trauma. An article in 1995 in *The Irish Times* written after a paper at an international conference in psychology dismissed the idea of post-abortion trauma as a myth, again evidence of some feminists not wanting to face up to reality. However, we now have an opportunity to look at the evidence. The evidence for post-abortion trauma is mounting. All estimates agree, from the tables of psychology books to the surveys of life organisations, that serious emotional distress is at least 10% and it is believed to be 25%. The standard reply to such figures from pro-abortion ideologists is that 10% had mental illness or mental problems anyway.

I would like to make two observations, 10% is a very significant number in the population; and in the estimate that about 250,000 women may have had abortions since 1970, we are assuming it's double the figure for the people who didn't give addresses. That's 250,000 women. That's 10% of those – 25,000 women may be suffering serious emotional distress and trauma, which is a very significant number.

It takes many forms and it may be a pattern of denial for years only evident in patterns of displacement and being unable to resolve things generally. I will be leaving you a file, which is more detailed, but I would like to say also that emotional distress or trauma or disturbance is not now classified as mental illness. This is actually not classified now, this kind of emotional distress or trauma. It is more in common with psychiatric illness brought about by injury. In fact some studies on post-abortion trauma have found similarities with post-traumatic stress disorder, first noted in veterans of the Vietnam War, now established as a medical condition worthy of compensation.

There are similarities here. If you legislate for the rape victim, what actually happens is … there are similarities in this case with Vietnam veterans and survival guilt syndrome, post-abortion stress syndrome. If, for example, there was a moral objection to killing, the act of killing then results in such existential grief and angst that it's one of the most painful of conditions. Perhaps the moral objection to killing in a Christian society, such as Ireland, has given rise to a wide incidence of the trauma as well as surrounding silence. Therefore, where there's a moral objection to killing, as in most civilised societies, the justification for killing unborn life has always to arise out of extraordinary circumstances, but when we look at what actually happened, as in the Bourne case in 1936 or in the C case recently in our country, we know that even legislating for the exceptional case of rape has perhaps allowed millions of abortions to be done and the rape victim often suffers existential angst.

It is worthwhile looking at what a very eminent psychologist has said about post-abortion trauma and angst. It's all to do with the duration of time. You see, when we're in the situation of looking at a rape victim or experiencing a trauma or a panic situation as regards rape, and that can include non-consensual sex, non-consensual pregnancy, because in the absence of detailed information about contraception, in that absence of information, there may not be true consent to the pregnancy. It may be in fact classified as non-consent to pregnancy. In other words, we are looking at a very wide definition here, but looking at that … we look at what Marvin Minsky has to say, which I think is very profound. If you give me the time to say that … 'We all know the seemingly ....

Chairman: Is it in your submission?

Ms Rowley: It's in my submission, but I would like to read it out because I think it's ....

Chairman: What page?

Ms Rowley: It's page 30 in last night's submission.

> We all know the seemingly inexorable span of mourning, in which it takes so long to accept the loss of things we love. Perhaps this, too, reflects the slowness of attachment change, though it is only one factor. This would also be partially responsible for the prolonged psychological disability that can follow the experience of physical, emotional or sexual assault upon a person. One might ask, since there are so many other devastating aspects of such an experience, why it should involve any connection with attachment memory. I suspect, he says, that any form of intimacy, however unwelcome, has effects upon machinery shared by both attachment and sexuality, and is liable to disturb or disrupt the machinery with which we make relationships in ordinary life. No matter how brief that violent episode, it may lead to derangements in our usual relationships, in part because these agencies are slow to change. It doesn't help very much for the victim to try to view the situation neutrally, because the rest of the mind cannot control these agencies, only time can reconstruct their normal functioning. It is an injury more terrible than loss of sight or limb, to lose the normal use of the agencies with which one builds one's own identity.

Therefore, if we look at … in cases where people have suffered from violence or sexual violence, the person is unable to assimilate or incorporate aspects of identity or incorporate them into the personality until much later on when the trauma is slowly healing. Therefore my view, as stated in the beginning of this paper, is that while a woman who has been raped and has become pregnant either as a direct result of the rape or because of the dysfunctional relationship arising out of a previous rape or abuse, she will view the pregnancy as a further alienating experience and may feel she does not have the capacity to carry the pregnancy through to term. Public outrage at the time of the X case shows that most people feel sympathetic towards a rape victim and that it would be justified to end the pregnancy. My own feelings is that it is even more complex in that the victim will have to live later on with two further and even more difficult states, the invasiveness of surgery, which is a further violation, and the even harder to heal trauma of having signed for or assented to a killing where her previous pre-rape

character found all killing repellent. This, I believe, is the status of a girl in the C case who found abortion further traumatised her and caused further mental distress as well as injury done by rape. We also consider the legislation for rape victims has allowed millions of abortions to be legally carried out. We have mentioned that before.

The use of the pill avoids the … I think the morning after pill avoids the existential anguish of a certain fact. You see, the grief is the certain fact that you've obliterated certain life, but the morning after pill doesn't actually allow you to know whether or not that has happened. It avoids 100% responsibility for wiping out a certain life. I think that's very important if we look at the results. So I think that's why its very useful and can be looked upon as a necessary remedy and classified under the Act of 1861, whereby the term shall be redefined in law as 'medical intervention is lawful at this point' – at that point I would say.

Chairman: Ms Rowley, your submission has been made to the committee and you're elaborating on it?

Ms Rowley: Yes, okay.

Chairman: Isn't that the position?

Ms Rowley: Yes.

Chairman: I'm very glad you did because the core point you addressed was the X case and you drew my attention to the section of the paper dealing with the X case. As you say, one of the great difficulties we have is to see how we can address the X case in this committee.

Ms Rowley: Yes.

Chairman: I take it that your submission is that we should not legislate for the suicide threat extenuating circumstance?

Ms Rowley: I think, I'm in favour of legislation to preserve the life of the mother ....

Chairman: Yes.

Ms Rowley: .... but in real terms if you look at the figures, in fact, there's a much higher rate of suicide for women who have had abortions than the women who have been pregnant. In fact, women who are pregnant hardly ever commit suicide. All the statistics bear this out. So, what we are looking at really in the case of a young girl or woman who has been raped, I think, given her decision causes her to feel 100% responsible. I think also medical intervention early on is advisable, but I honestly think invasive surgery can have dreadful effects as well as the existential burden of guilt.

Chairman: Of course under the present constitutional arrangement, rape of itself would not be a ground, a permissible ground for abortion? There's a connection between the rape and the threat of suicide, which is the circumstances that was posed in the X case.

Ms Rowley: Except in the cases of necessity as a defence against interference with your pregnancy in 1861 law. Like if you say ....

Chairman: The Constitution is superior to the 1861 Act.

Ms Rowley: Yes, on the other hand, there's no legislation, they're just covering the morning after pill at the moment.

Chairman: The Constitution is superior to the 1861 Act.

Ms Rowley: Yes, but the Constitution has decided that the mother's life had a prior claim and in a way I think there's every reason for this since simply because if you look at the history of women, they were almost looked upon as if their lives were expendable in childbirth. Now we have a situation where that's hardly the case anymore. I honestly think if we legislate for rape or for termination of it, we are actually legislating for the destruction of an innocent life.

I think you have to look at what John Finnis says in Natural Law about the consequential ethics that we think we are producing a good result but no one actually knows the outcome of any life. I think all of us have actually been here by extension of the fact that our mothers extended a right to life to us. Who gives anyone the authority to say that they have any justification for extinguishing any life because we simply do not know how it's going to turn out. So as regards the rape victim, there's only two courses, to legislate for the morning after pill and intervention within a time limit and then if there's the question of invasive surgery to actually think about the existential consequences of making somebody 100% responsible for a definite life. That is actually what I would be worried about.

Chairman: Yes, naturally. What do you mean by intervention within certain circumstances?

Ms Rowley: Well, I think the morning after … there's three days between implantation and conception, you know, for example, if a woman has found herself in a situation where she has been attacked or raped, there's three days before implantation takes place. So I think the GP should always carry, I think every GP should carry the morning after pill and I think there should be legislation to allow that. At the moment, it's not covered. I think it would be covered by the interpretation as a defence at the moment. It exists as a defence in the word 'unlawful' in the 1861 Act when, if something, the woman is … or when whosoever administers ....

Chairman: Yes.

Ms Rowley: .... a substance unlawfully. Therefore, the defence … a lawful defence would be that it was in the interests of saving the woman's life and that in the interest of her integrity as a person and it would not involve existential anguish afterwards because she wouldn't be certain of whether or not the life was actually … Now, this may seem – I see you're smiling – this may seem not very ... but actually a very important point because, I think, if you look, 20% of natural pregnancies, you know, have a natural abortion as they are known in the medical profession. So, therefore, the interference at this time is a correlation between an act which has abused a naturally

good thing and, therefore, the intervention is not in the same category as … it's actually within the natural occurrence of the uncertainty of … a general uncertainty surrounding the statistics.

There's a general uncertainty surrounding conception that 20% are actually naturally lost abruptly. People have to grieve about this naturally and they have the occasion to, but the difference between someone actually deciding that and consciously signing for it and bearing that guilt as a definite life is a much more difficult question and has occurred in all examination of people who go through this kind of trauma, that, in fact, if you look at the … it's the same thing as soldiers going out to war and having a moral objection to killing. You know, if you look at the Vietnam survivors, they come back to their country and it's a well known fact that there's a huge incidence of … and even in the Gulf War, the same thing arrived.

It is particularly difficult if people are morally conscious of their duty to preserve life and they're put in a situation like that and then if they're actually put in a situation where the instruction is to kill or to cause the death of another being, later on they have to deal with the consequences of going against their own conscience and that's a tremendous pain in the sense that it can never really kind of be restored. That kind of thing can't really restore to a person very easily, whereas, if a person proceeds with a pregnancy, difficult as it may be, the fact is that there is the option of adoption and, you know, if she was given a huge amount of compensation by the State, sort of running into something like £250,000, a really reasonable sum, in other words, if she was protected by the State in these kinds of cases with enormous compensation, then she might be able not have to make that decision to wipe out a definite life and may be glad when she meets her daughter or son later on – they may come back and say 'thank you, mother".

I've seen this a lot, you know, looking at the whole literature and I've never known a case actually – and apparently it's, with research, it is backed up. There is no case where a mother, in fact, has distinguished between a wanted or an unwanted child in any degree like a man does. There is no case where it has ever been proved that a woman, once the child is born, actually has any kind of degree of a change of relationship towards a wanted or unwanted child. That's actually proven and I have … actually research has been done by Cooper ... I have actually shown that.

So, in other words, it's terribly traumatic to go through the pregnancy, but I think if the State paid a huge amount of money, really big money – we're not talking about ... we're talking about, with due regard to life, which it has, enshrined in the Constitution, that you can't just have empty words. In that kind of case, a huge amount of compensation, a certain amount of privacy, if the girl was willing to talk about and if the statistics were shown for the kind of stress syndrome, she might be enlightened enough to take that path.

On the other hand, by giving her total consent, you're actually creating a 100% burden which will last for life if she has a conscience about killing anything, so … some people have variations of conscience and conscience can be very elastic, but basically we all know that if you go against your conscience, it causes tremendous difficulty and unhappiness. Sometimes we think pleasure is important but actually doing the right thing is actually what causes happiness.

Chairman: Very good. So the substance really of what you're saying to us this morning, elaborating on your submission, is that there are very strong arguments against allowing a rape exception be used as the basis of an abortion principle. Is that right?

Ms Rowley: Especially when we have a medical method to … if the GP has it in the surgery, it's not as if we didn't have some sort of way in which we could deal with … we have three days and that's something which is very interesting. The Vatican doesn't take that view but I take the view that it's there for a purpose. I think those three days, provided we tell young people about it, that they can do this, it would save a huge amount.

Chairman: I think one of the consultants who gave evidence before us made that point, that there's a 72 hour window of opportunity, as he described it.

Ms Rowley: There is really, and we should make that very clear to everybody, every young girl, that if, that she knows immediately to go to the GP and that she knows that. That's why I think you should legislate for it because, to allow it, because it hasn't been legislated for, as far as I know.

Chairman: Are you saying then that, in terms of legislation, if we were to define the unborn, we should exclude the first 72 hours?

Ms Rowley: I think that you have to look at the natural occurrence of miscarriage … 20% is a huge number of … that's the natural loss and there's no way we can actually arrive at any factual in natural occurrence of loss over another factor. Apparently, it can be due to a huge amount of different things and it seems nature sometimes decides – when I say nature, what I mean to say is that the general picture is not good for the … and so … the reason we don't mourn that as much as abortion is that it's not … it is the person who actually has no decision about it. They didn't get involved, it wasn't anything to do with them usually so, I think, that's really what we're looking at.

Chairman: So, when I summarised your submission, and I realise you covered quite a range of philosophical and psychological matters, but we're practical legislators, we have to make a decision.

Ms Rowley: Yes.

Chairman: The two main points you're making is, one, that there is that window of opportunity in the first 72 hours and that you'd be very opposed to the principle of introducing abortion on the basis of rape or the threat of suicide.

Ms Rowley: Well, it just hasn't worked in other countries, that's all. If you look at the … that's really what we … one of the things we could … another window of opportunity is that you look at legislation in other countries and it just doesn't work because it always seems to lead to abortion on … or millions of abortions ....

Chairman: On request.

Ms Rowley: So I honestly think there is a very difficult question about allowing the rape victim a choice and I think that is, would something … maybe the constitutional interpretation at that point would serve a purpose but as regards drafting the legislation, I think to allow the medical profession some kind of authority here that they wouldn't be prosecuted … I think very much abortion law in England came about because a lot of people involved in illegal abortions didn't want to be prosecuted for manslaughter. I think that was more of really a reason than the so-called women.

What I'm saying, the back street abortion figures are always used. I feel very regretful about that but I think now that if you look at it, there's no reason that should happen in the sense that people know a lot more than they did and that's historical. It isn't actually applicable to today's situation. It is bad … it's hard cases make bad law, you know. For example, I think legalising abortion means that people have doubts about the abortion. It's easier for them to obtain an abortion, that's the problem. If they found themselves in a situation where they hadn't planned for it and not entirely happy for it, what happens then, they say, 'Oh well, it's no problem, it's legal, I can go and have it done'. So it's like driving up a one way street. You're driving a car and, therefore, you can drive on the left or on the right. Suddenly you see something coming towards you and you avoid it and you take your life … you risk your life and somebody else's life but if you go to court, you can always defend yourself.

If we legislate for abortion, what we're doing is allowing people to drive on both sides of the road all the time. Having these both kind of laws is like having no law. Maybe it's not an exact example, I hesitate to say that I'm lacking compassion for … but I honestly think that it's been overused in argument. I think there are millions more women suffering just as equally, if not more, there's far more women suffering from post-abortion trauma than these women and I think that legislation was brought about to protect people from being accused of manslaughter. I think it's a very middle class kind of misplaced compassion, like identifying compassionately with the poor while being in a position of privilege yourself and wishing they had all the bad things you had that are bad for you. If you look at the story of Frank McCourt, people do write about their circumstances and having this point of view, if you keep saying it often enough, they'll never rise above their circumstances, they're just going to be written off. People start believing it then. We all know that if you repeat something often enough … I'm not lacking in compassion really about these women. I hate to sound like that, but all I'm saying is that it's a case where there are millions and millions of women suffering even more because of legislation of abortion. The silence of these women means that we're not entirely sure how they're suffering. The statistics are rising all the time. Life is giving a figure now of 25%.

Chairman: Go raibh maith agat.

Ms Rowley: Go raibh maith agat. An bhfuil mé déanta anois?

Chairman: Táir críochnaithe anois.

Ms Rowley: Críochnaithe anois. Go raibh maith agat.

Chairman: Tá fáilte romhat.

SITTING SUSPENDED AT 10.21 AM AND RESUMED AT 10.25 AM.

Mr Justin Keating, Ms Mary Hardiman and Mr Dick Spicer

Chairman: We are resuming. I welcome the Association of Irish Humanists, that is to say, Justin Keating, their president, Mary Hardiman, their chairperson, and Dick Spicer, secretary, to this meeting of the Joint Committee on the Constitution. We've received your presentation, your submission, which I have read and it has been circulated to the members. The format of this meeting is that one of you may make a very brief opening statement, if you wish, elaborating the position in your statement. That will be followed by a question and answer session. I want to draw your attention to the fact that while members of the committee have absolute privilege, this same privilege does not apply to you. Would one of you like to make the submission?

Mr Dick Spicer: Would it be all right if a couple of us did so?

Chairman: Yes, if you would indicate, the chairperson first, yes?

Ms Mary Hardiman: Yes, please. Good morning. I am here with my colleagues representing the Association of Irish Humanists. So that you are clear in your appreciation of humanism, I will begin by briefly stating that humanism is a democratic, non-theistic and ethical life stance which affirms that human beings have the right and responsibility to give meaning and shape to their own lives. It rejects supernatural views of reality. It is in this area of rights and responsibilities which we have dealt with in our submission in response to the Green Paper on Abortion that I wish to highlight.

Now keeping the EU Convention on Human Rights to the forefront, I would like to quote from the Green Paper, chapter 5, subsection 5.45, where it states: 'It is argued that the common good cannot be promoted through the violation of basic rights, such as the right to life, and that the common good requires the restriction of individual rights in some respects.' Now this argument by definition applies only to a small minority in this country, and that's pregnant women with crisis pregnancies. People are not merely a means to an end but are ends in themselves.

The woman treated as an incubator of a foetus by law is merely a means to an end and is, therefore, not being regarded as a conscientious person.

While we continue to criminalise abortion, we deny thousands of women their rights, the right to bodily integrity, the right to speak freely, the right to access necessary medical care. Denying a pregnant woman the right to choose is a form of coercion or social control which, as we all know, has been a devastating feature of our past history. Then we incarcerated pregnant women in Magdalene homes. We ostracised them. We exported them to Britain. We drove them to seek illegal abortions and to infanticide. That this regime no longer pertains in this country is because we have a humane, non-absolutist society on our doorstep and we have taken advantage of this to abdicate our responsibility to these women.

Lately we have decriminalised suicide and homosexuality in part because we recognise the irrationality of these laws and because they're inoperable. Now we must have the courage on behalf of our women to decriminalise abortion and to deal with this issue in this jurisdiction. Only when we do this and consequently stop demonising these women will we be enabled to seriously work to reduce the numbers who see abortion as their only option when faced with a crisis pregnancy. I do believe, based on my experience working as a counselling therapist in family planning and as a foster parent, that all agencies working in harmony together towards the same goal can effect change. Thank you.

Chairman: Thank you. Mr Dick Spicer.

Mr Spicer: I just want to briefly make a few points and summarise some of the things we have concluded in our various presentations. One, that the current situation is unacceptable and untenable and that a referendum is necessary, perhaps accompanied by draft legislation. The right of an individual woman to choose whether to continue with a crisis pregnancy within the first trimester of pregnancy is one that ought to be recognised constitutionally, legally and medically. That the issue of when human life in a pregnancy begins is central to a resolution of the issues of human rights involved. Following from that, that a real threat to emergency contraception exists in the present situation as submissions coming from the pro-life movement reflect hostility to contraception and abortion from a theological perspective.

Starting with this point, I would like to take this opportunity to pay tribute to the role of the pro-life movement in opening up Irish society to the debate of issues which were previously taboo. Its efforts have upset a cosy cloistered culture and forced people to think for themselves and debate a range of issues. People have been driven away from a purely theocratic approach to social issues and the process has encouraged the secularisation of our nation.

In a relatively short period of time, Ireland has moved from a situation where it was the only country in the world to have the entire programme of the moral majority enshrined in law to one in which your committee is addressing this, one of the last remaining issues. The hurt caused to many women by the actions and attitudes of the pro-life movement, however, has been a hard price to pay. I wish to briefly address an issue raised by them.

The submission by Youth Defence stated that Dutch abortion figures are low because they do not include first trimester abortions. This is not the first time this has been placed on public record. We have been in contact with the Dutch ministry responsible and they have assured us that all early interventions after 16 days – their definition of the implantation period – are counted in the abortion statistics. The Dutch figures, then, do indeed show the effectiveness of early and widespread sex education and contraceptive availability as a means of lowering the abortion rate, which is what our earlier submission argued should constitute the way forward.

The willingness of elements in the pro-life movement to try to utilise statistics so as to denigrate such measures shows, we believe, that some are not primarily concerned with the interests of women and the unborn, but are motivated by a theological perspective on human procreation in general, which threatens the provision of emergency contraception. The Catholic Church, other Christian denominations and the pro-life movement define human life as beginning when the fertilisation of ovum by sperm occurs. The Christian church for most of its existence, however, more reasonably saw the quickening as the key moment, i.e. when it received a soul. Muslims currently hold a similar position. This makes a great deal of sense, as the fertilised egg is but a potential human being, up to half being lost through natural causes in the first trimester.

Our perspective is one which accords the developing foetus more rights as life dawns within the womb, rather than one which vests it with full human rights on the meeting of sperm and ovum. We, accordingly, see the end of the first trimester as the earliest at which its interests as a potential human being have to be weighed against those of an adult woman. We have submitted arguments to that effect.

The Green Paper acknowledged the problems possibly facing emergency contraception if 'unborn' was taken by the courts as applying at the moment of conception, i.e. if they applied the Christian definition, but stated this has not troubled the courts or the medical profession to date. We would suggest there is absolutely no guarantee that this situation will continue and that it is possibly reckless to assume it will, given the aforementioned attitude of the pro-life lobby and the Catholic church, in particular, to the issue of contraception and abortion.

Emergency contraception, as distinct from the abortion pill, works in two ways. If ovulation has not occurred, it stops it happening and, so, it is simply contraceptive in effect. If, however, ovulation has occurred and sperm meets ovum, it stops implantation, which results in the loss of the fertilised entity. In that case, it can be argued from a theological perspective it constitutes abortion. We, therefore, ask the committee to reconsider the Green Paper's stated approach to the threat posed by the present legal limbo and to consider instead the horrific effect on women, particularly rape victims, of a challenge to emergency contraception on the above grounds.

It is the overriding of women's rights in the entire area of this debate, stemming from a theological perspective to the origins of life, which we feel makes another referendum necessary, from our perspective.

Mr Justin Keating: Thank you, chairman, for allowing

three of us speak. I will be very brief. I wanted to speak to two aspects of the whole problem which come from my own life experience. I was a Member of the Dáil, the Seanad, the European Parliament and, indeed, Government. I would have had occasion in my life to think when is it appropriate to make certain kinds of law or to initiate law which will result in a referendum. When is that appropriate and when is it moral to make certain kinds of law? In the end, this is a moral issue, inescapably. We may be as technical as we like but it is, at base, a moral question.

It seems to be that legislators, from my own experience, must always pay attention to the situation that actually exists – not to an ideal one, but to the one that is there on the ground. The relevant parameters of the present situation are that we are members of the European Union and that our citizens are guaranteed the right to travel and the right to information. It seems that a previous protocol would not be renewed in a new context. That's where we are at. We are promised by President Chirac that during the present French Presidency of the European Union there will be new and more rigorous initiatives in regard to basic human rights. That is where we are at.

We have been quoting the figure of 6,500 abortions of Republic of Ireland people in the UK. I think that isn't a figure that should be accepted. Firstly, it is a little out of date. The rise in the graph is a remarkably straight line and you can extrapolate legitimately to make it 7,000 at present. Secondly, I think it would be imprudent to conclude that that 7,000 includes all the people seeking abortion outside the Republic because many, with the historical connection between Ireland and Britain, will have friends' addresses etc. in the UK. My own instinct is that we are talking about 10,000 people a year – and, if not now, very soon. I say that with no joy, but to indicate the scale of the problem. That looks very, very roughly like about one in 100 women of reproductive age every year – 1% of the women of reproductive age every year go to the UK for abortions.

I will stop the contribution on this subject in a moment. The question is whether a national Parliament, an Oireachtas, is morally entitled to make laws which are irrelevant and which don't seize of the real problem. The real problem is that abortion has always existed and will probably always exist. Nobody likes it, but caring national parliaments make the best they can of a situation that nobody welcomes or is pleased about. To legislate in a way that says, 'This is the law, but the 7,000 or 10,000 of you go and solve it somewhere else at somebody else's expense, without the care and cherishing of your own society and culture at a particularly difficult moment of your life' – is it moral to make law like that? That is the question. I will leave it to the committee.

Secondly, because for 40 odd years of my life I have been teaching the veterinary students the mammalian reproduction – I was professor and associate professor, and part of my title was embryology, mammalian embryology, and I am not extending what is appropriate for animals to human beings. I recognise the gulf, but I also recognise it is my professional business to know the explosion of knowledge in reproductive science that has taken place in recent years. This year the human genome, last year cloning, and we are not at the end of a flood of knowledge, we are at the beginning. That seems to me to make a lot of received knowledge, including theology may I say, out of date or inappropriate. And again I will pose not an answer but a question. We are now able to clone mammals. We haven't cloned humans by decision but we have the technology to do so. If we clone a human being – we can and if we did, what would be the moment when the new individual came into existence? I borrow a word from an ideas' system which I don't accept: what would be the moment of ensoulment of the clone which initiated its development as one cell of a pre-existing individual?

I might go on to ask one other brief question. Humans produce billions, literally billions, of spermatozoa – males – and women produce, what, 500 or 1,000 eggs during their reproductive lives. Both are collectable and storable, and carry the code of life in them, analysed, and are utterly expendable. From the moment one meets the other and they fuse, the rights of the zygote, as it is called technically, are claimed to be equal to the rights of a mature adult woman. That seems to me not to be reasonable or rational. So, that, we should be very careful making legislation which will be almost immediately shown to be out of date, shown to be out of date because we know the delays of national parliaments, shown to be out of date before it becomes law. It is very dangerous now because of the reproduction science revolution.

Finally, I would say this on one issue: question – should we have a referendum? I remember and participated in a previous referendum. It was divisive and unpleasant. And I would beg people, and I might beg the committee if they feel moved to do so, to put it into a report, to say, 'Please, can the media and other responsible people, insist on decent standards of truth – and, indeed, can I say, within society – affection and respect and love on the part of the contending parties, that we conduct that debate honourably?'

But society is divided. We can't escape that. We may say that a referendum would be divisive but the division is there. And those who have caused previous referenda to be held have done Ireland a service because they made the unmentionable mentionable, they brought it out. We were enabled in a quasi .... We only half way got to a decent debate the last time, but we might try to get to a decent honourable debate this time. And the exposing of profound social divisions, and the discussion of them in a rational and cherishing way, accepting the good faith of all parties, is a healing process and not a divisive one. We mustn't conclude that a referendum would be necessarily the tearing apart of society or a damaging thing; because the more there is knowledge, the more there is rational debate, the more there is acceptance of the honour and morality, according to their rights, of the different participants, the more we can listen to each other and trust each other and draw together as a society.

Chairman: Thank you very much for a very stimulating contribution. But, Mr Keating, the vast majority of the submissions we have received have sought a referendum based on a particular form of wording, which would in some sense contain an absolute prohibition on the carrying out of an abortion within the jurisdiction, and would address the question of the effect of the Supreme Court decision in the X case. Of course, we have conducted these hearings and in the first instance we heard evidence

from various medical practitioners and it would appear as a result of the evidence they have given, that there is now no clear wording available to meet that particular objective, and you seem to be proposing a different wording this morning, I take it, if you are championing the cause of a referendum. So, I was wondering what is that wording?

Mr Spicer: We don't have a wording, but we ....

Chairman: You want a relaxation of the present constitutional position.

Mr Spicer: We do indeed. We feel that the current situation is the best that could possibly, or the worst from our perspective, be achieved from those of a different persuasion. We feel that under the present circumstances, any legislation that was enacted would be so restrictive as to really be pointless in terms of helping or assisting women who were in a crisis pregnancy, and remain possibly suicidal. By the time they had been through the whole process they'd be dead.

Another point, about the discussion that took place on suicide and pregnancy, I felt that an awful lot of the statistics that were produced were irrelevant because the effects of a crisis pregnancy on a woman's state of mind would be completely different in a jurisdiction where there was access to early abortion, and in a jurisdiction where there was no abortion. In other words, that very pre-existing situation would have a bearing on a woman's state of mind if she was facing a crisis pregnancy. So, I feel any comparison between our jurisdiction and the effects of a crisis pregnancy on a young woman, or any particular woman, would be completely different.

Chairman: You are essentially arguing for option seven in the Green Paper, isn't that right – that we would relax the present law, and a necessary preliminary to that would be a referendum ....

Mr Spicer: Yes.

Chairman: .... in which the Oireachtas would be empowered or authorised to provide for that?

Mr Spicer: I can see a virtue in having draft legislation accompanying a referendum so that people would be absolutely clear what they were voting for. And there might indeed be some virtue in a preferendum, but I haven't gone into the exact details of that. But yes, we feel that from our perspective an abortion referendum is required if we are to have progress and if women's rights are to be respected.

Chairman: And do you think that is in the realm of a serious practical political possibility as this point in time?

Mr Spicer: Well, you are the politicians. You are the politicians and you are asking to hear from us, you know. I mean, we are giving you our feelings on the matter ....

Chairman: Yes.

Mr Spicer: .... and our analysis. If you want to, you can be all practical politicians. That is your role, but this is our role.

Chairman: Thank you very much.

Ms Hardiman: I would like to say something here from my experience as a counsellor. Justin states 7,000. Each year the figures are going up. Each year you are having more people pro-abortion because it is their experience and it is their families' experience. I don't think that there will be such a black and white situation now among people because it is, as I say, a growing experience within our community. Not only do you have the woman who's choosing to have an abortion for her own reasons, but you have, in a lot of instances, her family supporting her. So, you have these growing numbers. So, saying that the submissions you are getting on the pro-abortion side are the greater number, I think that is because these people are very vocal but there are ....

Chairman: I think you meant to say the anti-abortion side.

Ms Hardiman: The anti-abortion side, thank you, yes. On the other side, there is a growing number of people whose experience is that they have been down that route themselves and they … and their families have been with them. I think the experience might be different in the next referendum.

Chairman: Can I make one point on that in relation to a referendum. This is a sensitive subject, it is a subject that arouses not just acute theological opinion, but philosophical disagreement as well. If a referendum is held – as you rightly say, there are a great number of women in Ireland who have been through the experience of having an abortion – does a referendum, of itself, not cause further trauma to these women?

Ms Hardiman: Yes. Every time it appears in the media, it causes trauma for these women, yes, and they cannot be here to speak for themselves. Even those women who are anti-abortion before they become … face a crisis pregnancy, they cannot speak for themselves either, even among their own friends now, and I have in my experience met these women, and the answer is 'yes', it does cause trauma but these women would rather that we face the issue and accept them.

Mr Keating: Chairman, I wonder would it be possible for me to go back very briefly about the question of wording, because this is obviously very difficult when much wiser heads than ours didn't get it right on a previous occasion. There is clearly difficult law and there are difficulties of choosing an appropriate consensus within our society. But let me start from each end. As far as we would be concerned from the humanist viewpoint, a total prohibition is not a serious alternative for the reasons that I indicated – that is it doesn't address the problem and that it exports it. That is not a responsible thing to do, or even a moral thing to do. On the other hand, abortion on demand of a frivolous, almost frivolous kind – it's not a frivolous action – but that is clearly almost as undesirable. In an ideal world, no child would be born unwished for,

no child unwanted born, but it's not an ideal world and, therefore, I think we would favour a form of words, a consensus, which made abortion possible, legal within the country but difficult and only at the end of a much improved system of prior counselling and only if the decision to go to term and bear the child were taken, that the child would be born into a context of a much more developed system of supports than currently exists – that one can make the argument much more strongly – bear the child – if the social atmosphere and if the structure of social services is such that it is not so terrifying and so unthinkable for a young woman often alone and in very difficult surroundings. So, I think difficult but possible in the context of greatly improved support systems is a shot at some kind of guidance of a form of words.

Mr Spicer: I would add to that that we do feel there ought to be a differentiation made between the very early stages and subsequent time. In other words, that the real problem … one of the real problems in this area is as has been mentioned – crediting this fertilised ovum with equal rights to an adult woman. We do not feel that that is reasonable, moral or ethical.

Chairman: Setting aside the rest of your submission for a moment, because I noticed you addressed this specific issue in considerable detail, it has been a thread running through the evidence and it has found support in different quarters – some surprising quarters – the point of view you've just expressed.

Mr Spicer: I'm very pleased to hear that. I haven't had a chance to read everything that's been put forward but I did notice some references to it. But, essentially, from the humanist perspective, we do feel that the theological view point, that this fertilised ovum should be given equal weight, is just not in any way sustainable and that this might be a possible option that would be put to people. You know, there ought to be some way of putting this as an option in a referendum – that the full equal rights or that the term 'unborn' applies at a certain stage. Now there are different suggestions as to when it might apply – ours is at the end of the first trimester, others might say at the end of implantation, others might say, as I noticed in some of the submissions, when there is a heart beat. But this is an area, surely, which should be open to national debate.

Chairman: Well, I think from .... Well, we've had a debate on it but I think … I interpreted your submission as meaning that while your strict position was three months, you'd be very anxious to see that 72 hours was cleared up as a ....

Mr Spicer: Well, indeed, absolutely. We do feel that is a definite danger under the present circumstance. I didn't want to dwell on it for fear you felt I was labouring that particular point again.

Chairman: No.

Mr Spicer: But we do feel that is a danger and given the theology of those who are opposed to abortion and given the theological ramifications of the fertilised ovum and the effects of emergency contraception, we do feel that that does introduce a note of urgency into the situation. I mean the international ramifications, quite apart from what would happen to women in this country, it would be just awful to behold this country dragged through the international mire again over something like this.

Chairman: But accepting that we recognise the value of all human life and accepting – even if you want to disagree with me in a moment, for a moment on this – accepting the proposition that a lot of people believe that unborn life must be valued as well to a very early stage, there must still be some discretion for the Legislature in any constitutional arrangement to deal with difficult, borderline cases. Would you accept that, Mr Keating? You can't have a referendum on all these subjects. The Legislature has to have some power to deal with them.

Mr Keating: I think that, yes … my feeling is to say 'yes' to that. But I would add that it's very dangerous in a referendum, in a constitution, in law to try to bind the future because the situation is changing, both in society in Ireland and in the basic science, extremely rapidly and whatever one does, one has to do it in the knowledge that the consensus, the paradigm of society in 20 or 30 years, may be quite different and, in fact, I think in the context we're in now – there are periods when change on earth is quite slow – but it's extremely rapid at the moment. So that I think the .... An effort should not be made to bind the future, if I put it that way.

Senator O'Donovan: Just briefly going back to the point your chairperson made there regarding the decriminalisation of abortion. Could you just, maybe, elaborate on that because what I would see as decriminalisation of abortion would basically indicate that abortion on demand would be available. I make the point in view of .... We, some years ago – not too long ago – decriminalised the crime of *felo de se* , or suicide, and since then, unfortunately, rates are alarmingly increasing. Do you wish to qualify that point? Because, if I was to take verbatim what you said in that point is that you would absolutely change the 1861 Act to make abortion legal at any stage, even in the second semester, thus creating a very open regime.

Ms Hardiman: I would not say the suicide statistics have increased alarmingly. Yes, they have increased, but remember, they were not documented when it was a criminal act, necessarily, so we did not really have true figures. There are statistics to show that the abortion rates in England and Wales pre the 1967 Act were not very dissimilar to those after the Act was brought in, so there was not an opening of the floodgates, just as in our divorce referendum there was not an opening of the floodgates. I personally do not think that there will be an alarming increase.

We then put in place legislation and education. I personally would not have a fear that the rates will rise alarmingly, but we do need legislation. I would like to remove abortion from the Constitution entirely.

Senator O'Donovan: You say that abortion should not be a criminal act at any stage. Suppose somebody with full *mens rea* and malice aforethought decides on an

abortion five months into pregnancy, whether it be in Ireland, England or Holland. Would you not see the need for some kind of law?

Ms Hardiman: Regulation.

Senator O'Donovan: It could cover a 72 hour or 14 week period. If abortion is decriminalised by repeal of the 1861 Act would you not have a problem if somebody who is five or six months pregnant decides to have an abortion for any reason?

Ms Hardiman: There needs to be regulation, yes, just as there is in Britain and in Holland. They have decriminalised it, so I do not see why we cannot do the same thing.

Chairman: Some of the medical representatives told us it would cause an earthquake in this country to introduce abortion facilities here.

Ms Hardiman: The medical profession is very authoritarian in this country. I think we have to challenge it. There is not a consensus among the medical profession. That would be my experience from working in family planning.

Senator O'Donovan: I am not a medical person and I would not have Mr Keating's experience in drafting legislation, but the impression I got from the vast majority of medical people we heard, including the Medical Council, was that there was a very conservative approach to the whole issue by the Medical Council and some senior gynaecologists and obstetricians. Some went so far as to say that if abortion was introduced in a restrictive fashion – say by use of the 14 or 16 week period as a cut-off point – they would opt out for religious reasons and would not perform abortions. I will not name names. Does this not mean that a seismic shift would be required? We have been told at these hearings that the Medical Council holds certain views and if there was a change to even half way towards what you purport to be reasonable, many of the medical people would opt out of such medical treatment or operations of any nature. That is my impression.

Mr Spicer: That could well be so. That is their right. We are not trying to impose anything on anyone. We would take exactly the opposite perspective. I mean, we are trying to cater for diversity and cater for individuals' choice. It would be completely inconsistent for us to be appalled at that prospect. But I am quite sure, as Mary said, that the description of it as a potential earthquake is probably exaggerated and we have seen and are seeing in Ireland at the moment, as in other parts of the world, the collapse of these hierarchical institutions of authority. Many of them have been seen as having feet of clay. I would possibly raise the question as to how really how representative is the Medical Council.

SITTING SUSPENDED AT 11.09 AM AND RESUMED AT 11.16 AM.

Mr Keating: Chairman, might I add to that though legislation is obviously a national issue, medical science is not a national issue. The Irish doctors, as I read most of the consensus opinion coming from them, would be very much out of line with their colleagues in other countries and would be out of line with the people who are at the cutting edge of evolving reproductive science. It is not that we are in the position of being the peculiar people *vis-à-vis* what is general public opinion, it is that Irish doctors, in their overall consensus, are very much out of line with their colleagues in most developed countries.

Chairman: But Mr Keating, despite 33 years operation of the 1967 Act in the United Kingdom, there are a growing number of doctors in England and Scotland who will not operate the provisions of the Act. The numbers of doctors who will not operate the Act is actually increasing.

Mr Keating: Yes, but we are not talking about something on such a vast scale as an influenza epidemic, that you need the whole medical resources of the country. We are talking about something first, that though it is on a very serious scale, it is not enormous and secondly, we hope that with ongoing knowledge by the young about reproduction, it will diminish and, therefore, it is perfectly feasible to have sufficient doctors to operate a limited scheme in Ireland and to simultaneously recognise the conscientious, and totally to be respected, objection of other doctors. It is not, I would have thought just looking at the numbers, an administrative problem. It is not a moral problem because one must totally respect the moral objections that certain doctors may have. But, my own experience would indicate that there would be quite enough doctors in Ireland who thought that it was moral and proper in certain circumstances to carry out abortions, so that on the ground, in the operation of our health services, it would not be difficult. I say that without expertise. That could turn out, if you looked at the numbers, to be quite wrong.

Chairman: I would like to thank the witnesses for their attendance today and I will suspend the session for a few minutes.

Mr Keating: I want to reciprocate your thanks because we feel it especially important, as we feel rather as outsiders to the consensus, to the paradigm of the country and it is a mark of the maturity of democracy that everybody is listened to and we would look on ourselves to some extent as an example of that and we are, therefore, particularly grateful for your gracious listening to our submission.

Chairman: Thank you very much, Mr Keating.

Mr Benedict Ó Floinn and Shane Murphy

Chairman: We are resuming our public session and I would like to welcome Ben Ó Floinn, barrister at law, and Shane Murphy, barrister at law, to this meeting of the Joint Committee on the Constitution.

We have received your presentation, which has been circulated to the members. The format of this meeting is that you may make a very brief opening statement, if you wish, which will be followed by a question and answer session. I have to draw your attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you.

We have received your submission and I have read your submission, and I do not want you to reiterate it but I think it is fair to say that it is a summary of legal difficulties associated with drafting a wording of an amendment to the Constitution which would reverse the X case. Is that a fair summary of ....

Mr Shane Murphy: That is a fair ....

Chairman: .... the substance of the submission?

Mr Murphy: The position in essence is … what we have sought to set out in our paper is a submission, which would seek to achieve a constitutional prohibition on abortion within the jurisdiction and which also seeks to address a question which seems to have arisen in a lot of the transcripts that we have been furnished with by the committee, where the committee has a concern expressed about the need for legislation, whether it is possible to legislate in the context of prohibiting abortion as a medical procedure within the State. So, it is with those two aims in mind, namely the constitutional prohibition and the subsequent legislative copperfastening of that position, as it were, regulation, that we have sought to address in the course of the paper. Obviously, in this particular situation we are very grateful for the opportunity to speak to the committee and to elaborate and to answer any questions that may arise from the submission.

There are just a number of points we would like to make by way of short opening statement. The first is that we have looked through the transcripts, which the committee has furnished us with and which indicate a variety of different formulations which have already been advanced to the committee. Having looked at that phraseology, the form of wording put forward by the pro-life group, which I think is one with which the committee is by now familiar, namely the wording which states that 'It shall be unlawful to terminate the life of an unborn unless such termination is the unsought side-effect of medical treatment necessary to save the life of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life', appears to us to be the most effective formulation that has been presented so far in relation to option one, that is to say, the option where you would consider prohibiting abortion within the State.

The question then arises, does that formulation permit any subsequent legislative intervention which might protect the interests, the legitimate interests of all parties concerned, that is to say, the rights of the mother, the rights of the unborn child and, interestingly in the context of the transcripts, another series of rights which have come up for the committee's consideration, the rights of doctors, who have expressed concerns about the current situation and about any prospective change in the law at how it might effect their application of best medical practice in the context of the treatment of expectant mothers or unborn children?

It is our view that, looking at that particular form of phraseology, the committee is confronted with one hard question and it has asked that question of all of the witnesses who have been called so far, and the question is whether or not it is possible to legislate, and we would have a concern that the committee should not ignore the fact that the Legislature in this jurisdiction over the last 60 years has on many occasions used well known legislative formulae to ensure that the legislation passed by the Oireachtas copperfastens constitutional rights and can regulate the exercise and application of that constitutional right.

It would be our submission that it is not impossible to apply legislative formulae to deal with the situations which may arise in this particular context. It is noteworthy, for example, that in the transcript of Dr McKenna, that he was asked specifically whether he thought the problems which he identified in the rare and exceptional cases were problems which were capable of being dealt with by legislation and/or by a constitutional amendment. He indicated that he did not believe he was legally competent to give an expert view but he did indicate that in his view it was something that was a soluble problem and we believe that in this context those concerns are capable of being solved by legislation.

Another area which is also evident from the transcript is in the response of the Master of Holles Street, Dr Keane, who expressed concerns in the course of the transcript and I can refer you to these later on in the course of our questions and answers, if required, the concerns that doctors might have if specific procedures were listed in legislation and, again, that is a feature we would like to discuss with you here this morning, but overall our principal concern would be to put before the committee the proposition that it is possible, as has been evidenced in the experience in other jurisdictions – and we set out a number of those examples which arise from state legislative proposals in the United States of America; we have illustrated two, one from Alabama, one from Arkansas – where it is clear that legislation can deal with medical matters in detail in a manner which may effect a proper regulation of an area which is of such fundamental concern to all the citizens of this State.

Mr Ben Ó Floinn: I think just by way of a supplementary point, Chairman, when you opened your remarks you used the word 'difficulties' that arise. I think we would use perhaps a more neutral word, that the issues that are thrown up by this first option, the absolute ban or the constitutional ban on abortion, and I think if one were to summarise in a single sentence what our submission intends to do, is that it has been said widely in the public forum that it is impossible to recognise the distinction between direct and indirect abortion and to deal with the question of intent by way of constitutional amendment and, as Shane has said, we have looked at the law in a

number of different jurisdictions but particularly in this jurisdiction. What is being talked about when that option is put forward, that a constitutional ban on abortion is being talked about, particularly if it is phrased in the way that that particular amendment or proposed amendment is framed, it draws on well-recognised principles of law. The difference between direct and indirect, intended and unintended is often presented as some arcane philosophical concept that the law is incapable of grappling with. We say in our submission that is recognised in this jurisdiction and in other jurisdictions and it is capable of very precise formulation.

So, if this committee makes a decision, it will, in our respectful opinion, have to make a decision purely based on policy as to whether option one is an acceptable option or not and it cannot make a decision based on the impossibility or the impracticality of a constitutional ban. It will have to be just a policy decision because we would be satisfied that legally it is possible to draw the distinctions that have to be made if one is to protect the life of the unborn and at the same time not interfere with medical treatment.

Chairman: That wording you mentioned in your submission, your preferred wording ....

Mr Murphy: The preferred wording in relation to the constitutional amendment is reflected in the submission, yes, as one of the options. I think we have detailed the options. I will refer you to it ....

Chairman: Yes, but is it set out in the submission itself?

Mr Ó Floinn: It is. We have grouped the wordings into three categories. The first category is the one that relies upon induced abortion as a term of art – we have described it as the term of art model. The one that we prefer is the second of the wordings that we have categorised in the second model, which is based upon an explicit distinction between foreseeability and directness. I think you will find it ....

Chairman: It is set out in the submission.

Mr Ó Floinn: Yes.

Mr Murphy: If I can hand that to one your researchers, Chairman.

Mr Ó Floinn: Yes, it is set out at 5.1. There are two sets of wordings set out at 5.1 ....

Chairman: And it is the second one ....

Mr Ó Floinn: It is the second of the ....

Chairman: It is on page 52 of the brief book we have. I think you have a copy of the brief book.

Mr Ó Floinn: We do not have the same pagination in our book of submissions. That's right, that's the one at page 52.

Chairman: Could that not be introduced as ordinary legislation under the 1861 Act, without any need to recourse to a constitutional amendment?

Mr Ó Floinn: The difficulty with that is that for as long as the X case embraces the interpretation that it does of the existing wording, it is an implicit recognition of the need for the direct termination of the unborn in certain circumstances, most controversially perhaps, in the case of suicide. For as long as that interpretation is given to the existing provisions, it would be necessary for an amendment to take place in order to set out the basic principles of the situation. It is central to what we say that there is no barrier if there is any residual concern on the part of the Government or this committee. They are all terms that can be amplified by way of accompanying legislation and we give the example of when the divorce issue was put before the people, it was put before the people in the context of a constitutional amendment and legislation showing how this would be operated. There is no difficulty with that in principle, once the basic principles on which we are proceeding are clearly set out in the Constitution.

Chairman: Which they are at present.

Mr Ó Floinn: Regrettably, given the state of affairs since the decision of the Supreme Court in X, we would respectfully disagree that they are set out clearly. There is actually a collision between medical ethics and the situation that's recognised at law and in those circumstances we say that what's needed in this area is a further degree of clarity. That is why it is essential.

Mr Murphy: Secondly, Chairman, any legislation, as you will be aware, has to pass constitutional muster and in considering a comprehensive solution to the current situation, the first option the committee is considering amongst a series of options, but the first option which will involve a total prohibition in relation to this area, is something which in our submission would require a combination, at the very least, of a constitutional amendment to the existing phraseology in the Constitution on the lines that we have submitted, and if legislation was passed, it would have to be under the umbrella of that phraseology. It is clear from the Supreme Court's interpretation, not just of legislation in this area but in every area, that the legislation must be consistent with the Constitution.

Chairman: I very much appreciate the fact in your submission that you are trying to assist us on this whole question of wordings but if you look at the evidence of the masters, in particular their description of the Eisenmenger's case and the HELLP syndrome, it is clear that the masters of the principal maternity hospitals here in Dublin are not happy with characterising the procedures they have to carry out in those cases as indirect.

Mr Ó Floinn: I think if we were to summarise the evidence that has been given to the committee, and I appreciate it was voluminous, what is actually striking about the evidence given by the various medical practitioners and gynaecologists was the degree of unanimity. It is true that in certain instances and certain witnesses, the manner in

which people have expressed themselves gives the appearance of a greater conflict than there actually is but in terms of what people consider to be acceptable treatment *versus* unacceptable treatment, when one actually looks at what people are doing in practice, the overwhelming bulk of the evidence seems to be based on a consensus.

Chairman: Yes, that is not in dispute, but there was far from a consensus on the idea that the use of expressions such as 'direct' and 'indirect' in this context .... I mean there was a substantial volume of opinion among doctors that were very unhappy with the introduction of that type of distinction to describe their procedures.

Mr Ó Floinn: What we see as the ....

Chairman: That is a real political problem for our committee looking at the wording you are putting forward.

Mr Ó Floinn: But what we find to be the attractiveness of the wording is that instead of colliding with, it coincides with the language of the Medical Council guidelines itself which are the guidelines that practitioners would be ethically bound by and, as I say, particularly in relation to the transcript of evidence of Doctors Keane and McKenna, when the issue was probed as to what exactly abortion was and where the dividing line should be drawn, this very question that our paper addresses, this distinction between directness and indirectness, one was left with two impressions. Either the doctors felt that this was a matter on which they didn't feel that they could comment because it was a legal issue, and that's where our paper comes into … steps into the breach, or, when as I say, there was … the question was pressed, they used language that was very resonant of the Medical Council guidelines, as one would expect, so one finds words such as 'aimed primarily at terminating the pregnancy".

As we've said, we've got .... We've adopted the synonyms 'unsought side effect', but they're still dealing with the same legal concepts which are intention and directness, concepts that interrelate at a whole host of different levels but that the courts are dealing with day in, day out. Where we are coming from is to say that these are not distinctions that are impossible to draw. They can be drawn and they ought to be drawn so that there's a clear framework within which doctors and medical practitioners of all sorts are able to operate.

Mr Murphy: Dr McKenna, particularly, in his submission, and again we don't have a page reference for it, but at one point he was asked by Senator O'Donovan to give an indication about how he would define abortion and he said that the term 'abortion' is conspicuous by its absence in the glossary of terms for definition in the Green Paper. He goes on to say that is the stumbling block. I would take the point of view that, if the treatment is aimed primarily at terminating the pregnancy, that is an abortion, and I would feel it is semantics to say otherwise, but the word isn't defined for the purposes of these discussions. Their definition is certainly as good as mine, but that's where I would call it.

There does appear to be a certain scope for argument about the manner in which the phrase is actually defined, and the use of the formulation of the unsought side effect would seem to me, Chairman, to open up the possibility that what the experts have described in their evidence is consistent with that formulation. I don't think it was put to them that that particular phraseology would or would not affect their daily application of best medical practice. It's clear, however, from the phraseology that it's the direct purpose and intention of the intervention which would be an issue in any legislative formula.

Chairman: Well now, suppose .... Take on your wording, suppose you have a rape victim who does not report the rape and the victim is aged 16, no, we'll say 17, and the victim wants … visits a psychiatrist and the psychiatrist says that she will certainly commit suicide and writes to an obstetrician who agrees with the psychiatrist and says, 'I can do this because I can terminate the pregnancy because it is the unsought side effect of medical treatment necessary to save the life of the mother where there is an illness or disorder, a disorder of the mother, giving rise to a real and substantial risk to her life".

Mr Murphy: I think, in the context of the particular situation you've described, that the use of the words 'not including the risk of self-destruction' added to that phraseology ....

Chairman: So, you'd have to amend that?

Mr Murphy: .... would cover that particular formula, yes.

Chairman: I see.

Mr Murphy: I think to that extent we've outlined from the answer that our concern about the X case is its acceptance in the context of the case but its acceptance of a proposition of law which was not supported by medical testimony at the time, and even on the evidence given to this committee, which seems to be very much open to question on the basis of the psychiatric evidence given by Dr Sheehan, for example, in the earlier submissions to this committee.

Chairman: Then you end up very close to the wording of the 1992 referendum, isn't that right?

Mr Murphy: There is a similarity in some of the phraseology, but it is not identical and the introduction of the concept of the unsought side effect of medical treatment in our submission would provide a stronger basis and stratagem, because, in effect, that amendment seemed to acknowledge the possibility of legitimate direct intervention, whereas we're indicating that that would not be necessary.

Chairman: So, you're introducing the word 'unsought side effect' so that you don't have to introduce the word 'direct abortion', isn't that right?

Mr Ó Floinn: There is a difference between what has been described, and we're guilty of it ourselves in our presentation. We've used loosely the word 'abortion' in the vernacular sense that it's bandied about, but when one actually brings a degree of precision to defining what

is and what isn't acceptable treatment and one starts to hone in on the issues involved, then there are these two key concepts, legal concepts, of intention and directness involved, and, as I say, they're almost commonplace concepts, and any amendment that is directed towards achieving a situation where there isn't an interference with the right of life to the unborn but that medical treatment which is necessary for the mother is given to her, then, I think, one has to hone in on those concepts.

That was where the mistake was made in 1992 because the phraseology was open to the interpretation, strongly open to interpretation, that it was permitted in certain circumstances to effect a direct abortion, an induced abortion, and that is where the difficulty lay in relation to the wording in 1992, and most commentators would agree that that's why the wording in 1992 was unacceptable, and I know there's been some debate about that, but that was the difficulty in 1992. That's why I prefaced our remarks by saying there is a policy issue and there is, if one could put it this way, a mechanical issue as to how the policy is carried out. We have to make that distinction clear because there are tragic cases, such as rape, such as the threat of suicide, that will evoke great sympathy on the part of everybody who reads about these cases. They're appalling tragedies for all involved.

There's a policy decision to be made on the part of the committee as to whether it should or should not permit abortion in those cases. The difficulty in relation to it is that, once one admits of the possibility in those cases, I think it is unchallenged by any of the submissions that one will eventually lead to a situation where abortion will be available on demand. We're not focusing in on that policy issue. We're simply saying this committee can't reject the option of a constitutional ban on the basis that the distinctions which are necessary are impossible to draw. We are saying that, as a matter of law, they're perfectly possible to draw. If the committee takes a broader view that, for some other reason, they're unacceptable, then that's a wider policy consideration that the committee will have to come to having weighed the evidence.

What we would be concerned about is that, one reads the submissions – and we were supplied with a substantial book of submissions; we read them all and we read all the transcripts – one comes across the occasional pejorative reference to directness and indirectness. There was one submission that said 'may lead to interesting case law, can't be drawn in any, sort of, legal sense'. There's no submission, other than our own, which seeks to analyse it in a purely legal framework. What we were concerned to do was to assist the committee to look at it from that legal dimension as to how a policy may actually be carried out.

Chairman: I know what your purpose is, but the Master of the National Maternity Hospital, Dr Keane, indicated that we weren't far away from arriving at what he viewed as the correct solution in 1992. So, clearly, here's a master of a major maternity hospital saying 'I was comfortable with the 1992 wording'.

Mr Ó Floinn: Well, as with Dr McKenna, I think what all the medical practitioners were uncomfortable about after the X case was that, in a situation where there'd be no challenge to the evidence in relation to suicide, where suicide itself was a Pandora's box ....

Chairman: Yes.

Mr Ó Floinn: .... I think everybody viewed 1992 as good in so far as it rowed back on the question of suicide which had been left open-ended after X. Where people diverged was in relation to the central topic, which is how one actually defined the medical treatment. The problem with the 1992 wording was it defined it in terms of there being circumstances where a direct, deliberate attack on the unborn was acceptable. That's where we say it went wrong, but we would fully concur with the doctors in so far as they expressed concerns on the X case on the basis of the risk of suicide.

I think the uncontroverted evidence to this committee is that the issue of suicide would be, A, so infrequent, but, B, so easily invoked in order to justify the termination of the right to life of the unborn that it would, in effect, lead to a situation as one has in the United Kingdom where, despite the strictures of the law, effectively one was free to allow an abortion to take place in any circumstance, and that was where people began to diverge in … that's where people agreed in 1992. Where they diverged was in the major premise as to what type of treatment ....

Chairman: Dr Keane in his evidence was happy with the major premise of 1992 as well.

Mr Ó Floinn: It is fair to say the overwhelming bulk of the evidence, as we've read the transcript, has been to the effect that although there may be differences of phraseology, when one looks at the actual treatment I think even Dr Keane, when it was put to him could he reduce the medical circumstances to a short checklist, well, contention even arises. I think although he had difficulties – and we would share those difficulties as to why there should be such a checklist – nevertheless, when he was pressed on the issue, the focus narrowed very quickly to these cases which, statistically, there's a strong argument that they're even outweighed by the risk of suicide and adverse consequences from an induced abortion. But leaving the statistical argument out of the question, it's when one looks at the actual practice, the medical practice, rather than the occasional discrepancies of language, I didn't appreciate any discernible difference between many of the medical practitioners.

Chairman: I accept that, but we did get a very strong – I don't want to open the transcripts – but the medical practitioners were unhappy with phrases like 'absolute prohibition', 'absolute ban'; they weren't comfortable with that.

Mr Ó Floinn: We would share the unhappiness with phraseology such as 'absolute ban' and I think everybody who has come to the debate, as I understand it, sharing a broadly pro-life platform, would say that 'absolute ban' is shorthand for respecting the life of the unborn, permitting necessary treatment to the mother. Even when one begins to use words like 'absolute' it conjures up an image of nothing being able – of women being forced to be in incubators for the unborn child. I don't think anyone is saying that existing medical practice should not continue. We certainly would not be saying that. Existing medical

practice, as the doctors have dealt with it, ought not to be interfered with and we say that this wording wouldn't interfere with it.

Chairman: How much is open to us under the Constitution? Can we take the view, for example, in relation to the morning after pill, that the definition of unborn life is such that it begins at implantation rather than conception? What is open to us as legislators?

Mr Ó Floinn: What is interesting in relation to the whole definitional question, particularly insofar as it relates to the unborn – this is something the Constitutional Review Group raised as a potential difficulty – what was interesting about their analysis was when they came to deal with words like the 'aged' or the 'infirm', words used in the same grammatical and syntactical sense as the 'unborn', they didn't express a difficulty with it. We say two things in relation to it: as it stands, insofar as it's been considered at all by the Irish courts, we have the former Chief Justice saying that it connotes from conception to birth. We put forward in our paper a number of different models as to how, definitionally, 'unborn' could be treated if there was any legitimate concern and one has to say that in all the cases that have been determined and in all the consideration of the issue, 'unborn' hasn't featured, but – as an issue of contention – but we have put forward a number of different models as to how definitionally it could be dealt with. Again it boils down to policy issues for this committee. If they take the view that, as with the human fertilisation and embryology act in England, the start point is the appearance of a two-cell zygote, which is the definition used in that Act, if this committee comes to the view that because of some other, wider policy consideration, that it needs to be addressed, we've given various models of how it can be addressed. It isn't something that's troubled the courts to date and we say that in other Articles of the Constitution similar phraseology is used ....

Chairman: My question was a very simple one. Is it constitutionally open to us under the present wording to deal with that?

Mr Ó Floinn: I think it must be and the reason I say that is it was roundly criticised, or the Oireachtas was roundly criticised, in the X case for failing to amplify the wording that then existed by means of legislation. I think that if this committee recommended that any wording should be accompanied by some form of legislation, as long as that legislation is consonant with what is to be put into the Constitution and there is no conflict, then in principle, as we've said, we've no difficulty with terms being amplified. And that could be put before the people in the same fashion as in the divorce referendum.

Mr Murphy: As you say in relation to Dr Keane's concerns, Chairman, he was asked at one point in the course of the transcripts whether there could be specific listing of the four or five conditions he identified as being important. His response was very interesting and I think it highlights another problem that the committee should be aware of. He indicated that the medical profession considered that option at the level of the obstetricians and they decided not to put forward a request for that kind of legislation on the basis that they could find themselves compelled by patients to provide them with certain procedures merely because that was provided for in legislation. To that extent that highlights a risk involved in the delineation of specific procedures in legislation of the type that was discussed at that particular session of this committee. I think if one comes again to the formulation of legislation or the formulation of the Constitution, one keeps coming back to the question of how to preserve best medical practice which already exists within the jurisdiction, which people like Professor Bollard, Dr Clinch said they were happy to stand over and their evidence wasn't in any way questioned by that of Dr McKenna or by Dr Keane. All the obstetricians of the value system enshrined in the Irish medical system are anxious to preserve its systems and practices and procedures. The question is what formulation, as a matter of law both in the Constitution and in legislation, is best suited to preserve existing medical practice? Our submission – the formulation we put forward by way of a constitutional amendment and/or some form of legislative protection for a doctor who carries out actions consistent with the phraseology used in the constitutional amendment, could provide a model for the protection of the medical interests which have been referred to. One example in standard legislation, under section 18 of the Non-Fatal Offences Against the Person Act, 1997, the entire concept of self-defence has been redefined, but in that context it may replace investigation by researches concerning the way in which the Oireachtas has sought to protect a person who exercises a particular form of activity consistent with particular conditions. Now, a doctor operating consistently within the Constitution could be protected by a similar clause if that was to use the formula which we have deployed, which effectively would involve establishment of the unsought side effect.

Another area where protection of the type of area that Dr Keane might be concerned about might be considered by the committee is in the context of the Criminal Justice Act, 1994, under sections 57 and 59, where, for example, financial institutions have obligations to report suspicious financial transactions. There is phraseology deployed by the Oireachtas in recent years which has given an immunity to those particular institutions if they make a bona fide report of that particular information and it is an immunity of any kind, whether civil or criminal. It would seem, trying to balance the concerns of the medical practitioners expressed by Dr Keane with other countervailing interests that it may be better (a) to advance the constitutional formula that we're suggesting, (b) if necessary, to back it up with the legislation consistent with that formulation and to build into that legislation either by way of a formula under section 18 of the Non-Fatal Offences Against the Person Act, by way of a defence and/or an immunity in the context of the Criminal Justice Act, 1994, for actions consistent with the constitutional prohibition.

Chairman: Can I bring you back to the X case, because I think you've both indicated to the committee this morning that the Supreme Court criticised the Oireachtas for failing to legislate in the X case, but we are faced with the paradox that when the Supreme Court criticised us for not legislating, they have imposed substantial fetters on our capacity and power to legislate to the actual decision in the X case. Now you could take the view that it is open to

the Oireachtas to reinterpret the constitutional provision, notwithstanding the X case, but there must be some area of legislative discretion here because the Constitution sets out the broad general principles that apply and the Supreme Court gave a particular interpretation of them in the X case. There's an abstract principle of law – at it's finest – a real and substantial threat to the life of the mother. You then descend in levels of generality to the question of suicide and self-destruction and so on. In your view is do we have a discretion to legislate in a sense that would exclude the X case as a matter of practical possibility?

Mr Murphy: I think not without a constitutional amendment. That's why I think we have to start from the premise that because the Constitution is the overriding umbrella which effectively shadows all legislation, it's important that the amendment we propose is put forward to the people. If that amendment is put forward, then the Legislature would have a discretion to implement a law consistent with that revised constitutional formula. Under the present aegis, this House is bound by the interpretation given by the Supreme Court in the X case. That is a constitutional interpretation. The legislation must conform with the constitutional interpretation described by the court. The people have the power to change that and it is in that formulation which we put forward that the people will have the ability to reverse that decision and thereby give back to this House the legislative discretion to effectively prohibit abortion.

Chairman: The Supreme Court recognised our legislative discretion in the X case.

Mr Ó Floinn: Had you asked the question in 1989 the answer would have been, 'Yes, the Oireachtas would have had the power to amplify or define the provisions of the Constitution'. Once the X case happened and an interpretation of the existing provision was given, I think it would be very unsafe for the Oireachtas to proceed on the basis that, notwithstanding that decision, one was going to attempt by way of legislation to row back on it because we're now in a post-Attorney General and X situation, and any legislation would be vulnerable on the basis that the court had pronounced their interpretation and, were the legislation to give a different interpretation, it would be vulnerable. That's why, as Shane said, it comes back to deciding the major principles by way of a new amendment and then, if necessary, there's no principled objection to legislation that backs that up.

There's one point I would make, that is, it may not have come across from what we have said because we focused in on one of the particular wordings that are in the public domain, that at the end of the day this committee is free if it feels there is some other aspect that needs to be dealt with in wedding wordings one to the other, changing it in some way. We have talked about self-destruction as a potential expressed saver. We have talked about the saver as distinct from the health of the mother being inserted. We've just put up for debate this morning one of the wordings that we have discussed. They happen to be the five or six wordings that come across from the Green Paper and one other from general documents that are in the public domain. But I don't think this committee needs to necessarily define its role in terms of, while there were a number of wordings put to us, we're not satisfied that any of those wordings holds water, therefore, option one falls. In a sense the challenge is to look at the evidence, decide as a matter of policy and in the resources of the State, the Attorney General and all the other officers that can be involved to determine a wording that embraces that policy. We've suggested that in our view those key concepts of intention and directness need to be in there. They can be in there in synonyms such as unsought side effect. They can be in the sort of expressed words that are used in other contexts, intended and direct. I don't think one should get preoccupied with wording. What we have tried to do is steer the committee through the various options, see the issues that are raised ....

Chairman: We are quite clear on this.

Deputy J. O'Keeffe: Sorry, I did not get to the other meeting and I didn't get this entire debate which is very interesting indeed. Can I just get back to the kind of issue that confronts us. I am not quite clear on what your advice is. Focusing on the words 'the unsought side effect of medical treatment', you may have covered this already. I am very interesting in hearing what your advice is on the approach and, in particular, wording that would cover the kind of situation outlined by the three Masters of the maternity hospitals. Can one genuinely say in the situation outlined by them – those rare cases where they say there is direct termination in some situations where the life of the mother is at risk – can one really say that some situations would be covered by the words 'the unsought side effect of medical treatment'? Being frank about it, it doesn't appear to me to be the unsought side effect. It actually is sought because it is necessary. What sort of advice do you offer the committee? If we were following or pursuing that particular option and dealing with it in a report, what kind of wording do you have (a) given the difficulty in writing about the wording in that situation and (b) have you another wording that might cover the kind of situation we're talking about.

Mr Ó Floinn: I am going to draw the ire of everybody in the room down on the heads of every lawyer that ever walked the city of Dublin by getting technical about the wording. As we said earlier, there are two concepts in a phrase like 'unsought side effect'. There is the concept of intention – did you seek it? Did you want it? Then there is the concept of directness. They are two concepts that overlap and inter-relate one to the other, but they are distinct at the end of the day. The situation you have talked about is where one has, if you like, an element of directness in the sense of the methodology. First of all, I need to say that, from my reading of the medical evidence, we wouldn't be happy with conceding that it is direct intervention. But even were we to say in relation to that ....

Deputy J. O'Keeffe: I do not mean to interrupt you while seeking your advice on this issue. I got the impression from the Masters that, in effect, in certain situations it had to be direct intervention, leading to a direct interpretation.

Mr Ó Floinn: That is why I prefaced by remarks by saying we wouldn't concede that point. But even allowing for a

concession on that point, which is where I think the thrust of the Deputy's question is, even where in terms of ....

Deputy J. O'Keeffe: When you say you would not concede the point, is that from a policy point of view or as somebody who is obviously an expert in law giving us advice on the issue?

Mr Ó Floinn: No, I am speaking in the sense that I wouldn't accept it because, just before the Deputy came in, we had been discussing that although in terms of language used, there is the appearance of some divergence on the part of the medical practitioners from what actually gets down to the nuts and bolts of the procedures. It simply … when I say I don't accept it, I simply mean in the context of when one actually looks at the procedures.

Deputy J. O'Keeffe: Okay.

Mr Ó Floinn: I am not sure that case is borne out. But even if one were to accept that ....

Chairman: Sorry.

Mr Ó Floinn: I will finish this. Even if one were to accept that, the consequence of your action legally, the thing that's going to happen is only one of the factors. It is not the sole test of whether you intended it. It's not the only thing that a court will use to determine whether or not you willed that it would happen. For example, in the law of murder, the natural and probable consequence of what you do can be used to infer, it can be used to raise a presumption that you intended to do it. But it's only one of the factors, and in this particular case, it's a presumption, to use the wording from the law of murder, that's rebutted by a medical condition in the mother. Even were it admitted that directness in that sense could be used that the law of murder … we've given examples from civil law and other aspects of law … it's only one of the factors to be taken into account.

Deputy J. O'Keeffe: On that issue, while I can understand that you would be very capable of raising an argument in this matter if it went before the Supreme Court, are we not in a situation where we have been trying to achieve as much clarity as possible, that it wouldn't be open to argument? If on a policy basis we are trying to achieve a situation where existing medical practice under any circumstances isn't going to be affected by any proposed new wording, and if we're aware that part of that medical practice does include direct termination in some rare cases where the life of the mother is at risk, mustn't we then be absolutely sure in any type of wording we will now put forward that it will be quite clear that that will be allowable?

Mr Ó Floinn: I agree with the need for clarity. We would certainly be of that view. That is why, on balance, when we have looked at the various wordings that have been floated we have tended to favour the type of terminology that the Medical Council has used itself and we would see it as desirable that ethics and law should coincide rather than collide. It is important for this committee to realise that intuitively this distinction that I am making in a sort of legal language is something that a doctor or even a man on the street would recognise immediately. Just to give a concrete example, if a doctor is carrying out an operation and he puts a scalpel into your flesh, no one would say because of that action that he is intending to kill you. If he did the same thing in Temple Bar ....

Deputy J. O'Keeffe: Sure.

Mr Ó Floinn: – that is an example that has been given – the whole surrounding circumstance would lead to a different interpretation. Another factor is the whole issue of proportionality. If you went to a doctor with some minor complaint and there were two courses open to him, one of which had minor consequences for you and another had major consequences for you, if you were to opt for the more extreme version to cut off your finger because you had broken a fingernail then proportionality would come into it too. The object is not the sole test of intention and it is not just a fine legalism which only exists in the Four Courts; it is something that intuitively and instinctively doctors are implementing on a daily basis because they are having to make those choices. That is why when presented with different wordings we have tended to favour the one that chimes with the language that the doctors use themselves and professional bodies use themselves. I would be the first to concede that there have been one or two discrepancies in terms of language but as we said before you came in, once one actually looks at the procedures there is a fair degree of consensus.

Deputy J. O'Keeffe: Getting back to the wording as contained on page 52, would that be your preferred wording?

Mr Ó Floinn: Well, it's one of the ones that were in the Green Paper. It was one that we found had a certain attractiveness. There is a strong argument for what we described in our paper as model one, which is one that is defined purely in the context of a term of art and that is represented by the wording which focuses on the words 'induced abortion'. That seems to be a wording that has a consensus behind it. We were struck, for example, even by the submission for Lawyers for Choice who use the words 'induced abortion' when they are using them in a technical sense. There is a fair degree of consensus. That terminology is used in the Medical Council guidelines too. In a sense in model one and model two there is a fair degree of overlap but we have tried less to get hung up on wordings or we have given examples of how it could be dealt with and we set out how these concepts could be dealt with.

Deputy J. O'Keeffe: I appreciate that and your submission which I have read is very valuable in relation to your approach to concepts but, at the end of the day, if we are to amend the Constitution we will have to have a paragraph which we can fully stand over.

Mr Ó Floinn: Well, there are two things I will say in relation to that. One is I do not think this committee .... there may have been a tendency, particularly in previous decades, to view the thing as we have to insert a slogan into the Constitution. One only has to look at Articles like 18.4 to see that there are Articles that are incredibly lengthy

in definition on dealings with Seanad elections and there is no necessity for this committee to feel itself bound simply to put in a sound byte into the Constitution unless it is satisfied that that deals with the situation. We fastened in on this wording but conceptually there is probably little enough to distinguish what we have described as models one and two. In the light of the evidence you have heard and will hear, there may be minor amendments to that but as long as that linchpin is there, then the intention of what is sought to be achieved by option 1, the constitutional ban on abortion, will be preserved and the Oireachtas will have restored to it the ability to flesh out those terms in accompanying legislation if it is necessary.

Deputy J. O'Keeffe: I think your advice is very helpful but at the same time I would recall – I was myself involved – debates on wordings back in 1982-83 and again in 1992 and each phrase, each comma, each word ....

Mr Murphy: I think the differences are not insurmountable. That is our proposition. There will always be a certain amount of testing that will have to take place in another place in the event of a controversy but essentially the obligation of this House is to provide something for the people to consider by way of a proposal under the Constitution and/or legislation thereafter regardless of the potential stormy waters that might lie ahead. Our concern is really to put forward a form of wording which we think might allow the people who come before you to give evidence, the doctors, to exercise best medical practice in accordance with their own ethics commission and, for example, in the course of the evidence, to take the example you raised a few moments ago, even in the evidence of Professor Bonnar where he did consider that Eisenmenger's is a very difficult area. His evidence was also unequivocal on the transcript where he said that while seeking to protect the importance of clinical judgment prevailing he went on to say that as far as he could see the decision so far in Ireland has not been to advocate termination to save the life of the mother based on his long experience in this jurisdiction.

Chairman: That is inconsistent with other evidence.

Mr Murphy: In so far as there is a choice of clinical options available to a doctor, this House in any context, not just in the area of reproductive medicine but in any context, might see it necessary to regulate the exercise of choices or options open in a manner which is consistent with the Constitution.

Deputy J. O'Keeffe: Even if such a choice involved prohibiting by constitutional amendment what we understand is current practice in the three main maternity hospitals in this city?

Mr Ó Floinn: That is precisely why we focused in on the issues we have. We are satisfied looking at them from a legal and a conceptual view, which is translated into ordinary commonplace at the coalface of medical practice, we are satisfied that those concepts are not impossible to pin down. You can pin them down and at the same time allow existing medical practice to continue. We have looked at that and we have given, I hope not too arid, an account in our paper of all the different ways in which one could do it in terms of wording. One could multiply the possible wordings almost *ad infinitum* but there are key concepts that need to be in there, need to be dealt with if one is on the one hand to safeguard the unborn and if one takes the view that there is not to be abortion on demand and at the same time safeguard existing medical practice. That is what we are putting forward, the wider statistical issues, the wider medical practice issues. You have heard medical evidence on that. That is a policy decision for this committee.

Deputy J. O'Keeffe: But you have studied the transcripts and again I put it to you that there appear to be nuances as to what exactly ....

Mr Ó Floinn: That was the point ....

Deputy J. O'Keeffe: .... some aspects of current medical practice ....

Mr Ó Floinn: We had that debate with the Chairman earlier as I said. It is simple, and that is not to avoid your question, it is simply when one looks at the actual activities, the actual objects, the actual consequences although there may be differences in nuances of language and you may have certain doctors who have in terms of the language in which they express themselves, there are nuances there undoubtedly but when one actually looks at the practice the overwhelming weight of the evidence appears to us to point in one direction. That is a policy issue for the committee.

Chairman: Just one or two short questions on your wording at page 52. Would that wording allow intervention by way of ending the pregnancy in an Eisenmenger's case?

Mr Murphy: In our view that particular formula would not permit a direct intervention of the type which has been canvassed by certainly Dr McKenna in the course of his evidence. The question is whether or not that is the only procedure which would be applicable in the circumstances and in terms of the intention, if I could refer you also to Dr McKenna's transcript he also said something which is important in this context because he seems to be concerned about the use of language. There may be a danger here that what we are looking at is a use of language by different people but where the Oireachtas might not be in a position to give some degree of clarity of definition which would effectively protect best medical practice consistent with the law. He said at one point: ' I understand your confusion. The procedures which I have referred to as abortion may be referred to by other people as treatment'. I said before that if treatment is to the uterus I cannot think of any more apt term to call that than an abortion. There would appear to be a dichotomy of definition between the doctors as to what exactly is abortion or what is medical treatment. It is obviously a matter for this House to decide what is abortion in accordance with legislation.

Chairman: On your wording, would that cover earlier intervention by ending the pregnancy in an Eisenmenger's

case? Would it allow the doctors to end the pregnancy in an Eisenmenger's case?

Mr Murphy: We have looked at all of the hard cases and we would be satisfied that ....

Chairman: The question I asked was specific. Would that wording allow early intervention in the Eisenmenger's case?

Mr Murphy: If that early intervention was directly to terminate the life of the unborn child, no.

Chairman: No.

Mr Murphy: Because it is clear that the phraseology would indicate that the procedures to be adopted must, to be lawful, have the unsought side effect of causing the life ....

Mr Ó Floinn: So that is where we come back to the definition of intention. You see, these are two reinforcing concepts. What you are talking about in the way you phrase the question is .... The question is being put with a reliance .... The first foot that is being put forward is, 'Eisenmenger's syndrome – there is a directness to this methodology, can you cope with it?' That is why we say there are two concepts here. You have got to have them both in because then you are not reliant on the simple directness of methodology; you are reinforcing it by 'what is the person's intention?'. What is sought to be outlawed is deliberate, direct – choose whichever two synonyms you want ....

Chairman: Can I go to a more concrete example? The HELLP syndrome described by Dr King and procedures carried out by the National Maternity Hospital in connection with that case which were described in detail to this committee, would that wording allow those procedures to be carried out?

Mr Ó Floinn: Again, you are talking in terms of the language. This is what Séamas said in terms of language and the precision with which it is used. Some people talk in terms of delivery and by the use of their language distance themselves from the directness part of it. Even were the committee to come to the conclusion that that limb lacked reality – and it is a matter of dispute on the transcript as to whether the language of delivery or the language of abortion is the appropriate language to use – even if the committee were to come to the conclusion that it was inappropriate to talk in terms of delivery in the HELLP syndrome, once you have these two reinforcing concepts of intention and directness we are satisfied that any of the existing medical treatments – whether one talks about the hard cases, the HELLP, the Eisenmenger's syndrome, pre-eclampsia or one talks about the more general issues – existing medical practice would not be interfered with once one has that clear conceptual distinction made.

That is why I say, in response to what Deputy O'Keeffe has said, there are two levels at which this needs to be approached. One is the legal and definitional and the other is that instinctive view that people have, and there may be differences of language which the committee may be more or less happy with. What we are talking about is, to get back to the conceptual side of it, that the distinction can be drawn. If a doctor were to come before the courts – and I suspect this is, in essence, the fear the committee would have, that a wording would be inserted, a doctor would carry out a procedure and would ultimately find himself before the courts – we are satisfied that in those circumstances if he were to outline the situation, whether one takes HELLP, Eisenmenger's syndrome, with those two reinforcing concepts there would be no danger to existing medical practice.

Deputy J. O'Keeffe: Let me be clear. I would be very concerned about the position of the doctor in such situations but that is not my main concern – of a doctor carrying out such a medical procedure to save the life of the mother. My concern is that he would not carry out the procedure and that the mother would die as a consequence. That is the sort of life and death situation we are talking about if we are talking about putting a constitutional ban on medical procedures that, apparently, are not common but are in use in our maternity hospitals. Could I just carry this a bit further? We have to separate the policy approach from the legal. We really have been searching, as the search has been going on for 20 years, for an appropriate wording. I myself believe there is a fairly large consensus as to what people want but they certainly do not want the life of the mother to be put at risk and I am also pretty sure of that. Even in your own replies to my Chairman, I get a distinction in the approach the two of you seem to have, say in relation to Eisenmenger's. Your amendment .... I gather from Mr Murphy he would not be satisfied that a termination in an Eisenmenger's situation would be allowable under your wording whereas you appear to be putting forward the view that it would be allowable.

Mr Murphy: No, the distinction I am making is that the question of direct intervention, the notion of direct intervention, is important in that context also. It is Ben's submission that that is the element he is concerned about in relation to understanding both the intention and the actions of the doctor who acts in that context.

Deputy J. O'Keeffe: But in a way are you not just putting forward what would be the legitimate approach in defending a doctor who had carried out such a procedure that his intent – you would say the *mens rea* – to do any harm was not there, that he was trying to carry out proper procedure and that the intent was right. Do you not see that if we are putting wording into the Constitution that we have to go beyond that? We have to be quite clear that we are not in any circumstances changing the Constitution in a way that would put a mother's life at risk.

Mr Ó Floinn: You have put your finger squarely on the issue of the life of the mother. I think it is worth remembering that as well as what we have talked about in terms of the definitional legalistic approach, as a matter of practicality the concern that you are expressing is dealt with in the following way: If the mother's life is not saved it is a necessary consequence of that that the child will not live. So the very premise on which the question is put … I think your own words were, 'I am afraid not that

what you are describing would happen but that a doctor would feel constrained by the law from actually treating a mother'. That was the way in which you framed the question and I would simply say, 'Well, he must treat the mother because without treating her the child dies in any event'.

Deputy J. O'Keeffe: Even if that involves the direct termination of the unborn baby, of the pregnancy?

Mr Ó Floinn: As a matter of law the direct intentional termination – those two reinforcing concepts that I talked about – it will not involve that in the legal sense. I am not talking now about statistics and any conflicts in terms of that. I am talking in the legal sense. It will not fall within that category of direct and intentional termination of life of the unborn.

Deputy J. O'Keeffe: Are we not skirting around now the central issue? If we are to follow that line of argument you are not really accepting that in any circumstances it is necessary to have a direct termination of the pregnancy to save the life of the mother.

Mr Ó Floinn: What we are saying is that having looked at the hard cases, having looked at the existing medical treatment, we are satisfied that once those two concepts are brought to bear in this fashion that treatment will not fall foul of them. The propriety of the treatment, the medical aspects of it are for other experts. We are simply saying as a matter of law, a distinction can be drawn that differentiates between the two. Whether the committee chooses to draw that distinction, as we said, is a policy issue and relies on other evidence.

Chairman: It is not so much a matter of law as a matter of legislative drafting. You are saying it is possible, through the use of your formulae, to devise a legislative draft which protects existing medical practice.

Mr Ó Floinn: Well, a constitutional amendment.

Chairman: The Constitution is legislation.

Mr Ó Floinn: Yes. If it is phrased in that general sense, yes. As a matter of drafting it is possible to draw that distinction, drawing on well recognised legal principles. You see, we come to this debate with a popular perception that these principles are somehow arcane, out of the way, outmoded. One finds all sorts of descriptions of it, all sorts of ideas about theology, double effect. One reads it in the newspapers. We are coming before the committee simply on the basis that, as a matter of drafting and as a matter of law, these distinctions can be made.

Chairman: Yes, but lawyers are very adept at convoluted drafting to avoid describing facts as facts. There are many examples of that in our Constitution. That's a technique of legal draftsmanship, but we have political responsibilities as well.

One of the matters to which Deputy O'Keeffe adverted, which is very important to me as well, is the protection of maternal health in maternity hospitals. We simply can't leave this question to convoluted draftings when there is a divergence of medical opinion about the operations that are being carried out and how you characterise them.

Mr Ó Floinn: That's why ....

Chairman: You are choosing to characterise the operations in a way that avoids the use of the word 'abortion'.

Mr Ó Floinn: No ....

Chairman: That's essentially what you are at in your elaborate legal drafting.

Mr Ó Floinn: No, that's why .... The instinct of every lawyer to present the committee with a page long draft that's arcane and convoluted – to use your own words, Chairman – that's what we have deliberately sought not to do. What we have focused in on are the wordings that are in the Green Paper. We have focused in on the concepts that are used. Part of the attractiveness of those concepts is they are concepts that the medical guidelines have recognised, having invited submissions, that doctors operate in the present ethical environment, so far from presenting the committee with some convoluted alternative of our own, what we have done is indicated how this committee, if it's minded to, can make the legal claim and the ethical claim coincide rather than collide, as I said earlier.

Chairman: Did you read the Institute of Obstetricians and Gynaecologists letter of 29 February 2000?

Mr Ó Floinn: Can you refer me to the page?

Chairman: It's at page 127 of the main brief book.

Mr Ó Floinn: Yes.

Chairman: '... the unavoidable death of the baby resulting from essential treatment to protect the life of the mother.'

Mr Ó Floinn: But the significance with respect, Chairman, if one reads that paragraph as a whole and particularly the preceding sentence, is that, again, there are two concepts – 'intention' is used expressly and then what we have tried to describe shorthand as the directness of methodology, so even there one has in that letter the very distinction that this committee is called upon to make. Those eminent obstetricians and gynaecologists who have given evidence have made substantially the same point. The language differs from time to time, but the essence is the same.

Mr Murphy: The full sentence, Chairman, reads, 'We consider that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example for social reasons, and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother.' The concept of intention is very real, not in an arcane legal context only, but also in the actual day-to-day practise of medicine and in the safety and security of mothers and children in that particular context, so its application is of fundamental

concern. In so far as Professor Bonnar has given evidence to the committee and has written that letter, it's an indication of an authoritative expert view in relation to the distinction which is material to best medical practice and to the legal supervision and regulation of that medical practice, not merely an arcane distinction.

Chairman: I don't think any of us has said arcane .... I didn't use the word 'arcane".

Mr Murphy: No, we don't hear that as being an intentional criticism ....

Chairman: 'Elaborate' was the word I used, not 'arcane".

Mr Ó Floinn: And 'convoluted', Chairman.

Chairman: There are other examples of that in legal drafting and it maybe as a matter of political prudence that we may wish to avoid the use of the word 'abortion' in formulating a proposal.

Deputy J. O'Keeffe: I think we are back to the core issue here. Again, the words used are 'essential treatment' for something which, according to evidence we have before us, amounts to direct termination of the pregnancy, whether that's abortion or not – we haven't a definition of 'abortion' – is, probably, another one of our problems, so essentially to pursue the line which you are advocating, we would have to classify that direct termination of the pregnancy as essential treatment.

Mr Ó Floinn: But you see, again ....

Deputy J. O'Keeffe: You say – I presume to summarise what you are saying – that it can be so classified because the intent is not directly to kill the unborn, but to deal with the medical problems affecting the life expectancy of the mother.

Mr Ó Floinn: It needs to be direct and intentional and whether one uses synonyms such as 'unsought side-effect', they are the two concepts used in that letter and they are the two concepts that come through from the medical evidence too because, as I say, it doesn't appear to be conceded on the evidence that that sort of direct methodolgy is the appropriate language to use, but leaving aside the nuances of the language, the objective is only one of the factors that one takes into account when determining intent. If the committee is minded to, that distinction can be made in a constitutional amendment.

Chairman: You have to put in 'unsought side-effect'; otherwise, the question of intention, of course, remains.

Mr Murphy: You have also hit an interesting fault line here, Chairman, because if you compare the transcript to which I referred earlier, the extract from Dr Keane, and the letter that you have very helpfully opened to us, that letter is the one, effectively, that he, I think, indirectly refers to in his submission as being the letter that the Institute of Obstetricians and Gynaecologists did send. That's the compromise measure, as it were and it seems to reflect the collective view of the institute. They are the experts in the area and their definition is the definition which, I would submit, is consistent with what we have put forward, that's to say, that fundamental distinction between action which is carried out with the intention of taking the life of the baby and unavoidable death resulting from essential treatment and is capable, in our submission, together with our wording, of being put in a manner consistent with action which doesn't bring it into contravention with the law at the present time.

Chairman: I have to close the session because there are further witnesses waiting for us. Thank you very much for your assistance. You have given us considerable material for reflection.

Mr Murphy: Thank you.

Mr Ó Floinn: Thank you very much, Chairman.

SITTING SUSPENDED AT 12.27 PM AND RESUMED AT 12.30 PM.

Mr Joe Foyle

Chairman: I resume the session. Mr Joe Foyle, you're very welcome to the committee. You made a submission to us and you also indicated an interest in addressing us. I've read your submission. First of all, I should say that you're welcome to this meeting of the Joint Committee on the Constitution, that we've circulated your submission. You may make a brief opening statement elaborating on your submission, if you wish, which will be followed by a question and answer session with the members. I have to draw your attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you.

Mr Joe Foyle: I've been two and a half hours in this place and I can't guarantee thinking straight for.... Okay. Mr Chairman and committee members, I presume you've read my 450 word summary and its back up 2,000 word letter. Reading them out here would take about 15 of my 40 minutes. So I shall confine myself to reading out this 800 word opening statement – copies of these two pages I shall give you at the end of the five minutes or so it will take ... at the newsreader pace. Okay.

Like the hundreds of thousands of words you have read and heard already for and at these hearings, my two and a half thousand ... theorised about abortion law and morality. So did the 3,000 word letter, which I wrote last week for the Catholic bishop who said I do not understand the indirect-direct distinction as it relates to killing generally

and to abortion in particular. It outlined my understanding and argued that the necessary/unnecessary distinction is superior. That completed my theorising.

Here I shall personalise. What concerns us all became a practical issue for me nearly 40 years ago when I married in my twenties and, for the first time, set about making babies. That first time aspect was usual then. Most of us figured that gambling otherwise with our hereafter was so unwise as to be rather stupid. My early years of marriage saw the appearance of the contraceptive pill and public exchanges up to and including and after the 1968 reaffirmation of our Catholic ban on using artificial methods to regulate births. Though I had argued for partial lifting of the ban, we accepted the ruling and used natural methods to plan our family of five and one miscarried child. As a columnist in a provincial and a Sunday nationwide newspaper and as a letter writer, I participated in the public exchanges at that time. With hindsight, I realise now that we Catholics made heavy weather of the exchanges because our clergy did not say what they could have said to women whose doctors said, 'Another pregnancy may kill you.' They could have said, 'If your pregnancy threatens to kill you, if necessary, you may instruct your doctor to have it terminated'. We are suffering now from nearly 40 years of clergy reticence in that respect.

The pregnancy issue concerns me now as a grandfather with sons and daughters who may have their children – our grandchildren – killed on a day trip to London. Due to clergy reticence, they and indeed all of us are without the help of the hereafter factor to deal with temptations. All of us now grapple with the wrongdoing fallout in its various forms, sex and non-sex. Our clergy's hereafter related reticence has handed you politicians a poisoned chalice.

Because hereafter related motivation cannot be relied on in sex matters, I now focus on this life, that is, secular motivation. I focus on minimising infanticide, that is, child killing, by promoting responsibleness. I say to our sons and daughter: 'Your use of sex intercourse means accepting that any children you may conceive will be reared by you or on your behalf. You are irresponsible if you so use without that acceptance. If a pregnancy threatens to kill you, with our approval, you may, if necessary, have it terminated, though that may entail killing your child, our grandchild. If you have pregnancies terminated for any other reason, it will be with our disapproval. We will not abandon you if you make that choice. We will renew our efforts to help you to be responsible in that as in other respects.'

That is the personal context in which I favour retention of our legal *status quo* in relation to pregnancy termination. Thanks to the timely and brilliantly worded 1983 Constitution amendment and the equally brilliant Chief Justice Finlay wording of 1992, we have a legal situation which helps our sons and daughters to be responsible in this respect. It permits terminations deemed necessary to save mothers' lives and prohibits those deemed unnecessary for that purpose. Now, as a result, unnecessary infanticide at the pregnancy stage is non-existent here. Even necessary infanticide at that stage is but a tiny fraction of 1%. That is surely something in which to rejoice with pride. In my view the 1992 Supreme Court members took a particular suicide threat too seriously. However, that eight year old precedent has never been used for infanticide purposes. Its precautionary elimination is hardly worth the expense of a separate referendum. Our legal situation is fine as it is. To minimise infanticide, we do not need more Constitution or Oireacthas laws to regulate what may concern one in every 30,000 pregnancies – repeat one in 30,000.

Finally, though minimisation of infanticide is your aim, as I said in the summary, what you decide will impact continually on responsibleness in our midst. You will help us all to be responsible or irresponsible. There is no in-between. Thank you for listening patiently. I am now open to questions. Okay.

Chairman: So essentially the option you favour in terms of the substantive question is the *status quo*? It's all right. You better resume your ....

Mr Foyle: It's governed by the two regulations, the Finlay judgment and the 1983 Act – wording.

Chairman: The X case?

Mr Foyle: Yes.

Chairman: But you're saying the *status quo* is sufficient.

Mr Foyle: Totally adequate.

Chairman: And that there's no need to amend the Constitution either to permit further abortion or to prohibit or to restrict the application of the X case?

Mr Foyle: No, Finlay very clearly posits ... we may only terminate to save a mother's life, not health. If you go the health route, you're into open ended abortion. There's no way around that. We can interpret 'health' as in England. So we have stopped that happening in the Finlay judgment, which is brilliant. The one weakness in it was going for the suicide threat. That has never been used since. If you want to have a referendum to take that out, it isn't worth the expense. We could throw in at the bottom a footnote to a referendum, say, on PR, stick in a footnote, take out the suicide threat as an excuse for having infanticide. Let's be blunt about the word.

Chairman: I take it from the general tenor of your remarks you're strongly opposed to the practice of abortion?

Mr Foyle: Not at all. I'm for indirect abortion. Abortion is a neutral word. It's just killing a baby. But there can be necessary abortion. It's interesting, by the way, the pussy-footing, if I might say so, of medical people about whether they are being involved in abortion or not. I am totally in line with what Michael Darling said here last week. Darling said, 'any termination of pregnancy before viability is an abortion'. Any termination of pregnancy before viability is an abortion. John Bonnar doesn't like using the word, but he is performing abortions when he does ectopic pregnancies.

Chairman: So essentially your submission to us today is that you think the *status quo* has more merit than has been conceded to it?

Mr Foyle: Enormously. It's interesting that last week by

the way the Archbishop ... He accepts indirect abortion – the first time ever that he was straight about ... He didn't want the first one, which excludes abortion completely because he wants to allow indirect abortion. But the reality is that direct abortions occur in the sense of directly killing the child as part of the surgical process. Indirect is where the child dies later after the child has been taken out, but as John Bonnar's evidence showed, that in doing ectopic pregnancies they actually kill the child as part of the process. I mean there's nothing wrong with that. Like, we accept killing people for a worthwhile purpose in all sorts of situations in life. There's necessary and unnecessary and the indirect/direct angle is only an intention thing which can be inferred, if we can, from the act, but it's very much a clairvoyant activity.

Chairman: Don't give us any further legal clairvoyance.

Mr Foyle: No.

Chairman: We've had some of it in the last hour.

Mr Foyle: Clairvoyance is rather up .... But, I mean, there are .... There's a serious matter here that we're only talking about one pregnancy in 30,000. How the words of this … is nobody's business when you think of it.

Chairman: Well, you're very kind to have come to us and made this point because it is a point that deserves articulation in the debate.

Mr Foyle: Well, I might say, my point by way .... Time limitation doesn't come into it if you want to save the mother's life. So that angle has come in. Also, I might make the point just which .... A snide remark by Darling last week and also repeated in *The Irish Times* last Thursday was about the … our tolerance of children going abroad to have … is hypocrisy. *The Irish Times* phrase was it's 'a cowardly abdication'. That was just a pity, you know, cheap shot. It's the very same situation, if you have rules in your house that a child, a youngster cannot shack up in your house ....

Chairman: Sorry, we don't want to go into criticism of persons who are not here to defend themselves.

Mr Foyle: Okay, I'll make this point, the idea that a hypocritical one … to hit it on the head … the idea that if I ban cocaine use in my house and my children go elsewhere, I'm being hypocritical. You know, I would set standards at home even if people go elsewhere to do other things. We shouldn't let them get away with the notion that 6,000 or 40,000 going abroad … that we should somehow change our rules here. We would have far more of it more likely, more morally irresponsible conduct if we allowed the … you know, made things happen at home, to let things happen that's going elsewhere.

Okay, if you want to leave it at that, but I think we should be .... We are involved in the abortion business direct and indirect already. Let's use the word and make sure we're doing it … necessary and unnecessary is the only basis we work on it. I don't see any problem as a Catholic in the least with that and I don't think any of us should. We have made more trouble because of trying to avoid using the word 'abortion' and that's what I would say.

Chairman: Well, thank you very much.

Mr Foyle: Okay.

Chairman: Right you are. I'll now hear the Cork Women's Right to Choose.

Mr Foyle: Sorry, could I make one point? Sorry, Brian?

Chairman: Yes, Chairman.

Mr Foyle: Another point which Deputy McManus is big on was a matter of if there is one possibility of a suicide threat causing a death ....

Chairman: Yes.

Mr Foyle: .... we should take it .... This is a very serious matter, I take it seriously, but the ....

Chairman: I do take it very seriously.

Mr Foyle: I do as well.

Chairman: I was smiling because you addressed me by my Christian name and, of course, we're in a committee of the Oireachtas so I'm supposed to be An Cathaoirleach.

Mr Foyle: Mr Chairman.

Chairman: That's why I was smiling.

Mr Foyle: The … too … seriously is another matter. Like, the interesting point made by Dr Darling is that when he tries to assess whether a mother's life should be … was in danger, it's at least 50% possibility of her dying by continuing the pregnancy. Well, the figures on suicide show, it says even 1%.

Chairman: Yes.

Mr Foyle: So what the heck? We can't equate them. We take them out of the equation all together and treat the .... Also, as you know, our laws that are made in health stipulate it should be given six months treatment in the mental hospital anyway. We haven't enforced that, you know. Thanks, Mr Chairman.

Chairman: Okay, thank you very much. I will suspend the session for one minute and I'll take the Cork Women's Right to Choose.

SITTING SUSPENDED AT 12.44 PM AND RESUMED AT 12.46 PM.

Ms Orla McDonnell, Ms Sandra McEvoy, Miss Linda Connolly and Ms Orla O'Donovan

Chairman: We are resuming our public session and I'd like to welcome representatives of Cork Women's Right to Choose, Ms Orla McDonnell, Ms Sandra McEvoy, Ms Linda Connolly and Ms Orla O'Donovan, to this meeting of the Joint Committee on the Constitution. Now, we received your submission which was circulated to the members and I think at that stage you did indicate that you wished to speak to us if you got the opportunity, isn't that correct?

Ms Orla O'Donovan: Yes.

Chairman: In your submission?

Ms Orla McDonnell: That's right.

Chairman: And we went through all the submissions and examined those who were anxious to speak to us. You're from Cork but I hope you don't take it badly when I say that we decided to hear the national organisations rather than local organisations in different parts of the country at the earlier stages of the hearings because … but, at this stage, we decided to finalise our hearings by hearing all the other individuals and groups who had decided to seek an oral presentation.

Now, the format of this meeting is that one of you may make a brief opening statement, if you wish, and that will be followed by a question and answer session with the members. Perhaps you've an arrangement among yourselves as to who will speak for you or perhaps you do wish too to make an opening statement. Have you ....

Ms Sandra McEvoy: I'll need an opening statement.

Chairman: Very good. Well, before any of you speak, I should say … draw your attention to the fact that while members of the committee have absolute privilege, this same privilege does not apply to you. So I'd ask Ms Sandra McEvoy to elaborate on the submission which you already made and which I have read.

Ms McEvoy: First of all, we … just explain what our organisation is and then we look at some of the issues that we feel are important. So, firstly, the Cork Women's Right to Choose group is a single issue group. It's a loose alliance of women who believe that a woman has a right to limit her reproduction. What does being pro-choice mean? It's a moral standpoint that recognises the complexity of the issues around fertility control and around abortion in particular. It should be emphasised that it means being pro-woman but not pro-abortion. On the contrary, it involves arguing that women should have access to the full range of reproductive choices.

The word 'choice' should be emphasised because the idea of having choice implies access to genuine alternatives and to the information required to make an informed choice between those alternatives. The views of the pro-choice movement should not be misunderstood or misrepresented on this issue.

We would argue that Irish women already exercise their right to choose. The fact revealed in published figures is that many Irish women believe that they have a right to choose abortion though they travel to Britain to exercise that right. It's currently estimated, as reported in the Green Paper, that approximately one Irish pregnancy in ten ends in abortion, a figure which suggests that these women make their decisions within a sphere in which legislation prohibiting abortion in Ireland or church teaching has little bearing.

Then we look at the issue of equity, for abortion is a social reality in Ireland. Over the past 30 years, we know that at least 100,000 Irish women have had abortions in Britain. By banning abortion we do not prevent it. We export it, disguise it and deny it. The current situation is an oppressive and inequitable one. Not only does it inflict silent and solitary journeys on women, it results in a two tiered system of eligibility to health care where abortion services are accessible only to those who are free to travel to Britain and can afford to do so.

While the 1995 abortion information Act removed some of the barriers to women accessing abortion services abroad, it did not remove the financial and other barriers faced by women, such as those living in poverty, minors and asylum seekers. The current cost of an abortion in the Marie Stopes Clinic in Britain can be as much as £750. Taking this together with travel costs puts abortion services beyond the reach of many Irish women who, as we know, have a higher risk than men of living in poverty.

The final paragraph of the Green Paper recognises the numbers of women travelling to the UK for abortions and that dealing with this is of primary concern. In addition, there is an awareness that Irish women have abortions for many complex reasons. The majority of crisis pregnancies arise from failure to access contraception or improper use of contraception. The Green Paper refers extensively to the Trinity College study of 1998 and the possible responses around sex education and the provision of free or almost free medical/contraceptive services, which our group supports.

Concerning the policy process, over the past 20 years the abortion debate in Ireland has been painful and polarised. Furthermore, it has been largely dominated by experts, be they legal or medical. The small number of women among the medical experts reflects women's general political marginalisation from the policy making process In Ireland. Given that it is women who are most directly affected by this debate, this is unsatisfactory. We urge this committee to strive for greater consultation with women on this issue.

While acknowledging that these public hearings may well be part of what an *Irish Times* journalist described as the Government's slow bicycle race approach to the abortion issue, they are to be welcomed. They highlight the complexity of the abortion debate, the shortcomings of absolutist positions in attempting to respond to the social reality of abortion in Ireland and facilitate the articulation of a wide range of views. Furthermore, they've revealed the absence of consensus among the expert groups.

Questions must be raised, however, in relation to the public accessibility of these hearings – for example, the transparency about the process of selecting witnesses, accessibility of the hearings, accessibility to briefing documents, the formality of the arena. It is a matter of concern that the abortion issue has not been more fully

discussed in fora that are more accessible to women. In the Department of Health's public consultative process for developing policy on women's health over the past five years, little attention has been paid in discussion with women to contentious issues, such as abortion, hepatitis C and fertility treatments at public workshops.

In taking up the health issues, there appears to be consensus that crisis pregnancies are a legitimate public health issue. Few support the idea that criminal sanction is an appropriate response to women in crisis pregnancies. Yet there is no comprehensive policy on reproductive health.

The medical profession has an important role to play in such a policy but the evidence given by representatives of that profession suggests that doctors feel ill equipped to mediate the social questions around abortion. The attitude of obstetricians and gynaecologists is that abortion is not legitimately part of their practice. Yet their profession influences attitudes. For example, in drawing distinctions between therapeutic and social abortions, they seem to suggest that the majority of women travelling to women for abortions do not have legitimate health needs. This distinction involves value and moral judgments. Drawing such a distinction fails to recognise the moral agency of women and has serious implications for how we plan a public health policy. Permitting the views of the medical profession alone to dominate this debate would be extraordinary, given the revelations at the hepatitis C tribunal, the retention of organs controversy and the Lindsay tribunal.

As medical witnesses suggest, advances in technology are radically transforming reproductive medicine – for example, pre-natal and genetic testing, the RU486 and radical pharmaceutical therapies and the creation, storing and freezing of embryos outside the womb. This raises questions about how therapeutic decisions are made and the decision making position of women on questions respecting their bodily integrity and health interests. With the gestational stage of foetal viability being pushed further back by technological advances, the fields of neonatology or neonatal paediatrics are fraught with ethical dilemmas. Women must be involved in a resolution of these dilemmas. They cannot be left to professional interests and clinical judgments.

From the evidence given by the Medical Council, the Institute of Obstetricians and Gynaecologists and the Masters of the maternity hospitals, it's clear that there is dissent on the technical meaning of abortion and that there are differing practices. There has been a change in practice in that pre-natal and, to a lesser extent, genetic testing and counselling have become part of Irish medical practice. Information may be given on the options open to a woman where a foetal abnormality is diagnosed. Should she opt for termination, since Irish doctors cannot offer this service or refer patients for such treatment in Britain, medical support is denied to the woman at the very point when compassionate care is required.

By contrast, one medical witness highlighted the dilemma faced by a woman and her doctor and the practical and emotional difficulties resulting from the separation from other health services in the case of a woman whose baby was diagnosed with a lethal congenital abnormality. She sought a termination outside the jurisdiction and was faced with the practical problem of how to bring her dead baby legally back to Ireland where an autopsy could be carried out.

It's worrying for women that the medical profession has distanced itself from what's called the export trail to Britain and the health risks that women face in any kind of underground situation. It concerned us that an obstetrician could say, 'but it isn't actually my business; I don't see them; I don't deal with them; I hardly ever have to deal with the complications that arise'. For all of these reasons, it is clear that policy decisions supported with legislation are required.

Then looking at the options, this statement outlines our view that abortion as one aspect of reproductive choice is a public health concern. It is, therefore, not something that can be dealt with in the Constitution. Recognising the complexity of the issue and the political context in which the debate takes place, our preferred options from the Green Paper are legislation to regulate abortion in the circumstances defined by the X case as a minimal response; a reversion to the position as it pertained prior to 1983 as this would allow for new legislation that responded to women's needs; clearly we are in favour or permitting abortion on grounds beyond those specified in the X case. We believe that options 1 to 4 in the Green Paper do not take account of the reality that thousands of Irish women choose to have abortions every year.

Chairman: I think I will suspend the sitting. You can come back at 2.30 p.m. Is that an inconvenience to you? You'd prefer to take questions.

Ms McDonnell: We left Cork at 6 o'clock this morning. There's a train strike and we had to drive. We have child care arrangements.

Chairman: Well then, I'll take the question and answer session now but I'll have to close it by 1.10 p.m. at the latest.

Ms McDonnell: That's fair. We do have to get back to Cork.

Chairman: That'll convenience you better. Very good. Just on the committee itself, you expressed certain criticisms how we had gone about our task. So I'd like just to go through those with you. What were they again? It was earlier in your statement.

Ms McEvoy: It is actually the issue of public accessibility. It's a very formal forum which people find intimidating.

Chairman: No, but there was a list of issues actually.

Ms McEvoy: Yes. The transparency of the process of selecting witnesses.

Chairman: I didn't get the note and I'd like to deal with it. I'd like to give you explanations on the issues. You have the selection of witnesses.

Ms McEvoy: Yes. The accessibility of the hearings.

Chairman: Yes.

Ms McEvoy: Accessibility of the briefing documents.

Chairman: Yes.

Ms McEvoy: And the formality of the arena.

Chairman: Yes. On the accessibility issue, of course we are constrained by the rules specified by the Houses of the Oireachtas and they are that any Deputy or Senator can introduce a visitor to hear our committee. That has been the procedure that has been followed throughout the proceedings. That's a matter of general regard in our national Parliament. I suppose on the last criticism formality also relates to that. This is the national Parliament and it's governed by certain procedures.

Perhaps you've a point that a more informal procedure would have merit; perhaps even an informal procedure which would engage the pro and anti sides in this argument. But from our point of view as a national Parliament, we have to treat the people who have elected us with some measure of dignity in how we carry on our proceedings. That's where we're on that. Politicians, as you know, frequently have many informal consultations, but when we have consultations here they are formal.

On the selection of witnesses and the briefing documents – because that does relate to our secretariat and the all-party committee – all the submissions are available for public inspection. The advice we received was that the Freedom of Information Act might not apply to them but, nevertheless, we decided to make them available. That has been made clear to anyone who has sought that information. The briefing documents are purely documents containing selections from the submissions which are available to the public, and which are prepared for the ease of the members and yourselves when we are conducting question and answer sessions.

The selection of witnesses was a very difficult topic. Again, it was discussed by the committee before going into public session. There is no end to the number of witnesses who might like to talk to us. We decided in the first instance to hear, as you noted, a large group of medical men – I think there was one woman. The bulk of them had made submissions to us and a few had written to say they wanted to speak to us. We decided, as a committee, that the best way to proceed, to supplement that, would be to insist on the presence of the masters of the major maternity hospitals in Dublin. That was illuminating in its own way and it helped to clarify medical evidence, in general.

Having heard medical evidence, we then went to hear protagonists to the debate. At that stage, we identified people on the basis of the organisations to which they belonged. Having heard all that evidence, we decided, as you know, to hear the principal churches. Today, we decided to hear a variety of individuals who made known to us their wish to speak to us. That is how the selection of witnesses proceeded. I was anxious to put that on the record. I think Deputy O'Keeffe wishes to ask some questions.

Deputy J. O'Keeffe: I am sorry that I was at another meeting and did not hear your full verbal submission but I have read your written submission. As I understand it, you are essentially in favour of a constitutional and legislative provision that would allow abortion on request. Is that right?

Ms McEvoy: Yes, we favour abortion on request, as is the case in a number of other European states.

Deputy J. O'Keeffe: Would you have any restrictions? I understand there are different levels of restriction in countries where abortion is permitted, from the point of view of terms, medical evidence that needs to be given and so on. Have you given consideration to that?

Ms McEvoy: I think one of my colleagues will answer that.

Ms McDonnell: Yes, I'll answer that. We have given consideration to that. I think, generally, we all work within the technical definition of abortion. However, the medics might disagree about the meaning of that. Abortion is the termination of pregnancy up to time of viability, and usually that is between 22 and 24 weeks, given the general model that's accepted across other European countries. The medics argue that viability is something that changes with technology. We agree that, yes it is, but is not that technology provides us with solutions to difficult ethical problems – in fact, it only raises more difficult ethical problems. The process involved here, particularly the evidence given by the medics, is that they certainly are not in a position to decide these questions.

On the question of abortion on request, the model, for example, in Holland is that abortion is given on request up to 12 weeks. We think that is a good model, in terms of best practice. In Holland abortion is part of a comprehensive reproductive programme, in terms of women's health. It is not dealt with as a single issue or only as a moral issue, but is dealt with very clearly within the context of women's health. We feel that any legislation has to foreground the issue of health policy.

Deputy J. O'Keeffe: Am I right in saying that, apart from the broad issue of what you term health policy, you would feel there should be legislation backed by constitutional provision to allow abortion on request up to 12 weeks? Is that what you are saying?

Ms McEvoy: I don't think we are calling for a constitutional provision. We are actually calling for the removal of the abortion issue from the Constitution.

Deputy J. O'Keeffe: Constitutional change, then.

Ms McDonnell: Yes.

Deputy J. O'Keeffe: Up to 12 weeks. As you are aware, any changes to the Constitution would need to be passed by the people.

Ms McDonnell: Yes.

Deputy J. O'Keeffe: Therefore, if one is proposing any such change, one would have to bear that in mind. Would you accept that there probably isn't a great strength of feeling in support of the proposal you are making and, for that reason, any such constitutional change would probably not be successful?

Ms McEvoy: We don't know for certain that there is not support. There was an idea produced by some of the other organisations talking to you that what they termed a 'preferendum' might be used in order to deal with the more complex issues.

Ms McDonnell: What we have learned is that the Constitution is not the place to debate or decide issues in relation to the question of abortion. It has basically hijacked Government after Government. It has brought down a Government. This is not peculiar to the Irish case. For example, if you look at Germany after unification, the abortion issue basically jeopardised the whole programme of unification. Although the politicians and the public came to an agreement on abortion reform, when that legislation was introduced it was overturned by the supreme court because of the constitution in Germany. So, even if you introduce legislation, as long as you maintain, in particular, the present constitutional provision, there will always be difficulties and this issue will never be legislatively resolved or resolved through public consensus. There must be another way of dealing with these questions.

Senator O'Donovan: First, I would like to welcome you, coming all the way from Cork, as I do myself. I understand the difficulties of trying to get here, with train strikes and so on. I have to travel a good few miles beyond Cork city to get here.

Recognising that the Constitution belongs to the people, whether we like it or not, we are faced with a dilemma, as a committee, that there are some groups saying that we must row back and that the last referendum was a disaster which went the wrong way, and others suggest an absolute ban on abortion. Some groups, like yourselves, feel we should take a more flexible approach, if I may use that word, in maybe taking the whole abortion issue out of the Constitution.

How do you suggest that can be done without going back to the people again? In other words, the Constitution is paramount and superior to our legislative structure. It is in there now, whether wrongly or rightly. My question to you is, how do we extract the whole thing about abortion or controls without revisiting the people, in one way or another? You may suggest we have a referendum or preferendum saying, 'We totally bring this issue out of the Constitution and let it be dealt with by the Oireachtas and legislation'. I gather that is your preferred choice, but one way or another, I put it to you that, to placate the pro-life people or the pro-choice people, it seems to me, although I am not an expert, that we must revisit the Constitution and that we must have a referendum before we take the second track of legislation. Do you see the difficulty we are in as a committee?

Ms McDonnell: Indeed, but that is the awful dilemma that you got yourselves into in 1983, despite being forewarned. I have to say that when we look at public policy on this issue, it has been dominated by what we term the pro-life agenda. Because of that, we have not really dealt with abortion as a public health issue. However, I see certainly coming out of this inquiry that crisis pregnancy is now a legitimate public health issue, and there is nobody who wants to sanction women faced with a crisis pregnancy. So, however we imagine that we are going to deal with the legal complexities and the political complexities, there has to be a political will to address the situation that women find themselves in. We have moved away, I mean the debate has moved away from the moral absolutes. We can't have this debate any more in terms of moral absolutes, and we know that from the evidence that the medics gave. It is quite clear from the evidence of the masters of the three general maternity hospitals in Dublin that, for example, option one in the Green Paper, or any option that would support that, is just not feasible from a health perspective.

Chairman: It's a long way from the position of the masters to your position, though, isn't it?

Ms McDonnell: Yes, I agree, but I also have to say, we recognise how brave the three masters were to come out in public and to talk about this issue. I think that is a sign that this issue is beginning to be opened up.

Senator O'Donovan: Just to get back to the point for the committee again, and I don't want to labour it, moving on from what the chairman said, there are lots of stepping stones to be got over in very tortuous and dangerous waters.

Ms McDonnell: Do you think?

Senator O'Donovan: I would again go back to the point, because this is one of our later days, that this committee – I pay tribute to our Chairman – has tried to encompass everybody. Maybe it seems slow but we have been here for long days trying to accommodate everybody. We would not wish in a few months time if you said, 'You dealt with A, B and C, but you left out X, Y and Z'. We hope, when we have finished in a few weeks' time, that we will have listened to, including yourselves, all aspects. I understand where you are coming from and the sincerity of your approach. That is the difficulty we are in, to try to accommodate everybody and then to try to get a solution that the public will accept.

Ms Connolly: Just to reiterate, I think it is very important to state that, regardless of any of the views that any of us hold, the question of abortion is in Ireland and is, in fact, outside the Constitution in the sense that thousands of women are choosing to travel to Britain. Irish women in the area of reproductive choice have always acted, or in the past have acted, illegally, and in a sense actions are preceding the legislation. So, regardless of the constitutional dilemmas, this is happening outside of the Constitution and we feel in particular that options one to four in the Green Paper cannot account for that or cannot deal with that reality in any great sense.

Chairman: Thank you very much for your patience this morning and for assisting us.

Deputy J. O'Keeffe: Safe home to Cork.

Chairman: Perhaps we will call the proceedings of our committee 'The Annals of the Three Masters'. In any event, thank you very much.

SITTING SUSPENDED AT 1.14 PM AND RESUMED AT 2 PM.

Ms Geraldine Luddy and Maureen Gilbert

Chairman: We are now resuming our public session. First of all, I'd like to apologise to you that we are a few minutes late and I'd like to welcome you as representatives of the Women's Health Council, Geraldine Luddy, who is the director, and Maureen Gilbert, to this meeting of the Joint Committee on the Constitution. We received your submission which I have circulated to the members and have read. The format of the meeting is that one of you may make a brief opening statement, if you wish, elaborating on your submission. This will be followed by a question and answer session. I have to draw your attention to the fact that while members of this committee have absolute privilege, this same privilege does not apply to you. Ms Luddy.

Ms Geraldine Luddy: Thank you.

Chairman: You are a statutory body set up in 1997. Under what Act?

Ms Luddy: That's right. Under the Health Act.

Chairman: To advise the Minister for Health and Children on all aspects of women's health.

Ms Luddy: That's ....

Chairman: That's your mandate.

Ms Luddy: That's correct, yes. I'll repeat it here for you anyway.

Chairman: .... in this hideous modern official term.

Ms Luddy: Chairman, members of the committee, the Women's Health Council welcomes this invitation to meet you and to present and discuss our submission with you. My name is Geraldine Luddy and I am the director of the council. My colleague, Maureen Gilbert, has been an independent member of the council for the past three years.

The Women's Health Council is a statutory body set up in 1997 to advise the Minister for Health and Children on all aspects of women's health. Its mission is to inform and influence the development of health policy to ensure the maximum health and social gain for women in Ireland. Our work is based on three principles, equity based on diversity, quality in the provision and delivery of health services to all women throughout their lives and relevance to women's health needs.

From this perspective we have submitted proposals to you which we believe are crucial if there is to be national progress on this complex issue. The Green Paper sets out seven constitutional and legal issues – approaches to abortion. The Women's Health Council contains within it a range of views as to how each option would affect the situation with no consensus or majority view in favour of a particular option. This reflects diverse public opinion and the complexity of addressing the issues through a constitutional or legal framework. The council is, however, unanimous in its view that choosing from among these options will not resolve the issues.

The council, in approaching the preparation of the submission, was conscious that at the centre of its response should be the concern for the health gain and social gain for women, as our statutory obligations require. We also assumed that in considering ways forward that our expectations of potential outcomes are shared by many, namely, reducing the rate of crisis pregnancy, eliminating the negative aspects on the health and social well-being of women resulting from crisis pregnancy, offering real and practical alternatives to women who currently believe that their only choice is abortion, and addressing the reality of the current situation and the upward trend indicated by the abortion statistics from the UK, with practical programmes and services across a range of disciplines.

For almost 20 years the issue of abortion has been on the political and public agendas. Despite intense debate the evidence indicates that we have been unsuccessful as a nation in combining a commitment to life with a practical response to the reality of life and of women's lives in particular. Over this time the situation has moved from one where abortion has been illegal, through a period of apparently absolute constitutional guarantees and now to a legal interpretation of the guarantees. In parallel, the numbers of women opting to have abortions when faced with crisis pregnancy has steadily increased and the limited research in this area indicates that there has been a failure either to reduce crisis pregnancy or to offer the women alternatives that they found compelling.

The Women's Health Council believes that it is time that the energy and commitment of so many people concerned about this issue shifted from a narrow legalistic framework to a holistic approach tackling the range of issues comprehensively and thoroughly. We wish to see a qualitative approach with long-term resources and targets. We have proposed a ten year strategy which would embrace such areas as education, health care, family support structures, women's social and economic rights, child care and research. The goal must be national programmes based on international best practice, and not a series of limited pilot projects that, while of value in themselves, are never mainstreamed. Such a strategy must have a clear set of targets which are monitored annually so that in a decade we see a definite reduction in the rate of abortion among Irish women.

The strategy would ensure that the services available to women facing crisis pregnancy today are as comprehensive, accessible, welcoming and supportive as possible. This includes women's general health care, reproductive care, contraception, counselling, maternity care and follow up care, regardless of their decision. Crisis pregnancy is not a new issue and will remain a reality in the 21st century Ireland unless a specific, targeted, coherent and cohesive approach is taken to tackling its root causes and current outcomes.

As a Women's Health Council we view progress on this issue as one which can demonstrate a genuine national concern for women and children. Historically, we have not risen to the challenge but it is our firm belief that action is possible which will make a real difference.

I'd like to conclude by summarising that the Women's Health Council recommends that a national strategy be developed with the aim of reducing the rate of crisis pregnancy significantly over a short timeframe. Such a strategy should involve policies, actions and initiatives at national, regional and local level, with a view to implementing evidence based on formal policy, procedures and programmes within five to ten years. Thank you.

Chairman: Thank you. As your submission makes clear, the council is a statutory body, but there is a range of views within the council on the various options set out in the Green Paper. Is that a fair summary on that issue?

Ms Luddy: Yes.

Chairman: You have decided not to address that issue and instead to express a unanimous view that the real issues we have to address are reducing the rate of crisis pregnancies and eliminating the negative effects on the health and social well-being of women resulting from crisis pregnancies. Your conclusion then is that the Government should draw up a ten year strategy which would reduce the rate of abortion by Irish women. So, you are focusing on the practical statistics, which have been revealed to us in our hearings already. You also make the point that quality services and support should be in place to protect the well-being of women who choose the option of travelling and having an abortion elsewhere.

I wonder could you help me. We have had a lot of evidence on various measures that might be adopted to reduce the rate of abortion and some of the proposals have complemented each other, but like all policies and proposals, there is an element of stick and an element of carrot in them, if I can use that metaphor in this context. In the realm of education we heard the view that education for chastity is very important, but also education for knowledge about sexuality and how to prevent conception. Would you agree that both of those proposals can be complementary in the educational system?

Ms Luddy: I think they can be complementary in terms – are you talking about sex education in schools and for young people at this stage?

Chairman: Yes, I am just starting at that level before I go nearer. Do you consider that within your statutory remit, or is that more a matter for the Department of Education and Science?

Ms Luddy: Well no, I think in terms of how the approach to it would be certainly one that we would consider. I think it is important that, for instance the current RSE programmes we would support, but, you know, I think in terms of advising young people particularly not to have sex, I think that is fair enough, particularly when they are very young, like 12 and 13, but I also think that people are advised all the time not to smoke and as we can see from our rate of smoking, it is going up all the time. So, whereas we can put in measures to educate in terms of themselves and their sexuality, and certainly I think it is important that they are educated in terms of having sex when they want to and not when they are forced into it by peer pressure or by the culture that they are living in. I think it is equally important to balance that with information, that if they do decide to have sex that they do have safe sex and that, you know, would include avoiding pregnancy, STDs, AIDS and everything else that can go with it. Perhaps, Maureen, you would like to add something to that.

Ms Maureen Gilbert: I think that there appears to be no alternative sexual ethic available to young people, other than abstinence. At the present time there would seem to be less discussion of what that means and how you can approach that as a young person than perhaps there could be, and maybe it is a little early to see what the effects of RSE, as it is currently constructed, might be. I think that would be one element, perhaps, of a national strategy to monitor how these programmes have worked.

There have been some criticisms of the approach, that it has been sort of pick and mix and that it is not consistent across the board in all schools, in all places. I would not be aware of whether that criticism is accurate or not, but it certainly would be something that would be important to look at. I think this is one of the things that the Women's Health Council felt that there are a number of very good programmes of all sorts relating to all parts of this issue in different parts of the country, but there appears to be no one coherent strategy pulling the whole thing together and looking at it holistically. It is the opinion of the Women's Health Council that that would certainly assist the process to move forward.

Ms Luddy: Just one other thing if I may add. The other issue that should be included in any education classes is the whole issue of gender based analysis of sex education in the sense that health is determined by many things, and sex and our reproductive functions are just one of them, but our gender is also another and how we interact roles in relationships in society. So, for instance – I think we mentioned it in our submission as well – where you have a lot of peer pressure on young people to have sex and for young women, they sometimes can find it very difficult to actually be assertive and say if they do want it, and then if they want it that they want it safely. So, there are a lot of issues around that which links into the whole area of relationships between men and women and I think it is important that sex education, contraception, chastity is not just seen in isolation, because it is not in isolation.

Chairman: I am not suggesting that, but I am questioning you. I have to ask questions in isolation.

Ms Luddy: Yes, sure, but I am just saying that ....

Chairman: I was only beginning my questioning when I raised that issue and I was beginning with the area that is furthest removed from the crisis you talked about, in a sense, because the effect of the education system is the remotest influence because it is the furthest away from the point of decision and the point when problems arise.

Ms Gilbert: How is this reflected in the home, the involvement of parents – all of that, I am sure, has been discussed before.

Chairman: Yes, but your ten year strategy, what are the key measures that are proposed in it?

Ms Gilbert: I think it is important to say that the strategy does not exist in our heads as a finished item at the moment. If only it did then we would happily present it to the Department of Health and Children.

Chairman: Yes.

Ms Gilbert: Clearly it does not exist as a finished item at the present time. It does contain all the … it is a suggestion of a way forward. I do not think we could come up with a strategy unless we were also talking to those women and men who had been involved in crisis pregnancies already and those women and men who might be considered to be at risk of being involved in crisis pregnancies. So, it would probably be a bit previous of us to have a finished plan, even if we did, but the elements, I think, are fairly well known. They would be education, the availability of contraception, the availability of information and so on.

Chairman: You mentioned wider factors, for example, the stigma attaching to lone motherhood. We have heard a lot of evidence on that. We have also heard evidence about the stigma attaching to adoption nowadays. Would you agree that that is a real problem nowadays as well?

Ms Gilbert: Yes.

Ms Luddy: I think it is, yes. I think there is a stigma in relation to adoption. I think in some ways women still choose adoption because of the secrecy involved, because they do not want anybody to know about it. I think at the moment there is a change, because there are so many people who have been adopted in the past who are now seeking to contact adoptive parents and *vice versa*, parents who have put up their children for adoption. I think it is being worked on by the Department in another area, but I think that we need to tackle in terms of crisis pregnancy … abortion is only one option that women take and I think that adoption is very definitely another one and single parenthood then is the other. So, I think the national strategy would not just look at ....

Chairman: Parenthood is the other option.

Ms Luddy: Parenthood, of course, is the other, yes, exactly.

Chairman: Not necessarily all parents are single.

Ms Luddy: No, that is very true, but in terms of crisis pregnancy, the majority of women are looking at those three options.

Chairman: Yes, of course, sorry.

Ms Luddy: That is all right.

Ms Gilbert: I think a lot of the time, a big factor in the decision making about what path to choose in a crisis pregnancy is around issues of what will give a child the best start in the world. At the moment, the view of adoption is quite ambivalent in this area, that on the one hand a mother may feel that by having her child adopted this will give the child the best start in the world, in another way she may feel she will be very much criticised for giving away her child and so on. So, I think it is a particularly tricky option and perhaps particularly at this time, where there has been so much discussion of it.

Chairman: There is some evidence in the United States, though, that negative portrayals of motherhood in itself are part of the problem.

Ms Gilbert: Could you explain that to me?

Chairman: In some states in the United States advertising programmes have been mounted to portray a positive view of motherhood as such, and it is argued that this reduces the rate of abortion.

Ms Gilbert: Certain positive approaches to motherhood are very important.

Chairman: Practical support is important as well.

Ms Gilbert: That is what I was about to say. I think the stereotypical image of a lone mother in a bleak block of flats struggling to bring up her child is seen to be not only very bleak for that mother but particularly bleak for the child and, therefore, is perhaps not the option that people want to choose, and equally the well documented links between lone motherhood and poverty and some notion that again you would not be just reducing yourself to a life of poverty but also reducing your child to a life of poverty. So are things which are not simply the spin that one would put on them but also to do with the level of support that this or any other state might provide.

Chairman: I appreciate you are the Women's Health Council but do you not think that education of men in their responsibilities would have a part to play?

Ms Gilbert: We think that the education of men is absolutely crucial in this regard.

Ms Luddy: It is essential.

Chairman: All right. Turning to contraception, we had evidence that the promotion of contraception among young people of itself does not necessarily solve our problems in terms of irresponsible sexual behaviour. Would you agree with that?

Ms Gilbert: I think whether contraception is available or not, if young people decide they are going to have sex, they will. Although it is also ....

Chairman: I am not saying that young people having sex is irresponsible sexual behaviour.

Ms Gilbert: No.

Chairman: I chose my words carefully.

Ms Gilbert: I am sure you are not.

Chairman: I said making contraception available as such does not reduce the incidence of irresponsible sexual behaviour.

Ms Gilbert: No, but I am not certain that it increases it either and I think contraception is simply one element in this complex situation.

Chairman: Yes.

Ms Gilbert: I think it is tempting to try and say that any one element is perhaps more important than the other. Without looking at this in a very cool and thorough way, I am not sure that it is possible to say which is the dominant element. I also feel that the information which is available to people about contraception, frequently that the people who feel that the information is least available to them are the people who are most vulnerable and most at risk, and the people to whom any pregnancy is more likely to be a crisis than those who are perhaps better at accessing information. So the ability to access and understand information and the ability to deal with an unexpected pregnancy may – I do not know that they are – be linked.

Equally it not just, I think, an issue for young people but also for older people. I mean, the consistent use of contraception, while that improves where one is in a stable relationship, first of all, not everybody who is not a young person – who is an older person or whatever – is in a stable relationship and one goes inexorably back to these issues of the negotiation of sexual relationship between men and women.

Chairman: One issue relating to contraception we did hear evidence on, and it is directly related to the subject of a crisis in relation to childbirth, was post-coital contraception. It was suggested to us that in Northern Ireland the widespread availability and advertising of post-coital contraception did, in fact, reduce the rate of abortion. Would you accept that as a proposition?

Ms Luddy: Well I think we would accept it in the sense that it is a fact in some of the … from research in Northern Ireland, but I think again it depends a lot on whether or not the proper information is out there about post-coital contraception and also the availability of it to the individual involved. I think there are differences between accessibility to contraception, both ordinary contraception and post-coital contraception, in urban areas and rural areas and ....

Chairman: In this State you are talking about now, in Ireland.

Ms Luddy: Yes. I think there are differences. I think women still find it difficult to access contraception in some rural areas, where there is no family planning clinic and where they do not want to go and ask for it from their GP. So there are difficulties around it and there are certainly difficulties around accessing post-coital contraception in that context.

Chairman: That is what I am talking about. That is what I asked you specifically about.

Ms Luddy: So I think that if you had wider information about it but also accessibility to it, I mean, there is no … you would have to have the information to say it is available but then you would have to have it available so as they could actually get it within a timeframe because the timeframe is very important in terms of its effectiveness as a post-coital drug.

Chairman: It is only the first 72 hours.

Ms Gilbert: Equally in terms of ensuring responsible sexual behaviour, an over-reliance on post-coital contraception is perhaps not to be encouraged. So it would have its place but I think certainly it would be only within a ....

Chairman: An overall system.

Ms Gilbert: .... broad range of options.

Chairman: Yes, because we have heard evidence that undue reliance on it can be very damaging ....

Ms Gilbert: Yes.

Chairman: .... to health. We have had that evidence as well. There are no further questions. Thank you very much for assisting us today. I will suspend the session for two minutes.

SITTING SUSPENDED AT 3.06 PM AND RESUMED AT 3.13 PM.

Ms Máire Kirrane

Chairman: I will resume the public session and I would like to welcome Ms Máire Kirrane, barrister-at-law, to this meeting of the Joint Committee on the Constitution. We received your presentation which has been circulated to the members. The format of this meeting is that you may make an opening statement, if you wish, which will be followed by a question and answer session. I have to draw your attention to the fact that while members of the committee have absolute privilege, this same privilege does not apply to you. I have read your submission and you advocate developing the Offences Against the Person Act, 1861, so that the controversial words 'direct' and

'indirect' are avoided. Perhaps you could develop that for me.

Ms Máire Kirrane: Thank you, Chairman. If I may firstly just say why I sent in this submission. Anything I know of law leads me to believe that, as I said in my submission, lawyers can always find a loophole, and in the eighth amendment to our Constitution which did seemingly provide absolute protection for the unborn, there is actually no such thing as an absolute right that can be enshrined in the Constitution or otherwise, but it seemed to give the fullest protection possible with due regard to the equal right to life of the mother. In my opinion, I perceive that as being a fatal flaw to that particular amendment because, as I said in the submission, it asserted in opposition to each other two equal rights, equal constitutional rights, and as a result of that, when a challenge arose the only way that could be decided would be in a court of law. As we know, that has already taken up court time on two very tragic occasions, two young girls who happened to be rape victims in each case.

It is my opinion and I believe it is acceptable all round that the decisions in both of those cases are in themselves seriously flawed, in that there was never in either case a properly adversarial hearing. I think it is a basic principle of law, in fact it is a constitutional right, that both sides … there is a full hearing with all the evidence that is necessary to prove or disprove what is alleged. In neither case was this before the courts, in particular the second case, the C case where the young girl was alleged to be suicidal. In that case, the only evidence before the court was the evidence of a psychologist. I think it is accepted, certainly in medical spheres, that suicide is part of a disease of the mind, or at least it comes from the mind being so battered or shattered that it is not functioning properly, and that then becomes a disease if it is prolonged. The only person who is qualified enough to treat that is a psychiatrist. In neither of the two cases that came before our courts, a psychiatrist was never called upon. There was in fact … a psychiatrist advised in the X case but the person, the doctor, it was Dr Peter ....

Chairman: The present Master of the Rotunda Hospital, Dr Peter McKenna. He discussed that with us.

Ms Kirrane: Yes, I will not go into that except to say that he did suggest a psychiatrist but was told by, I think, one of the doctors in the Rotunda that they had their own expert and that expert was a psychologist. That was the only evidence admitted before the court and the evidence was accepted on face value. There was no proof that the girl was suicidal and there was no attempt, which ought to have been the case, to treat the girl for her suicide and to evaluate it would take at least two or three psychiatrists, in communion I would suggest, to decide in a big hurry whether a girl was suicidal and her case history would be relevant there. In both those cases they were exceedingly disappointing and unsatisfactory.

That caused me to take another look at the wording and I do believe that as long as that eighth amendment stays there, it is going to, forever, pose problems. Even if it's left there and another addition or supplemental section given to it or added to it, it still won't cure the basic flaw which is the two rights.

So, I was very interested in Dr Denham's submission. Now, while he wouldn't be on all fours of my thinking, I would say that there is no need and that there ought never be abortion *per se*, but it is crystal clear to me that the problem with getting a proper wording is the problem of the definition, and I am sure you have heard that *ad nauseam*, the definition of abortion by doctors is one thing and by lawyers it's another. To that extent, I believe Dr Denham where he says in reply to Deputy O'Keeffe who asked him, 'Is it that there should be some degree of flexibility in our laws that, where there is expert evidence available of these conditions?', that is, an incurable or a fatal condition, though, indeed, Dr Denham wasn't talking about a fatal problem in a baby, he was talking about cystic fibrosis. As he rightly said, they are now living into adulthood, but he said ....

Chairman: I think, in fairness to him, he was discussing the circumstance of a second cystic fibrosis.

Ms Kirrane: Of course, yes, but ....

Chairman: I'm not saying I agree with his position, but I'm just summarising it for the record.

Ms Kirrane: I certainly sympathise with his position and I think he's absolutely right in most of what he said. When you read and listen really properly to what he has said, he was asked by Mr O'Keeffe, so you more or less suggested that he required, Dr Denham required, 'that a provision be made for termination to be available', and Dr Denham answered, 'Yes, I .... ' and he was interrupted again, 'provided it is carried out in one of our recognised maternity or public hospitals'. That's at page 113 of that document, and Dr Denham answered:

> I have a great faith in the ethics committees of our hospitals. I think they have by and large run the hospitals very well, supervised what goes in them very well and I think if you said tomorrow that termination of pregnancy is freely available to anyone subject to the rulings of the medical ethics committees, I think you would find there would be very very few terminations and that they would be looked at very carefully by the hospital ethics committees. Without having to legislate for [special] conditions, which is very difficult, I think the ethics committees would look at each case in great detail and … by the clinicians [and that] the decision, the advice would [probably] come from the doctors [etc.]

The gist of what he's saying is that it's only when medical aid is necessary, is absolutely necessary for the life of the mother with just those few exceptions. Now, I would not go along with him in relation to that, because a person had cystic fibrosis or the likelihood of having such a child, that the victim, the infant, the innocent victim, the child in the womb should, for that reason, be denied the right to life.

If, moving away from the law of it, philosophically speaking, once you drop a principle, once you say that you go beyond, say, protecting the life of another, then you are into … it's all gone. Once you drop that, it's all gone as anybody worldwide from all the literature can plainly see, that it is no longer a principle. It's merely something, an *ad hoc* thing.

Chairman: Yes, just, but you have proposed a wording.

Ms Kirrane: I have indeed.

Chairman: You're that rare beast before our committee, somebody who has proposed a wording.

Ms Kirrane: Yes, well I'm a little worried about it because I can't see any side approving of my wording. It's somewhat very controversial, I think, but ....

Chairman: Well, I see you propose it as a constitutional wording. It could equally be a provision of the criminal law, I take it, were the Constitution to permit that to be the case.

Ms Kirrane: Well, with great respect to our legislators, I wouldn't be happy with it as an Act, just as a statute. I believe that it is such an important thing that the people, by virtue of Article 6 of our Constitution, that they should really decide the policy. Mind you, I would even fear a referendum because I would fear that, just maybe with all the 'huzz' and buzz of media and the power of it, that people would not … would feel hard cases, and that there should be provision made for them to have abortions in hard cases.

Chairman: Can I just look at the wording with you now?

Ms Kirrane: Yes, certainly.

Chairman: One point strikes me. You're saying the people must be consulted on this matter, and I'm not criticising you for saying that, but in a sense your wording delegates to the medical profession the decision of what the hard cases are. If the matter is important enough for the people to decide upon, can we really delegate all these decisions back to the medical profession? That's the one question of policy now, leaving aside legal draftsmanship – draftsperonship, should I say – the question of the policy of this suggests that the medical profession, as a profession … you know, you use the phrase 'the treatment':

> Nothing in this section … shall be invoked to prohibit, control or interfere with any act, made, done or carried out by, or on the instructions of a medical practitioner in the treatment of a pregnant woman patient in the ordinary course of medical practice,

Of course, that leaves it to the medical profession to decide the whole question in a sense, doesn't it?

Ms Kirrane: Not exactly. In one sense, it does, and to that extent, I applaud Dr Denham's submission or his evidence to you here, but there is a difference … 1861, the whole thing, where the first part of it is that:

> subject to the provisions of sub-sections 4 and 5 … it shall not be lawful to procure, or attempt to procure, or in any manner to aid or abet or assist any person, to attempt to procure, or to procure the miscarriage of a pregnant woman within the State or in any [part] ....

Chairman: So your definition of abortion is clear. It's the procuration of a miscarriage.

Ms Kirrane: Yes, but I ....

Chairman: You're prohibiting that.

Ms Kirrane: I think I underline that with the next section which says:

> For the purpose of this section an … abortion is attempted or procured by any act or procedure carried out … for the sole purpose of procuring the miscarriage of a … woman.

Then, I go on to say ....

Chairman: So it has to be an intentional procuration of the miscarriage, not an accidental ....

Ms Kirrane: No, of course not.

Chairman: In the next paragraph, not an act 'in the ordinary course of medical practice".

Ms Kirrane: It's only in the ordinary course of medical practice. If I can answer your question, Chairman, on that, I think that in all cases there would have to be, under the ethics of hospitals and under the eye of the Constitution, and, of course, the legislation that would have to come from this constitutional amendment, then there wouldn't be any danger because there would always have to be empirical medical evidence of the necessity for any procedure that the doctors would take because if the treatment they proposed was not necessary to save the life of the mother, then they'd be subject to the criminal, not just to a civil action for damages. They would be subject to the criminal law because this would be a constitutional offence and it would be written into legislation as such.

Chairman: Would you not have to include a reference in that paragraph to the fact that there must also be a real and substantial risk to the life of the mother before the medical practitioner could invoke the subsection?

Ms Kirrane: In fact I only noticed the omission today, Chairman. Thank you. One is blind to the things they write themselves.

Chairman: So you'd have to supply that omission, otherwise the medical practitioners could argue ....

Ms Kirrane: No, you would just say nothing in this section prohibits control or interfere … the practitioner with the treatment of a pregnant woman patient in the ordinary course of practice, notwithstanding that such treatment would or could have a termination of that patient's pregnancy. Now you'd have to fit in – the procedure would have to be in order to protect the life of the woman patient.

Chairman: Yes, I think so.

Ms Kirrane: I should have written it in.

Chairman: You should have, because otherwise your medical practitioner could argue that abortion was in the ordinary course of his or her medical practice, that it was a medically recognised treatment as such.

Ms Kirrane: It couldn't be because, with respect, the first three, the first provision would prevent that, but in any event I certainly take it that the medical practitioner could be in the treatment of a pregnant woman patient … the treatment necessary for a pregnant woman patient to save – necessary to save the life of a pregnant woman patient in the ordinary case – that's only – you may add, Chairman ....

Chairman: Those words would have to be supplied.

Ms Kirrane: Yes, in there just after 'woman patient'.

Chairman: Your formula does have the advantage of avoiding concepts like direct and indirect effect, isn't that right?

Ms Kirrane: Yes, well that is true, while, with respect, Chairman, no one would know better that 'direct', 'indirect' and 'intent' are all very much part of our law and the law of the whole world, because there is no culpability without intent. For instance, a rape victim in my opinion, if you'd like to ask me a question about it I'd like to answer one, about a rape victim and being treated.

Chairman: I'm sorry, a rape victim being treated, yes?

Ms Kirrane: In the case for instance a rape girl, a girl who was raped.

Chairman: Yes, who is threatening suicide.

Ms Kirrane: Or who wants to have an abortion – no, I would not say that a rape victim *per se* would, should be entitled to have an abortion unless of course her life is threatened and if it's threatened by suicide inclination, then that has to be proved, and that was an interesting thing in the submission of the Rabbi who was here, Rabbi ....

Chairman: The Chief Rabbi of Ireland.

Ms Kirrane: Yes, Rabbi Broeder. He said in that thing rape is not a reason for abortion. He also said the Talmud says abortion, though not like, not murder, remains a grave offence and he went on to say that he himself or that his religion would consider it a moral offence but wouldn't force it down anybody else, while the bishops didn't go any further than that. The Catholic Church, the Talmud, that is the Jewish, the Muslim are all at one, that it is an offence and an absolute crime. Under Muslim law, of course, it's a crime, Islamic law, and it's interesting that the Islamic people here, of which I gather there are quite a number, would favour constitutional protection for the unborn as opposed, as against legislation while the Methodists, on the other hand, would favour maximum freedom, only restricted where clear and unmistakable social necessity – that surprises me because social necessity – this is a Methodist Church, so I would have thought a moral rather than social, but it was perhaps a slip of the tongue there. In all those cases, in the three main religions, the Catholic Church, to take in Christian churches, the Jewish and the Muslim, all agree that only when the life of the mother – it particularly impressed me that Rabbi Broeder said that only if there was a grave risk to the mother – and in all those cases he said that would have to be proved in relation to suicide. That with suicide, it would have to be proved. That is another thing when you allow for suicide, because the timescale necessary to prove a suicide, once you have proved there is a pregnancy, say, by rape, then it takes time, but under our law you must have a proper hearing and that is one of the reasons I would say that suicide most certainly should not be, *per se*, unless it's going to be a danger to the life of the mother.

In relation to rape, that is the awful thing and how could you say: 'No you can't' but of course you can treat a woman if she is suicidal, absolutely suicidal, and the doctor, the psychiatrist would be dealing with her mind and he or she would be able to treat the girl and counsel and more than – and make sure that she doesn't, couldn't commit suicide, but the psychiatrist would have to be happy or satisfied that she, allowing an abortion would cure her and I think we all know that that has not happened – with the C case most definitely not so there was no need for it in the first place, for the abortion, in that case.

I was interested in listening to the ladies here just before me, if I may say, in relation to the changes that should come about in our legal system and in the Government's help for families, especially for young families and poor families. They should be given all the help in the world to have their children and if there's a child born outside wedlock, to have that child, if they could not, in fairness to themselves or the child, if they couldn't keep the child properly, then abortion. Worldwide there is a huge, huge demand for adoption and there are no babies.

Chairman: The previous body in fact was a statutory body so they didn't express an opinion on the merits of the various options, they didn't take a position on that because of divergent views within their council and they decided simply to present a submission that focused on reducing the rate of abortion.

Ms Kirrane: Yes, that is the way, but contraception, I agreed with the lady who said that it doesn't reduce it. It really doesn't, but I would not agree with her when she said – well no, in fairness she didn't know whether it increased it or not, but I would say the availability of contraceptives to young people most definitely increases abortion, it really does, because it leads to promiscuity. As such the danger is far more, there is a far greater danger of becoming pregnant.

Chairman: Your wording does have the merit that it hammers out how you can protect the medical practitioner and protect above all the pregnant mother in her treatment and reconciles that with a ban on abortion. Isn't that really the purpose of your wording?

Ms Kirrane: That is the wording. I would be pleased if I could now write in those few words into that.

Chairman: They're on the record.

Ms Kirrane: On the record that on the instructions of a medical practitioner and the treatment of a pregnant

woman patient whose life would otherwise be in danger or is in a situation where ....

Chairman: 'Whose life would otherwise be in danger' are the words you want to supply I think?

Ms Kirrane: Something like that.

Chairman: Something of that order where there is a real and substantial threat. Of course, that raises evidential questions as we saw in the X case.

Ms Kirrane: Yes. If that's in the Constitution, but I would not put in a real and substantial risk where the doctor is treating the woman patient for something that is … I think I have dealt with it at section 4 which reads, 'For the purpose of this section an Induced Abortion is attempted or procured by any act or procedure carried out with the intent and for the sole purpose of procuring the miscarriage of a pregnant woman'. I could add in there, 'In any situation where such procedure is not medically necessary [I did have that in in the beginning] to save the life of the pregnant woman'.

Chairman: Your wording seeks to reconcile medical practice, which is essential for the safeguarding of the pregnant woman with a clear prohibition on induced abortion. Isn't that the nature of your proposed amendment?

Ms Kirrane: That is it.

Chairman: You have managed to draft an amendment which does not include a reference to direct or indirect effect in that context.

Ms Kirrane: Yes. I hope that is ....

Chairman: That is a substantial contribution to the debate.

Ms Kirrane: I would ask in my first draft of paragraph 4 to leave in the provision in subsection 4 'the miscarriage of a pregnant woman in any situation where such procedure is not medically necessary to save the life of that pregnant woman'.

Chairman: Yes. Thank you very much for your assistance.

Ms Kirrane: Thank you. Sorry for rattling on.

SITTING SUSPENDED AT 3.43 PM AND RESUMED AT 3.45 PM.

Ms Frances Kissling, Mr Jon O'Brien and Ms Eileen Moran

Chairman: We are now in session. The delegation which includes Ms Frances Kissling, President, Mr Jon O'Brien, Vice President and Ms Eileen Moran are in attendance at a meeting of the Joint Committee on the Constitution. We have received the presentation which was circulated to members of the committee. The delegation requested in its presentation that there be a hearing before the committee. Before I give the members of the delegation that hearing, I take it they are citizens of Ireland.

Mr Jon O'Brien: I am a citizen of Ireland.

Chairman: Are you a voter here in Ireland on the voting list?

Mr O'Brien: I have been on the voting list.

Chairman: Are you the only member of the delegation who is a citizen of Ireland?

Mr O'Brien: I am the only member of the delegation who is a citizen of Ireland.

Chairman: We are concerned with the Constitution of Ireland.

Mr O'Brien: Absolutely.

Chairman: I appreciate you wrote and made a submission to us and indicated you wanted a hearing. As far as we can ascertain, we have afforded a hearing to everyone who asked for a hearing. We received a very great number of submissions and we have endeavoured to hear everyone who asked for a hearing. However, I would not be satisfied in entertaining you unless you were established as a citizen of Ireland. That is just a point of concern to me. I appreciate we have heard certain non-citizens in the course of our hearings. Some of them were to do with the hearing of technical evidence, whereas you clearly have a very clear point of view on this issue. Naturally I am anxious that where you are entering the debate in that format, you establish your citizenship before we proceed. So you are a citizen of Ireland?

Mr O'Brien: I am indeed.

Chairman: Your organisation is not an Irish organisation?

Mr O'Brien: No, the organisation is not an Irish organisation.

Chairman: The members of the delegation are welcome to the committee. The format of this meeting is that you may make an opening statement if you wish, elaborating on your submission. That will be followed by a question and answer session. I must draw your attention to the fact that while myself and the members of the committee have absolute privilege, this same privilege does not apply to members of the delegation.

Mr O'Brien: Thank you very much. Chairman, Vice Chairman, Secretary and members of the committee, I would

like to thank you for extending an invitation to Catholics for a Free Choice to participate further in your deliberations concerning abortion law reform in Ireland. The cordial nature of your deliberations and your search for a compassionate and justice seeking resolution to the abortion impasse are to be commended. The work of the committee stands in sharp contrast to the divisive and destructive nature of the discourse in 1982. This time we are optimistic that the abortion debate in Ireland will result in more light than heat.

My name is Jon O'Brien. I am from Drimnagh in Dublin and I have worked for 15 years as a communications specialist in the area of reproductive health. I worked for the Irish Family Planning Association in the early 1980s and 1990s as head of information and education. I went on to work with the International Planned Parenthood Federation in Eastern and Central Europe, working with local people to establish family planning and women's health centres in the former Soviet bloc countries to reduce the rate of abortion and improve the health conditions for men and women. In 1996 I joined the staff of Catholics for a Free Choice, where I am now Vice President based in Washington, DC.

I would like to introduce you to my two colleagues who have come to share with you their expertise and answer your questions today. We are all lifelong Catholics with a deep respect for the Church. Frances Kissling has been President of Catholics for a Free Choice since 1982. She is a writer, advocate and policy analyst who was educated at St. John's University and was a postulant in the Sisters of St. Joseph. Ms Kissling has briefed parliamentarians and development professionals on reproductive health and rights, religion and public policy in a number of countries, including Brazil, Mexico, the Philippines, Germany, Poland and the United States. As President of Catholics for a Free Choice she has brought some of the most respected liberal Catholic theologians to the board leadership and position development of the organisation, including Daniel Maguire, Professor of Moral Theology at Marquette University, Mary Hunt of Georgetown University, Giles Mulhaven, former Jesuit and Professor of Religious Studies at Brown University, former Jesuit Joseph O'Rourke, Rosemary Radford Ruether, Georgia Harkness, Professor of Religion at Garrett Evangelical Seminary, Julian Cruzalta, a Mexican Dominican priest active in human rights issues, Jesuit Juan LaFarga, former rector of the Ibero-American University in Mexico and Maria Jose Rosado Nunes, a professor at the Pontifical Catholic University of Brazil. The submissions we made and the positions we will take today reflect the insight and scholarship of these theologians.

Dr Eileen Moran received her doctorate in sociology from the graduate school and university centre of the City University of New York and is currently associate director of the Michael Harrington Centre for Democratic Values and Social Change at Queen's College and teaches in the sociology department. Her academic work focuses on inequality rooted in differences of class, race ethnicity and gender, particularly the barriers women confront in politics and in the labour force. Dr Moran has directed services for battered women and their children and co-edited *Violence Against Women: the Bloody Footprint*, an analysis of the structural and cultural supports for violence. Dr Moran is also a political consultant who has managed and advised the campaigns of numerous democratic candidates for public office in New York state. She is a member, as well as a former Chairman of the board of directors of Catholics for a Free Choice. At the moment she is on the executive committee of the professional staff of Congress at Queen's College.

In March of 1998 Catholics for a Free Choice made a submission to the interdepartmental working group on abortion to offer input into the Green Paper from a pro-choice Catholic perspective. Our submission, Catholic Options in the Abortion Debate, Reforming Irish Law, concluded from traditional Catholic principles ....

Chairman: That is in your submission which has been circulated to members. I asked you to elaborate on your submission. Are you simply going to read out the submission to us?

Mr O'Brien: No.

Chairman: I would be concerned if you did.

Mr O'Brien: The ethical-moral context section of the Green Paper notes that the Catholic Church Hierarchy teaches that the direct and intentional killing of innocent human life at any stage from conception to natural death is gravely and morally wrong. We have noted in our submission that there is much room in Catholic theology for the acceptance of policies that favour access to reproductive health options such as contraception and abortion. The Irish members of the Catholic Church, like Catholics elsewhere, clearly do not accept the teaching that abortion is always wrong in every circumstance. Public opinion proves it and the droves of women who travel to England and Wales each year to have abortions prove it. Some 78 per cent of Catholics in Ireland say they follow their own consciences in making serious moral decisions. Only about half of Catholics in Ireland believe that abortion is always wrong when there is a risk of foetal abnormality, but it is the nearly 6,000 women who travelled to England and Wales last year for abortions who testify most eloquently to the rejection of the Church's ban and its lack of legitimacy in influencing the public policy debate.

We would have liked the Green Paper to address more strongly the need for separation of Church and State in Ireland on this issue. While we recognise that religion can and does make a contribution to law and policy making and while we recognise the right of religious institutions to participate in the life of nations, it is equally important that that diversity of religious opinion and traditions be respected and promoted. The Irish system has instituted a separation between Church and State that must be honoured.

Catholic teaching calls for respect for the freedom and beliefs of other faith groups and the Church accepts the principle of Church-State separation. This is especially important on an issue such as abortion where the Church hierarchy's position, as on the issue of contraception, is more conservative than most of the world's religions. Many other faith groups accept the possibility of abortion's morality in some or many circumstances. Current Catholic theology makes a clear distinction between the moral teachings of the Catholic Church and the right of legislators to use prudential judgment in developing public policy.

As the theologian Daniel Maguire noted in Catholic Options in the Abortion Debate, even legislators who personally believe that abortion is immoral can support a policy that permits abortion because the goal of legislators is not to codify their own personal moral positions but to preserve a society in which legitimate disagreements may be disputed freely in the context of mutual respect. He noted that both Saint Augustine and Saint Thomas Aquinas taught that while prostitution is evil, wise legislators would permit it in the interest of preventing the greater evils that would result if it were eliminated. One of the evils cited was the probability that laws against moral matters such as prostitution, if not enforced, would create widespread disrespect for the law itself. Since almost no country where abortion is illegal enforces the laws against abortion, this needs to be taken into account in the Irish situation.

Clearly a solution must be reached that would allow abortion in Ireland under some circumstances. While the Green Paper noted that many Irish people regard abortion with abhorrence, it also concluded that a total ban on abortion is not realistic because of even the remote possibility that women may require abortion in life threatening instances. It also noted that the very significant number of Irish women obtaining abortions in England and Wales means the issue must be addressed. Of the seven options laid out by the Green Paper, number seven most closely reflects the social justice tradition of the Catholic Church and respect for the moral agency of women. The other six do not represent the ranges solutions but a narrow continuum of extremely restrictive policy options that range from explicit or *de facto* bans on abortion to very limited availability on a case by case basis. Option seven would permit abortion on grounds beyond those specified in the X case ranging from risk to the physical or mental health of the woman to cases of rape or incest, congenital malformation, economic or social reasons and abortion on request. This is the only position that begins to reflect our assertion that women must and can be trusted to make the abortion decision in conjunction with husbands, partners, other family, doctors, clergy and other trusted advisers and is most respectful of individual conscience.

The reality is that any solution that does not truly reflect the reality of women's experiences will be short-lived. As with the ban on contraception in Ireland, the issue will wind up in the courts again and again until a solution that is compassionate and realistic is codified into law. The Catholic Church has come to accept democracy and the democratic process and this process gives certain responsibilities to legislators. While there are many options in the hands of the Irish people, legislators, we believe, have an obligation to address the abortion issue in a way that is reflective of a commitment to justice and the well-being of the Irish citizenry.

The CFFC welcomes the opportunity to be part of the continued dialogue on abortion in Ireland. While we respect the right of the Catholic Church to participate in the policy making process, we respectfully submit that our position offers a lens for viewing the situation that can reduce the need for abortion while simultaneously respecting the rights of women.

Chairman: Is it correct that the National Conference of Catholic Bishops in the United States has stated publicly that you are not a Catholic organisation, that you do not speak for the Church and that you promote a position contrary to the teaching of the Church as taught by the Holy See and the national conference in the United States? Is that correct?

Ms Frances Kissling: Partly correct. It is stated that we are not an official Catholic organisation. However, we have never asserted that we are an official Catholic organisation. It is also stated, as we have stated quite clearly, that our position is not the position taken by the Catholic Church at this point in time and that indeed we do take a different position. However, I would note that there has never been any action against any of us as individual Catholics. We are all baptised, we are members of good standing of the Roman Catholic Church, we receive the sacraments at will and in accordance with our own sense of our being in good grace and in that sense are full participants in the Church and have the right to organise as Catholics, calling our organisation Catholics for a Free Choice, for indeed its associates, its staff and its board are all members of good standing in the Roman Catholic Church.

Chairman: Your practice of your faith is your business and I certainly do not want to make inquiries about that here today. That is not what I asked you and I was not looking for that answer. What I was trying to establish was your status *vis-à-vis* the Holy See and St. Peter, who as an article of faith is the infallible definer of faith and morals, according to that particular form of teaching and that particular religious point of view. I was simply trying to explore your relationship with that particular entity. Essentially, I do not wish to use the word 'unofficial' because that word has not been used but the national conference of Catholic bishops has stated that you are promoting a position which is contrary to the teaching of the Holy See.

Ms Kissling: That is correct.

Chairman: You are a group of believing Catholics who dissent from the Church's position on this issue. Is that a fair summary of your status?

Ms Kissling: That is a fair summary.

Chairman: I just want to be clear on that at the outset.

Of course, the public position of the Church on these questions in Ireland was articulated by our own Episcopal Conference. I do not know if you read the transcript ....

Mr O'Brien: Indeed we did.

Chairman: .... of what they had to say last week? The Episcopal Conference in Ireland, which in fact represents the bishops of Ireland on both sides of the border, spoke to us last week, as did some of the other principal religious bodies in the State. They, I suppose, are delegated by the Holy See to express the view in Ireland. That is their position, if you like, but you are anxious to put forward an alternative point of view and you put it forward today.

In the experience of the United States the debate has been a very divisive and difficult one. Is that a fair comment?

Mr O'Brien: That is a very fair comment.

Chairman: It has excited great public interest and public disputation.

Mr O'Brien: Yes, indeed.

Chairman: And many years have passed since the decision in Roe *v.* Wade. There is still permanent controversy in the United States about this subject. Is that a fair comment?

Mr O'Brien: Yes.

Chairman: In relation to the unborn and the living person born, what is your view of their relative standing? What is your philosophical and religious position on the relative standing of the born and the unborn?

Ms Kissling: In our reading and understanding of Catholic theology, what we read is that there is no definitive statement by the Roman Catholic Church on the question of whether or not the foetus is a person, i.e. in theological terms, has it been endowed by the creator with a soul, at what moment does that begin? More recently we looked at this in two documents. The first is the 1974 declaration on procured abortion issued by the Vatican Congregation on the Doctrine of the Faith which says, within that declaration, of course that abortion is immoral, evil in all circumstances, is forbidden in all circumstances but it acknowledges that the question of when the foetus becomes a person has not yet been definitively determined by the Roman Catholic Church. So we first state that foetuses do not have a definitive status as persons within the Roman Catholic Church. However, women do have a definitive status as persons within the Roman Catholic Church so there is, indeed, a distinction between foetuses and women in terms of their standing as persons within the church.

Secondly, the position, not the belief but the position of the church that foetuses must be respected from the moment of conception as if they were persons is not an infallible statement by the Roman Catholic Church. It has never been declared *ex cathedra* and, in fact, the most recent document on abortion issued by the church, the encyclical *Evangelium Vitae* issued in 1995, which deals with the question of the church's opposition to abortion both legally and morally, in early drafts contained the word 'infallible' and said that the church's position on abortion was an infallible one. When the document was finally released by the church – the final document itself – the word infallible no longer appeared. It had been removed from the draft and there was no assertion by the church in that document that the teaching on abortion is an infallible teaching.

One of the problems in terms of the church's ability to speak infallibly on the question of abortion is the fact that any infallible teaching must be consistent and without change over time. It must be factually provable. Since the Roman Catholic Church has favoured … although it has never affirmed any specific position on when the foetus becomes a person within the interiority of the argument around abortion there can be no claim of consistency over time since different positions on when the foetus becomes a person have been held at different times within the church and they have never been held infallibly. What we would state in summation – I see that you are ready for me to conclude on this ....

Chairman: No, I am not. I am going to ask another question arising from it.

Ms Kissling: .... is that there is a distinction within Catholic theology between foetuses and women, that the foetus is not doctrinally or dogmatically considered to be a person and women are, indeed, doctrinally and dogmatically considered to be persons.

Chairman: With respect, that is not of assistance to this committee because we cannot act on matters of faith. We have to act on matters of reason and conscientious reflection.

Ms Kissling: Absolutely.

Chairman: Our own Episcopal Conference, when they came here, did not take their stand exclusively on revealed religion and I put this question specifically to the Archbishop of Dublin. They are reflecting conscientiously on their experience and their view of the world. That is why I put the question to you about your philosophical convictions and on what, in your personal view, is the relative standing or right, or ought to be the relative standing and right, of the born and the unborn in civil legislation. I appreciate you may have a personal conscientious view of your own on this question but it is not that question I ask you. I am asking you what is your view on the relative standing of the born and the unborn in relation to civil legislation. What is the view of your organisation on that question?

Ms Kissling: The view of our organisation is based, again, upon legal history, particularly US history which has, again, no relevance here, on medical and scientific opinion, on sociological opinion and what we have discovered is that whatever discipline one looks at, whether it is legal, medical, sociological, philosophical or theological, what you have are differing views on what are the criteria for establishing an entity as a person. Within those differences what our finding is, is that the majority of those opinions hold that foetuses do not possess the characteristics normally associated with personhood, whether those characteristics are considered sentience, presence in the world, the ability to enter into social relationships. So that our view is that foetuses are not able to be defined as persons, that our sense is the predominant opinion is that foetuses are not persons and, therefore, do not stand before the law with the rights of the born.

Chairman: They do not have the rights of the born. That is the answer to the question.

Ms Kissling: I would say for us, yes, they do not have the rights of the born.

Chairman: That is your view on civil legislation.

Ms Kissling: That is right and we understand there can be different views.

Chairman: Should they have protection in civil legislation? Should the unborn be protected in civil legislation?

Ms Kissling: Well, I think we need to look at the unborn over a continuum of time in that context. The foetus normally exists within the womb for nine months and within the context of that nine month period our view would be that value increases – value, not rights – over time so that as the foetus comes closer to personhood, i.e. to its entry into the world, it may well be appropriate to accord it more legal protections, although we would never assert that it possesses rights. Protection is certainly appropriate.

Chairman: A viable delivery can now take place between five and six months. There can be no question of intentional destruction of the foetus after five or six months, is not that the position?

Ms Kissling: We would agree with that unless, of course, the life of the woman were directly at risk, in which case we would assert that the protection of the life of the woman takes precedence at any moment in the pregnancy over the life of the foetus.

Chairman: If the baby can be delivered at six months ....

Ms Kissling: Then delivery would be appropriate. They both could survive.

Chairman: Roe *v.* Wade has been superseded, as far as the last trimester is concerned, is not that right?

Ms Kissling: I think, to some extent, that is correct, although Roe *v.* Wade always held that abortion in the third trimester could be prohibited by the state, except to protect the life of the woman. If abortion is unnecessary at that stage to protect the life of the woman and, indeed, delivery can be effected, then delivery would be the appropriate action.

Chairman: But your position on the relative standing of the born and the unborn is that the unborn do not have any rights, but they are worthy of a measure of protection in the course of the development of the embryo. That is your position on this question.

Ms Kissling: Yes.

Chairman: In relation to the separation of church and state to which, I think, you refer in your submission, of course our constitutional arrangement expressly honours and respects religion and allows and obliges the State to support parents in their religious preferences and, in particular, allows parents to establish schools which accord with their religious preferences or their humanist preferences, if that be the case. That's a very different constitutional arrangement from that of the United States.

Ms Kissling: Yes, but it still does not preclude the concept of separation of church and state. What concretely constitutes separation of church and state can be understood differently in different legal systems. However, I do believe that there is some measure of acceptance of separation of church and state in the Irish political system and in the Irish Constitution.

Chairman: Yes, it's a fundamental value in the Constitution and the State cannot endow a religion or discriminate on the grounds of religion, but there is not a complete separation in the sense that religion is honoured and respected and there would be no question, for example, in this jurisdiction of a prohibition on prayer in the schools, so the constitutional tradition is not exactly the same. In any event, I don't quite see where the separation of church and state comes into this because our Episcopal Conference put forward that argument on the basis of moral teaching. Of course, anyone is entitled to impart a moral teaching. All of the religious bodies came into us and gave us their moral teachings. Would you like to comment on that?

Ms Kissling: I think that it may well be true … I am sure that it is true that in your presentation before this committee and in your submission the bishops argued their position not from strictly Catholic theological concepts, but also from a general sense of moral values and moral principles. I guess the question I would ask is whether the bishops really have the ability to separate Catholic principles and teachings from general moral principles and teachings. When one looks at Catholic teachings and you look at the theory of natural law, for example, within the Catholic context, what you see is still a very close link between what the Church believes is generally knowable as morally correct to all people regardless of their faith and what is, indeed, a Catholic position. It is my experience that, generally speaking, the institutional Church's assertion that, indeed, it is speaking from broader moral principles rather than the principles of Catholic teaching deserves some looking under the statements to the reality and the extent to which the institutional Church actually accepts a distinction between natural moral law, which is the basis on which they argue their position on abortion, and Catholic Church teachings.

Chairman: Yes, I take your point. Thank you very much for your presentation today.

Ms Kissling: Thank you.

Chairman: I suspend the sitting.

SITTING SUSPENDED AT 4.15 PM AND RESUMED AT 4.20 PM.

Dr Everard Hewson

Chairman: I would like to note the attendance of Dr Everard Hewson today at this meeting of the Joint Committee on the Constitution. You have written to us on numerous occasions and you have asked to make a presentation to the committee.

Dr Everard Hewson: Yes.

Chairman: So we've decided to facilitate you and allow you to make a submission to the committee.

Dr Hewson: Thank you, Chairman.

Chairman: Now the format of this meeting is that you may make a very brief opening statement, if you wish, and that will be followed by a question and answer session. I have to draw your attention to the fact that while members of this committee have absolute privilege, you do not enjoy that same privilege.

Dr Hewson: Do I enjoy any privilege?

Chairman: Well, it's a matter of some legal debate. My view, for what it's worth, it's only the view of a Member of the Parliament, of the National Parliament, is that – I am not giving it to you in any other capacity – is that if you speak without malice, you have qualified privilege.

Dr Hewson: Right.

Chairman: That is my view of the law, but my official is tugging at my arm here and saying that has never been authoritatively settled, but I believe it would be authoritatively settled, if the question ever arose.

Dr Hewson: This is one of the reasons why I brought this in with me. What I should like to think of is factual ....

Chairman: Yes.

Dr Hewson: As necessary, you have already had ....

Chairman: You're a strong opponent of the legalisation of abortion in this State. Is that a fair summary of your position?

Dr Hewson: It is not. I am an opponent of the legalisation of the devaluation of human life from it's very origins.

Chairman: Where do you trace that origin?

Dr Hewson: The origin I've just been thinking about, actually, when I was coming up today .... Article 43.3 refers to the 'unborn'. In the 1996 review report, constitutional review report, it refers to the unborn as capable of being born, on its way to being born etc. 'It' – what is 'it'? The 'it' is nil until fertilisation of the ovum by the sperm occurs and scientifically, in other words, as a matter of fact, which is relied on by the courts, especially the criminal courts in DNA fingerprinting to specify and mark an individual's human being, then I can say that the beginning of life is when the full genetic capacity of the chromosomes are achieved by the sperm uniting with the ovum. So, from the time that you have fertilised ovum, that is the beginning.

Chairman: So once conception takes place.

Dr Hewson: It depends on what you mean by conception. It has two meanings. One, it is the ovum taking in the sperm, *con* – with, *cipere* -take, and, on the other hand, the uterus taking the fertilised ovum, *con* – with, *cipere* – take, so we can look upon conception in theory as fertilisation in the lateral part of the tube or the formation of the placenta when it implants in the uterus, which might be of help to you legally.

Chairman: Yes.

Dr Hewson: Implantation.

Chairman: You take a view that implantation, which can take up to 72 hours to take place, of course.

Dr Hewson: Well ....

Chairman: That could be the decisive moment in your view?

Dr Hewson: No, the decisive moment of when there's a human being is when it's fertilised.

Chairman: Yes, that's what I would have thought.

Dr Hewson: Of course, but the point is that before that, there's nothing to be born.

Chairman: What core point do you wish to make to us in your contribution?

Dr Hewson: The core point I would make would be to ask you a few short questions and, secondly, to point out that the X ruling is not legal precedent in law.

The questions I would ask is are we dealing with criminal law or are we dealing with civil law?

Chairman: Yes.

Dr Hewson: Well, which?

Chairman: Sorry, I'm not here to be questioned.

Dr Hewson: No, but my point is .... As a matter of information, I am not clear as to whether we are discussing here the law about a civil matter or about a criminal matter.

Chairman: We are talking in the first instance, of course, about the Constitution of Ireland.

Dr Hewson: Right.

Chairman: A constitutional norm, as you know, is superior in our legal system ....

Dr Hewson: Correct.

Chairman: .... to a item of civil or criminal law, but plainly any constitutional question has implications for civil and criminal legislation.

Dr Hewson: Correct.

Chairman: That would be my answer to that.

Dr Hewson: Well, my reason, if I may make it, is that … the preliminary … that I wanted to make is .... The question of *mens rea* arises with regard to direct and indirect, medically because, as you know, legally it isn't recognised, although it is in Great Britain in the Regina *v.* Cox case, 1992 BMLR, 38.

It is also recognised by the international UN War Crimes Tribunal because it is quite obvious that the thousand Kosovans who were innocent civilians who were killed by the bombing as, for example, in the village of Korisha with 600 Albanian Muslims, whom they were supposed to protect in a warehouse … of these 84 were killed by the allied bombing by NATO planes, amongst them 12 children. The village of Korisha. That is a foreseeable side effect of the direct bombing and, if in law, they're as guilty as that as of the other, why doesn't the war crimes tribunal indict them as war criminals? In any event, it was illegal, as we know, because they broke the UN Charter, all the more so why they should be indicted. The broke the UN Charter, which doesn't allow war except with Security Council permission. I better come back to the point.

Chairman: Yes.

Dr Hewson: I'm talking about the direct-indirect effect on *mens rea*.

Chairman: Right, well do you support the direct-indirect distinction?

Dr Hewson: It's not a question of supporting something which exists. If it exists despite you, it's not a question of whether you support it or not. Objectively, it is the case that, as the judge in Regina *v.* Cox pointed out, when a doctor is treating a patient, he may pursue a course of treatment, the direct intention of which is to save the mother's life and as an aside, an unintended effect, he may in fact by that treatment endanger her life. If the mother dies as a result of this honest intention to save her life, foreseeably recognising the indirect side effect that may kill her, perhaps he would discuss it with the patient, then in law, according to the judge in Regina *v.* Cox, that doctor cannot be charged with murder, as in the case of Cox in which the doctor was convicted of killing his patient.

Chairman: Sorry, doctor, are you supporting a particular option in the Green Paper.

Dr Hewson: My option in the Green Paper is that I would think that no law should be brought in which will devalue human life from its origins. That means that you cannot bring in a law to directly kill human beings for any reason or none, as the crisis report shows, under ground C of the Abortion Act in England for silly reasons, which are on record.

Chairman: That's the wording which you would like to see put into the Constitution?

Dr Hewson: No, the wording I would like to see would be, I'm afraid, an absolute wording. I brought a copy of it here, which I can give you afterwards, but it's too long to read now. It probably too long to put in the Constitution. I say it's absolute because you cannot give legal support to killing innocent human beings, however wantonly conceived.

Chairman: Do you support a referendum to the present Constitution?

Dr Hewson: Well the point of the matter is that the, what's it called, the Oireachtas is not in a position to change it. It cannot depend on the X ruling because the X ruling is simply not legal principle … legal precedent. If you look up Salmond's jurisprudence, the chapter on precedent, 12th edition, by Fitzgerald, you'll see in that the *sub silentio* principle which has been established on these islands for the last three or four centuries.

Chairman: Yes.

Dr Hewson: Don't you know it?

Chairman: You might … is this in Salmond's jurisprudence?

Dr Hewson: Yes. If you look up the 12th edition by Fitzgerald, you'll see under … I have a copy of it here, I'll give it to you afterwards.

Chairman: Well, tell me, what does the principle say about the doctrine ....

Dr Hewson: Well, what the principle says is this – it has been long established – if there are two points, and this was told to me by my nephew who is a judge incidentally ....

Chairman: Yes.

Dr Hewson: .... in another jurisdiction.

Chairman: We better not bring him into it.

Dr Hewson: No.

There are two points perhaps at issue as there were in the X case, A and B. A is adequately evident and adequately argued, right? The judge has passed this and they rule so, based on the evidence which is sufficient and on the argument which fulfils the requirement, for example, Article 26.2.1. That is not alone applicable in the incident case, but if it is the superior court, it is also legal precedent. Right?

The second point, B, may be so attached to it so inextricably, as it were, so closely, that it isn't adequately evident and it isn't adequately argued because there is so

much time devoted to the other and *per incuriam*, through a mistake or through lack of care, as you wish, the judges ought consider it with the consideration which is due it. In the case of direct abortion, as an operation as such, there was no medical evidence. You had a lay man advising a medical surgical operation which no one would dream of having on the say so of a layman. He wasn't medically qualified and the dissenting judge kept pointing this out … kept pointing out this matter quite clearly.

Secondly, there was no argument. On pages 40 to 41 of the ICLR X report, we had a lot of reference to medical lists, personal injury cases and medical … the doctor talking about a prognosis. There was no doctor in the X case. What's the point of bringing in medical this and medical that? Suddenly, from this medical vacuum, on page 41, the learned Chief Justice asked the question of the equally learned no doubt senior counsel, acting for you and me, for the Attorney General, in a manner which was contrary to 26.2.1, as a matter of probability, if the medical evidence is that, as a probability, she will take her life, is she justified to seek an abortion? There was no medical evidence. It was a lay man speaking and the lay man, whom we now know from this tribunal, who has a preconception about so-called rape entitling a woman to kill her baby .... But you know, as well as .... If I may say so ....

Chairman: We're not .... We don't sit as a tribunal here. We're just an Oireachtas committee.

Dr Hewson: Well, I beg your pardon.

Chairman: The Oireachtas establishes tribunals which establish facts, but we're an Oireachtas committee.

Dr Hewson: I beg your pardon.

Chairman: We received various submissions and what we're doing in these hearings is, where we have difficulties with the submissions ....

Dr Hewson: Yes.

Chairman: .... where we feel people have a strong point of view, that their interests … to put forward … we hear them. The point of view, if I can summarise, that you're putting forward is that the X case is not a valid and binding and legal precedent.

Dr Hewson: I can give the reasons for it, short and to the point.

Chairman: Yes.

Dr Hewson: Right, I'll give the reasons for it – you've got them there actually already. In the first place, the judges didn't fulfil the basic written and unwritten presumptions of the Constitution – I haven't got it here; it's here somewhere, you have a copy of it.

Chairman: But you can summarise it.

Dr Hewson: It's all right, I'll summarise it. Number one, Article 34.5.1 lays down that the judges declare to execute my office with knowledge to the best of my ability, with knowledge. That doesn't just mean legal knowledge. It means knowledge of the facts of the case which they can only get by material evidence which, in this case about a medical or surgical operation, required medical or surgical evidence which was not provided.

Secondly, there was no argument. Therefore, under Article 26.2.1, because there was no argument, we find that there's a question, as Mr Brian Walsh pointed out, the late Brian Walsh, in Galway … a point unargued is a point undecided – the *sub silentio* rule in another guise. If we get on from .... We could also say that *audi alteram partem* was not fulfilled because Article 40.3.3 makes the unborn, like it or no, a living … you don't give rights to unliving things, you don't give rights to animals … and, therefore, a human being and deprived of *audi alteram partem*, there was no guardian *ad litem* appointed and such like.

If we get on to the legal principle as distinct from the constitutional, proportionality, which is supposedly guaranteed under the Treaties of Maastricht and Amsterdam … the German and Italian courts to keep out people like Hitler and Mussolini in the future … were also disregarded. There was no proportion between, for example, the knowledge that the lay witness have on which they based their sole legal principle, their sole proper test, and what he was advising, a medical or surgical operation.

To get on, proportionality, sufficiency of evidence, well the dissenting judge kept pointing this out anyway. Fair procedure – there was no fair procedure accorded to upholding the Constitution … Article 40.3, the unspoken abandoned innocent person, however wantonly conceived I grant you.

If we get to European principles, we've got the principle of protection of confidence of which the main aim in subprinciple is the legal expectation, the legitimate expectation that all professionals, including lawyers and not least judges will act with a due care and skill, reasonably expected of ordinary prudent professionals. Therefore, it is *sub silentio* – there was no evidence, there was no argument and it does not fulfil the basic unwritten presumptions under Article 34.4.6 and, therefore, it is not final and conclusive.

Chairman: You haven't thought of instituting proceedings yourself?

Dr Hewson: Yes, as a matter of fact, in 1992, I instituted … I issued a plenary summons, acting as a lay litigant, against the Attorney General for failing to fulfil his duties under Article 30 by providing the necessary and requisite opinion witnesses and such like. Having served the plenary summons, when they sent and asked me for the statement of claim, I then had realised that the points that I'm making … and I said, 'Well, this is not legal precedent so it doesn't matter'.

If abortion were to be made legal precedent here, I would repudiate my Irish citizenship and I would leave the country. One of the reasons why I intended to take the matter up myself, since no one else seemed bothered doing so – it may seem amusing ....

Chairman: I think in fairness, just before I close this session, you .... There has been great concern expressed at our hearings about the X case on a variety of grounds.

I think that's the point you're making. So, I'm very grateful for your attendance here today and I don't think .... Your submission is very detailed and I've been reading it and I thank you for coming up and meeting us today.

Dr Hewson: Not at all.

Chairman: Thank you very much.

Dr Hewson: I sent five bound volumes with a similar number of photocopies of original documents to Hawkins House and I left in copies for each of the members of the committee with Mr O'Donnell. So you've got all this in detail.

Chairman: We've got quite an amount of detail, I have to say, on the subject.

Dr Hewson: Well, the thing is, of course, maybe it's self-defeating but it's such an important matter. Do you legally devalue human life from its origins and give it legal support? It's as simple as that. The IRA don't bother, I suppose, or terrorists or whoever, or rapers and such like. Well, that's another matter, but I mean, if you're going to devalue human life, I'd be surprised … women are raped. Since they decriminalised suicide, the number of suicides, especially among children, has increased and so on. Thank you very much.

Chairman: The clear submission you want us to incorporate by way of constitutional or legislative arrangement is maximum protection for innocent human life.

Dr Hewson: If by maximum you mean complete, excluding all direct abortion, yes.

Chairman: No, maximum.

Dr Hewson: Well, what does maximum mean?

Chairman: As far as practicable.

Dr Hewson: I understand. The point is that the courts must be reasonable and the judges must be reasonable. As you know, the law is supposed to be reasonable as well as being reasonably in proportion and observe proportionality. Therefore, I presume that the judges will exercise their due care and so forth in regard to the provisions of the first section and the first subject and whatever it is of Article 40, as you say, so far as they can be vindicated, in so far as it's possible, etc.

However, the point about it .... The difficulty is that in the X case they disregarded principles right, left and centre as I mentioned and as I have detailed without being in any way malicious or unkind as a straight statement of the reality of what happened. On that basis, I'm very worried about the fact that if you leave it to certain judges, then, as Professor Ivana Bacik wrote in the *Irish Independent* of 26 January 2000, about the subjectivity of judges, and on page 95 of her book, with Kingston and Whelan, Abortion and the Law, she states under general principles of law that, of course, in countries like Ireland and Germany the outcome of judicial cases, court cases concerning direct abortion, have been a matter of luck – a point made by Mr Dessie O'Malley on the wireless about a legal case in which he referred to the outcome as a lottery. In other words, the subjectivity of the judges is all important.

Chairman: Very good. Well, thank you very much for your assistance.

Dr Hewson: Not at all.

SITTING SUSPENDED AT 4.41 PM AND RESUMED AT 4.42 PM.

Ms Lelia O'Flaherty

Chairman: I will resume the public session. I would like to welcome Ms Lelia O'Flaherty to this particular meeting of the Joint Committee on the Constitution. You made a written submission to the committee which was received in the committee offices and noted. I think you wrote last Monday ....

Ms Lelia O'Flaherty: Friday.

Chairman: .... last Friday seeking to make a presentation. I was not disposed to call you but I was advised today that you had in fact made a written submission and you are here today. No one else has made such a request. We're about to finish our hearings, so I will hear you. The format, as you know by now, is that you may make a statement elaborating on your submission, if you wish, and that will be followed by a question and answer session. I have to draw your attention to the fact that while members of the committee have absolute privilege, this same privilege does not apply to you.

Ms O'Flaherty: Thank you very much, Mr Chairman. It was when I learned that a number of extra, if you like, people might be speaking to you today, that was the reason why I wrote in to you. So I'd just like to thank you very much indeed for giving me the opportunity to say a few words. I wasn't totally prepared for today, so you'll have to forgive me. I have a sort of a draft of thoughts I put down over the weekend. So, is that all right?

Chairman: Yes. Have you been following the hearings? You've been here a few times, I think.

Ms O'Flaherty: I have.

Chairman: Yes. Well, develop your points.

Ms O'Flaherty: All right. I'll read, if that's okay.

Chairman: Yes.

Ms O'Flaherty: My understanding of the reason why your committee has invited both written and oral submissions is that you wish to contain and put a legal framework on the judgment of the Supreme Court in 1992 following the X case.

When the Bourne case in the UK led to the Abortion Act of 1967, it was no doubt sincerely thought that abortion would be legalised only in limited circumstances. We now know that the case on which the Bourne judgment was made was based on a false claim and that it has resulted in the killing by abortion of five million unborn children since that time. We also know that Dr Bourne was so horrified at what resulted from his no doubt well meaning intervention that he became one of the founder members of the Society for the Protection of the Unborn Child in the UK.

Similarly, the Roe *v.* Wade case in the US opened the way for the deaths of millions of unborn children by abortion there. And again we know now that Jane Roe has since revealed that she was used as a pawn in the push to legalise abortion in the US. We now know that the evidence on which the X case judgment was made was wrong and that the Supreme Court judgment was seriously flawed.

I have been looking on the Internet at some of the submissions presented here to you. Despite the fact that very nearly 100% of all the written submissions made both to the interdepartmental working group on abortion and to your own committee called for a properly worded referendum which would restore and ensure for all time, unequivocally, protection for the unborn child while, at the same time, protecting existing medical practice in relation to the mother, nevertheless you appear to be at pains to find some excuse to allow for abortion in limited circumstances. Now, as has been pointed out to you during the course of these hearings and as we all know, wherever abortion has been allowed in limited circumstances, this has inevitably led to the legalisation of very wide and open abortion regimes. Is this what we want in Ireland?

In the EU in recent times our MEPs voted in favour of abortion. What pressure were they under? The committee of CEDAW has admonished the Irish Government on what they term our restrictive abortion laws and they tell us that hardship is being caused to asylum seekers because of our restrictive abortion laws. Is this what all of this is about, that we must bow to the EU and the UN and legalise in Ireland the killing of unborn children?

Dr McKenna stated here recently in relation to the young girl in the X case that – now just for time I won't give the whole quotation, I'll just give a short one.

Chairman: No, you can give the full quotation.

Ms O'Flaherty: 'I must say I do share some of the reservations that are expressed by many of the people who have written to this committee about the conclusion that was arrived at and how it was arrived at in 1992'. Again, he stated, 'I felt that the evidence presented from the suicide point of view was not challenged, for whatever reason. In other words it was not subject to scrutiny by a second or indeed a third opinion'. Further, he said that when he was asked at the time whether the X case girl was depressed, he replied, ' No, she is upset, she is tearful'. Mr Lowe, in his submission to you here on 9 May said, 'I'm not a medical person, I'm a principal clinical psychologist'. He was quite emphatic when asked about the X case that he didn't want to talk about it, that he 'believed that was not something that was going to be dug out later'. Yet here is a clinical psychologist on the sole evidence of whom the X case girl was declared suicidal and as a result of which the Supreme Court 1992 judgment was made, here he is now saying that he doesn't want to talk about it nor about suicide either. And here we are sitting around a table discussing how best to legalise abortion in this country, because that's what's being done here.

Do you really know what abortion is? There has been a lot of discussion at these hearings as to a definition of the word abortion. There may very well be various dictionary definitions of the word but what the vast majority of people in Ireland anyway and world-wide understand when you refer to abortion is the direct and intentional killing by whatever means of an unborn child at whatever stage of his or her development from conception up to birth and including birth. At the moment of birth, the killing of the child is called partial birth abortion. After birth, the killing of the child is called infanticide. In the UK recently there was discussion on the possible acceptance of fourth trimester abortion, that is, killing a child up to three months after birth. Once you introduce the legalisation of abortion, you have opened the gates to abortion on demand.

During the course of these hearings there has been, as far as I can see, great emphasis put on two areas in particular. The first of these is the concerns of the masters of the three maternity hospitals who gave evidence to you. These concerns appear to centre on the fact that if there is a total ban on abortion then they fear that what has always been accepted in Ireland as medical treatment required for a pregnant mother would in some way or other be penalised. Why this sudden alarm?

The Medical Council guidelines state in a very straightforward way:

> The deliberate and intentional destruction of the unborn child is professional misconduct. 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. Refusal by a doctor to treat a woman with a serious illness because she is pregnant would be grounds for complaint and could be considered to be professional misconduct.

Standard medical treatment does not involve killing a child. The age at which a premature child can survive is coming down all the time and the medical team will do everything they can to preserve the life of the child as well, of course, as the life of the mother. If, despite all the efforts of the medical team, there is no possibility owing to the prematurity of the child that that child could or would survive, then that is not unethical and the Medical Council confirms this.

There has been very little reference made here to the evidence of Professor O'Dwyer, Professor Clinch, Dr Conway and Professor Bonnar. In fact, what they said to

you appears to have been very much ignored altogether. I would like to quote to you from Dr Conway. He said:

> Our obstetric care in this country, certainly for the last 30 years, is probably the safest place for the mother and her baby in the whole world, and I do not think anybody would dispute that at the present time. If you change it, I guarantee you that [i.e. medical care] will change.

Professor O'Dwyer, in his evidence, told you that in over 40 years of looking after mothers and their babies, not one of the 9,000 mothers under his care died because of the absence of abortion.

Why do you not listen to these people? Why do you have such concern for the concerns of the three Masters? Yet, you appear to be ignoring totally the expert advice of someone who has worked as an obstetrician for over 40 years and who can categorically state that abortion is never necessary to save the life of a mother. Why are you so set on legalising abortion in limited circumstances?

Chairman: We have not arrived at any conclusion on this committee.

Ms O'Flaherty: I accept that, but just the way ....

Chairman: Your submission is very interesting and shows a tremendous awareness of what has been transacted before the committee, but our task is not how best to legalise abortion, as you put it. Our task is to consider a Green Paper, which I have no doubt you're familiar with, which was referred to us by the Minister for Health. That is our task, as members of the Parliament, of the Dáil and the Seanad. Our task is not to legalise abortion. As much as ....

Ms O'Flaherty: I accept that.

Chairman: Your submission is very interesting and that is the only exception I take to what you have said. I do take exception to that and I think the members would expect me to raise that issue.

Ms O'Flaherty: All right. I accept ....

Chairman: We do not have a task of that type set before us. We have a Green Paper to consider.

Ms O'Flaherty: All right.

Chairman: But, certainly, proceed because I find your analysis of the evidence very interesting.

Ms O'Flaherty: It is not very much longer, anyway.

Chairman: That is your own business.

Ms O'Flaherty: What you have to do – it may appear as if I am telling you, but these are just my thoughts ....

Chairman: No, you are a citizen, you are entitled to give your view. Give your view.

Ms O'Flaherty: Thank you.

Chairman: I told you where we stood, you tell ....

Ms O'Flaherty: What you must do is to roll back, by constitutional referendum, referring to Article 6 of Bunreacht na hÉireann, the Supreme Court 1992 judgment, and then make legally watertight the wording of the 1983 referendum. In conjunction with these measures, every effort must then be made for, and every support and assistance given to, a pregnant mother to whom abortion might have seemed to be the only way out of her dilemma.

The second area in which you appear to be particularly interested is that relating to the 5,000 to 6,000 Irish women and girls who go to the UK annually for an abortion. The so-called 'limited circumstances' would not cater for these people.

We agree, I am sure, that even one abortion is one too many. How do you, at least, reduce as far as possible that number? Certainly not by promoting or providing more contraception. Abortion is quite often resorted to because of failed contraception. When Alan Guttmacher, of Planned Parenthood, was asked how best to ensure abortion would be firmly established, he replied 'More sex education'. He should know.

I suggest to you that there are many things you can do to help reduce the number of abortions. One of these – and I am quite serious about this – is that you would immediately ban all advertising for the sale of alcohol. A survey carried out in Limerick some time ago showed that alcohol was responsible, to a large extent, for unplanned pregnancies. Young people, in particular, are very prone to peer pressure and they should be constantly encouraged, therefore, to say 'No' when put under pressure from other young people. They should also be encouraged to respect the integrity and dignity, not only of themselves but also of others. More truthful and accurate information about abortion should be made available, especially to young people, so that they will understand the real facts of abortion – the pain suffered by the baby, the immediate and long-term medical and psychological effects on the mother, etc. I will also mention what came up this morning, which is the very important matter of post abortion syndrome, which does not seem to have got – generally, I mean, not from you – the attention which it should have got and should be receiving. Thank you.

Chairman: Thank you very much. I am sorry for interrupting, because it was a very interesting submission. One of the reasons we heard the doctors first was to inform the debate, in a sense, and you have reacted to that. Would that all of the people who made submissions did that and informed their view in that perspective.

The other criticism you made of us was that we were inclined to listen too much to the evidence of the masters. But the masters are the senior people in the three big maternity hospitals. I think it was Dr Conway himself who said to us that when there are problem cases they are referred to these hospitals.

Ms O'Flaherty: Yes, I read that.

Chairman: A huge proportion of the problem cases are addressed in the major maternity hospitals, the teaching hospitals. We have to have some regard to the evidence of the people who are actually running those hospitals

today, in relation to what their practices are. I think that is why there was a concern about that.

Ms O'Flaherty: What I took from Dr Conway's comment in that regard was that hospitals outside Dublin would not necessarily have the expertise to deal with situations which might arise and, say, those to which Professor O'Dwyer referred. I don't think Dr Conway meant in any way that he would send somebody to Dublin for something he wouldn't approve of ....

Chairman: I was not suggesting that at all. No, no. What I was suggesting was that the vast majority of complicated cases in childbirth and in connection with pregnancy are treated and cared for in these institutions.

Ms O'Flaherty: Yes, but then Professor O'Dwyer pointed out, and Dr Clinch I think too, that there is no necessity. Maybe it comes back again to the definition of abortion. I know you have had a lot of discussion on that but I think, basically, in the long run it comes back to that.

People outside this room – I am not saying in this room … a lot of people tend to, whether by choice or unthinkingly so, associate abortion with medical treatment. They are two totally different things. Again, all the discussion you have had about intent. Medical treatment does not involve taking a child out and killing it. That is what abortion is. That is what is accepted worldwide. That is what over 70% of the Irish people took to mean by 'abortion' when they looked for a properly pro-life worded referendum. Abortion is killing the child. Abortion is what happens to the vast majority – I think it is over 98% – of the women and girls who go to Britain from Ireland, for social reasons. If there were a medical reason, that could adequately, and more than adequately, be treated in Ireland, as has been shown over the years. Even UNICEF pointed out that we are the safest country in the world for a mother and her child. So, if there are medical complications, which is what you are trying to cater for in legislation, that doctors won't be penalised for carrying out medical treatment – am I correct in that?

Chairman: Yes.

Ms O'Flaherty: Medical cases can, as I say, be more than adequately looked after in Ireland.

Chairman: Yes, with appropriate legislation, but a very large number of people go to England. They are our citizens as well.

Ms O'Flaherty: Yes, and that is a problem which we must tackle, but it is not a problem to be tackled in any way by providing abortion for them in Ireland.

Chairman: Public opinion here is not ready to compromise its moral principles by doing that – isn't that your point?

Ms O'Flaherty: Whether it is or not, I think it would be the worst possible solution in the world. In fact, it would not be the solution at all. Apart from the moral aspect of it, in every other country in the world where abortion – that is, the killing of the unborn child – has been legalised, the numbers have gone up. So it does not cure the problem. The problem is alleviated – I suppose it will never be totally cured, unfortunately – but the problem can be addressed and alleviated, to a large extent, by more information explaining to people what abortion actually is. I do not know if you are aware of the little feet, the precious feet, which is the symbol ....

Chairman: Of course. I am quite familiar. I am a Member of Dáil Éireann and I meet people regularly who carry them.

Ms O'Flaherty: People ask me what it represents and when I tell them it represents the size and perfection of an unborn child at ten weeks, probably before the mother is even aware that she is pregnant, they are absolutely amazed. I think, unfortunately, a lot of people don't understand about the development of the human being from conception. If they did, number one, they would be very careful to avoid unnecessarily, or...I can't think of the proper word now, but to be in the position where they may become pregnant.

Chairman: As you know, our President referred to this issue in her address to the Houses of the Oireachtas last winter.

Ms O'Flaherty: Yes, indeed, and she referred to the story of the little baby Samuel. That's what you are referring to?

Chairman: Yes.

Ms O'Flaherty: Yes, who was operated on.

Chairman: It is 5 o'clock.

Ms O'Flaherty: Well, thanks very much indeed then.

Chairman: I want to thank the staff of the Houses of the Oireachtas for assisting the Joint Committee, because often they have waited beyond 5 o'clock so that we could finish our questioning. This evening we have just finished at five. Thank you very much for your assistance.

Ms O'Flaherty: Thank you very much indeed, Mr Chairman, and all the members of the committee.

Chairman: You are very welcome. Thank you.

THE JOINT COMMITTEE ADJOURNED AT 5.02 PM SINE DIE.

Appendix V

SUBMISSIONS (GENERAL)

Appendix V

SUBMISSIONS (GENERAL)

PRO-LIFE CAMPAIGN
34 GARDINER STREET UPPER, DUBLIN 1
VALUING* ALL *HUMAN LIFE
30TH NOVEMBER 1999

INTRODUCTION

The All-Party Oireachtas Committee on the Constitution is charged with reviewing the issues raised and the solutions proposed in the Green Paper on Abortion within a constitutional perspective, considering the implications of the various proposals for the values on which the Constitution, and our democracy, are based.

The Pro-Life Campaign's Submission is based on the view that all human beings possess an equal and inherent worth by virtue of their humanity, not on condition of size, level of physical, emotional or mental capacity or development, dependence, race, ethnic origin, financial status, age, sex or capacity for interpersonal relationships.

Constitutional democracy is based on the equal and inherent value of every human life and the equality of all before the law. If these values are not respected, one simply cannot have a democratic society. Abortion, denies the equal inherent dignity and worth of the unborn and treats them unequally before the law. If the principle of equality is respected, then one cannot legalise abortion.

The aim of this Submission is to evaluate the options proposed in the Green Paper on Abortion, as requested by the All Party Oireachtas Committee, in terms of their compatibility with these values. To evaluate the seven proposals set out in the Green Paper, it is necessary to take up statements made in other chapters, so this Submission includes a section on the medical issues, one on the legal issues in which the seven options are discussed, and a section on the social context of abortion.

The social policy framework in which the issue of abortion should be addressed

The All Party Oireachtas Committee on the Constitution's call for submissions on the Green Paper's seven options, involves the public in its deliberations, making it a defining moment for Ireland as a modern democracy. The needs of women and children facing crisis pregnancies present us with a profound challenge. The attitude we adopt to them shapes who and what we are and what we stand for as a people.

The public back support for women in crisis pregnancy

People in Ireland today are fair-minded and generous - they see the need to change attitudes and social policies so that every woman facing a crisis pregnancy knows and feels she has real alternatives to abortion. As the recent Pro-Life Campaign/INIS poll found, there is a huge groundswell of public backing for the provision of an ample range of professional, practical and personal supports for them.

A referendum to protect the unborn will strengthen public commitment to support women in crisis pregnancy

The Pro-Life Campaign believes that the public commitment to putting in place the supports women need will be strengthened by a referendum restoring adequate legal protection to the unborn. Polls show a consistent and substantial majority of the public support such a referendum.

Our Submission responds to the Green Paper on Abortion's review of the medical issues, showing that the legalisation of induced abortion is not needed to safeguard medical treatment of women, and surveys its discussion of the legal issues, in particular answering objections to Option One, a constitutional amendment to ban induced abortion.

The Pro-Life Campaign would welcome an opportunity to make an oral presentation to the All-Party Oireachtas Committee on the Constitution.

Pro-Life Campaign
30th November 1999

CHAPTER ONE
PREGNANCY AND MATERNAL HEALTH

Introduction

In its introduction, as elsewhere, the language used by the Green Paper is unnecessarily confusing and inaccurate. The term *termination of pregnancy* is not an adequate term for induced or procured abortion. As everyone knows, all pregnancies are terminated – most with the normal delivery of a live healthy baby. It is in this sense

that the term termination of pregnancy is used in some papers cited in the references found in the Green Paper.[1] Other cited papers speak of early termination of pregnancy in cases where foetal death has already occurred *in utero* – a perfectly correct use of the term that has no implications for induced abortion.[2] We strongly recommend that the Government adhere to the more accurate terms of *induced* or *procured* abortion where it is clear that the intent of the procedure is to procure, by means of the procedure, the death of the unborn child and where, furthermore, the survival of that child would constitute a failure of the procedure.

As indicated in the introduction, Ireland's maternal mortality rate is so low that it can hardly be improved upon. This, we suggest, makes it clear that there can be no grounds to support an argument of medical need for induced abortion to save women's lives.

The Green Paper quite rightly points out that there are anecdotal and case reports in the medical literature where an induced abortion was carried out with the purported intent of saving a woman's life. The Green Paper also rightly goes on to point out that there is no evidence to show that this was the only course of action open to the clinicians managing the particular patients and that, accordingly, it is unsafe to conclude that the woman's life could not have been saved by means other than by induced abortion. The mere fact that an induced abortion was carried out in particular circumstances is not evidence that it was necessary. This is particularly so when the source of the article or case report is a jurisdiction where induced abortion is an accepted fact of life and medical practice.

The Medical Council, the statutory body regulating the medical profession in this country, has repeatedly affirmed that induced abortion is medical misconduct and that doctors have a duty of care to both the mother and her unborn child. In the 1998 Guide to Ethical Conduct and Behaviour it states unequivocally that '*the deliberate and intentional destruction of the unborn child is professional misconduct*'.

Maternal mortality

The Green Paper notes an Irish study of maternal mortality which observed that the absence of the provision of induced abortion in this jurisdiction had not had any detrimental effect on our rates of maternal mortality. It is apposite to note that previous studies of Irish maternal mortality had reached the same conclusion.[3]

In this section the Green Paper also alludes to the fact that so called therapeutic abortion can itself be a cause of maternal deaths. In this regard it should be noted that the Report on Confidential Enquiries into Maternal Deaths in Britain for the triennium 1991-1993 reports 5 deaths directly attributable to legal induced abortion and a further 4 deaths from suicide and/or drug overdose in women who had had legal induced abortions within the previous year.

In the Report on Confidential Enquiries into Maternal Deaths in Britain for the following triennium 1994-1996 there was one death from the induced abortion procedure itself and a further 11 deaths associated with legal induced abortions. One death was a suicide, 2 deaths resulted from thrombosis/thromboembolism, one death each from myocardial infarction and from a ruptured ectopic pregnancy (after an induced abortion had supposedly been performed) and finally 6 deaths occurred in women who had so-called medically indicated induced abortion for cardiac conditions such as primary pulmonary hypertension and Eisenmenger's Syndrome.

A review of maternal mortality from induced abortion over a 15 year period in the United States found 240 woman died as a result of legal abortions: the main causes of death were sepsis, haemorrhage and anaesthetic complications. It is generally accepted that such deaths are underreported.[4]

Abortion trends

This analysis of the Green Paper confirms what has been often noted in the debate about induced abortion: namely, that once legal induced abortion is introduced, for whatever reason, the number of abortions inevitably increases, as those who are tolerant of abortion will use the grounds established by law to fit the need of the particular case. If one can find a reason to abort 180,000 unborn children in any one year in Britain, then one can find a reason to abort any one.

Maternal mortality and termination of pregnancy (meaning induced abortion)

The first section of the Green Paper on this issue lacks clarity because of the confusing use of terminology as noted above. It is indeed normal practice to terminate a pregnancy in cases of severe preeclampsia and eclampsia but this termination is not an induced abortion but rather the delivery, by medical or surgical means, of a pre-term infant.

The definition of direct abortion as given in this section is both inaccurate and misleading. A direct abortion is not, as stated in the Green Paper, 'the termination of the pregnancy with the objective of preventing or treating the underlying maternal condition'. An example of such a termination of pregnancy would be the early delivery of an unborn child at, say, 27 weeks gestation, in order to treat severe pre-eclampsia in the mother. This child would have a greater chance of surviving following delivery than if the pregnancy were allowed to continue. A direct abortion is, in fact, a procedure, the aim of which is the death of the unborn child, whose continued survival, as noted above, would constitute a failure of the procedure.

The distinction between direct and indirect effects for the purposes of induced abortion has already been set out in the Pro-Life Campaign's Submission to the Inter-Departmental Working Group on the Green Paper;

1 For example Probst BD: Hypertensive disorders of pregnancy. *Emerg Clin North Am* 1994 Feb, 12(1): 73-89 and Hsieh TT, Kuo DM, Lo LM, Chiu TH: The value of cordocentesis in management of patients with severe preclampsia. *Asia Oceania J Obstet Gynaecol* 1991 Mar,17(1): 89-95.

2 For example Alsulyman OM, Castro MA, McGehee W, Murphy Goodwin T: Preeclampsia and liver infarction in early pregnancy associated with the antiphospholipid syndrome. *Obstet Gynecol* 1996,88: 644-6 and Elliot D, Haller JS: Eclampsia: a paediatric neurological problem. *J Child Neurol* 1989, 4: 55-60.

3 Murphy, J, O'Driscoll K: Therapeutic Abortion: the medical argument. *Ir Med J* 1982, 75:304-6.

4 Herschel WL et al: Abortion Mortality, United States, 1972 through 1987. *Am J Obstet Gynecol* 1994, 171: 1365-72.

Appendix D pages 53-55. Briefly put, all treatments have side-effects. Some are major and life-threatening, some minor and merely irritating. In choosing the best treatment for any patient, a medical practitioner must choose the most effective and least toxic in terms of unwanted side-effects. However, in those situations where the illness is grave and life-threatening, the likely direct benefits of certain treatments may be held to outweigh the risk from unwanted side-effects. But, in those rare and difficult situations where a patient in fact dies as a consequence of an unintended side-effect of treatment it has always been understood by the profession, the patient's relatives, society and the courts that what was sought was the best outcome for the patient, not his death. It was not intended to kill him. For if this was not so clear, who in fact could ever practise medicine as doctors would be continually before the courts answering charges of assault and homicide? Such considerations apply equally strongly to an ill mother in pregnancy, be that illness a consequence of cancer, leukaemia, severe bleeding or whatever. To propose that abortion legislation is necessary in order to treat ill mothers where such treatment may result in the death or deformity of the unborn child is tantamount to suggesting that homicide be decriminalised so that doctors wouldn't be charged in respect of a patient's death, say, following major surgery. The idea of legal intervention by a third party to direct that treatment be otherwise than that dictated by good, modern medical practice is risible and irrelevant in a modern context.

Cancer

This section of the Green Paper broadly represents and endorses the position taken by the Medical Council, Doctors for Life and the Pro-Life Campaign. It is, perhaps, worth re-iterating that chemotherapy and radiotherapy may be given to a pregnant woman if required. The Green Paper makes the point that such treatments may have deleterious effects on the foetus but, with judicious choice of drugs and careful screening and more accurate radiation dosing and focussing, these effects can be minimised. For more extensive treatment of this issue and appropriate references we attach as Appendix G a paper on this topic prepared by Doctors for Life and included in their submission to the Inter-Departmental Working Group on the Green Paper.

Cardiac disease in pregnancy

Improvements in diagnosis and surgical technique for correction have led to an increasing number of women with congenital heart disease reaching childbearing age. With one exception, there is no increased mortality associated with pregnancy in such conditions.[5] Eisenmenger's Syndrome is an eponym that is applicable to 12 different congenital cardiac lesions.[6] Recently published retrospective studies of the condition in both males and females indicate that most patients survive for 20 to 30 years, although they can lead adequate though symptomatic lives until late middle age or longer.[7]

As an indication of the rarity of the incidence of pregnancy in Eisenmenger's Syndrome, no more than a couple of hundred cases are reported in the whole of the world medical literature. For example, between 1991 and 1995, only 15 cases were identified in Britain.[8, 9] In Ireland, only two cases have been identified in the past 20 years. It is readily acknowledged that pooling of data on rare medical conditions in pregnancy is required to aid management of individual cases.[10] The problem for many patients is that they are scattered as occasional clinical curiosities in practices and non-specialised clinics.[11]

Eisenmenger's Syndrome is a serious and generally life-shortening illness for which no surgical treatment is available. Early consideration of heart-lung or lung transplantation – the only significant interventions that are effective – may be required.[12] When carried out, pregnancy should not pose particular difficulties.[13]

Given the rarity of the condition, its serious and life threatening nature and the very high risk of sudden death and death following any surgical intervention, it is hardly surprising that pregnancy is also associated with a high mortality. The only firm conclusion that such studies as have been carried out on patients with severe cardiac disease in pregnancy lead to is this: they should be treated in specialist tertiary referral centres. With care in such centres, it is expected that patients with Eisenmenger's Syndrome will have a 60-80%-plus chance of survival, while foetal survival is now expected to exceed 90%, compared with less than 60% in the past.[14, 15] This situation may further improve with anaesthetic advances and heart lung transplants.[16]

It is furthermore clear, that induced abortion is also a hazardous procedure in these patients. As already noted, the Report on Confidential Enquiries into Maternal Deaths in Britain for the triennium 1994-1996 indicated that there had been 6 deaths during or following induced abortions performed because of maternal cardiac disease in that

5 Schmaltz AA, Neudorf U, Winkler UH: Outcome of pregnancy in women with congenital heart disease. *Cardiol Young* 1999 Jan, 9 (1): 88-96.

6 Lieber S, Dewilde P, Huyghens L, Traey E, Gepts E: Eisenmenger's syndrome and pregnancy. *Acta Cardiol* 1985, 40 (4): 421-4.

7 Somerville J: How to manage the Eisenmenger syndrome. *Int J Cardiol* 1998 Jan 5, 63 (1): 1-8.

8 Chelsea and Westminster Hospital, London: Eisenmenger's syndrome in pregnancy: maternal and fetal mortality in the 1990s. *Br J Obstet Gynaecol* 1998 Aug, 105 (8): 921-2.

9 See, for example, Oakley CM, Nihoyannopoulos P: Peripartum cardiomyopathy with recovery in a patient with coincidental Eisenmenger ventricular septal defect. *Br Heart J* 1992 Feb, 67 (2): 190-2.

10 Chelsea and Westminster Hospital, London: Eisenmenger's syndrome in pregnancy: maternal and fetal mortality in the 1990s. *Br J Obstet Gynaecol* 1998 Aug, 105 (8): 921-2.

11 Somerville, J: How to manage the Eisenmenger syndrome. *Int J Cardiol* 1998 Jan 5, 63 (1): 1-8.

12 Weiss BM, Atanassoff PG: Cyanotic congenital heart disease and pregnancy: natural selection, pulmonary hypertension, and anesthesia. *J Clin Anesth* 1993 Jul-Aug, 5 (4): 332-41.

13 Chinayon P, Sakornpant P: Successful pregnancy after heart-lung transplantation: a case report. *Asia Oceania J Obstet Gynaecol* 1994 Sep, 20 (3): 275-8.

14 Gummerus M, Laasonen H: Eisenmenger complex and pregnancy. *Ann Chir Gynaecol* 1981, 70 (6): 339-41.

15 Chelsea and Westminster Hospital, London: Eisenmenger's syndrome in pregnancy: maternal and fetal mortality in the 1990s. *Br J Obstet Gynaecol* 1998 Aug, 105 (8): 921-2.

16 Weiss BM, Atanassoff PG: Cyanotic congenital heart disease and pregnancy: natural selection, pulmonary hypertension, and anesthesia. *J Clin Anesth* 1993 Jul-Aug, 5 (4): 332-41.

period. There is no evidence in the medical literature that justifies, on ordinary clinical and research criteria, induced abortion in heart disease in pregnancy. In this regard it is also apposite to note that there is no evidence from the annual reports of our maternity units that induced abortion would have altered the outcome in any pregnant woman with cardiac disease. Nor is there any evidence that Irish women with cardiac disease seek induced abortion in Britain on that account.

Nobody would deny that women with serious heart disease, especially Eisenmenger's Syndrome and primary or secondary pulmonary hypertension, should be cautioned about the risks inherent in pregnancy. Nevertheless, with careful cardiac and obstetric management in a tertiary referral centre better than heretofore maternal and foetal outcomes are now expected.[17, 18, 19, 20] With improved anaesthetic[21, 22] and intensive care the outcome should be better than ever before.

Ectopic pregnancy

Tubal gestations,which constitute up to 95% of ectopic pregnancies, do not consist of ongoing viable gestations, but rather are in the process of dying within a confined area. There are no official figures available for the rate in Ireland but reports in the medical press suggest that it is between 0.3% to 1% of all pregnancies. In the United States, the rate is 14 per 1000 pregnancies[23, 24] and 11 per 1,000 pregnancies in Sweden.[25] The highest rate occurs in women over 35 years of age,[26] being three-fold higher than in the 15 to 24 age group. The mortality rate from ectopic pregnancy in the United States has fallen by over 80% over the past 20 years.[27] This fall in mortality is not age related but reflects a fall in the overall case fatality. In the past 25 years, there has been one death from ectopic pregnancy in Ireland out of an excess of 1.6 million births. No such death has been recorded for nearly 20 years.[28] Nevertheless, 12 such deaths occurred in the last triennium examined by the Report on Confidential Enquiries into Maternal Deaths in Britain, where an induced abortion on request regime operates. One of these deaths was of a woman who supposedly had an induced abortion but subsequently collapsed and died: post mortem confirmed a ruptured ectopic pregnancy.

Patients with ectopic pregnancy (up to 90%) present because of tubal rupture or bleeding (in which cases emergency intervention is mandatory) or with tubal distension (caused mainly by bleeding into the original gestational sac).[29] Tubal gestations result in either foetal death followed by spontaneous resorption or tubal bleeding/rupture followed by foetal death. In either situation, the outcome for the pregnancy is the same. Hence the determinant of treatment is maternal outcome and the goal of treatment is control of haemorrhage and prevention of maternal mortality.

Thus, surgery has been the mainstay of treatment since the report of the first successful surgical treatment in 1884.[30] Salpingectomy is the standard surgical treatment for tubal pregnancy regardless of the site of implantation.[31] Linear salpingotomy, making a linear incision in the fallopian tube and subsequently closing the incision, was first described in 1953.[32] Linear salpingostomy, where the linear incision is left open, is currently the preferred surgical method of treating uncomplicated (early-recognised) ectopic pregnancy. However, its use is limited, essentially to those clinical situations where the patient is haemodynamically stable and the tube is unruptured.[33] Systemic methotrexate was first used in the treatment of an interstitial pregnancy in 1982.[34] Again, its use is limited, essentially to those situations where the patient is haemodynamically stable and the tube is unruptured.[35] The presence of ectopic foetal cardiac activity is regarded as an absolute contraindication to systemic chemotherapy,[36, 37, 38] It offers no advantage over laparoscopic surgery unless the diagnosis of ectopic pregnancy can be consistently established with transvaginal ultrasound (10-15% of cases). Only 12% to

17 Weiss BM, Atanassoff PG: Cyanotic congenital heart disease and pregnancy: natural selection, pulmonary hypertension, and anesthesia. *J Clin Anesth* 1993 Jul-Aug, 5 (4): 332-41.

18 Smedstad KG, Cramb R, Morison DH: Pulmonary hypertension and pregnancy: a series of eight cases. *Can J Anaesth* 1994 Jun, 41 (6): 502-12.

19 Avila WS, Grinberg M, Snitcowsky R, Faccioli R, Da Luz PL, Bellotti G, Pileggi F: Maternal and fetal outcome in pregnant women with Eisenmenger's syndrome. *Eur Heart J* 1995 Apr, 16 (4): 460-4.

20 Chia YT, Yeoh SC, Viegas OA, Lim M, Ratnam SS: Maternal congenital heart disease and pregnancy outcome. *J Obstet Gynaecol Res* 1996 Apr, 22 (2): 185-91.

21 See, for example, Goodwin TM, Gherman RB, Hameed A, Elkayam U: Favorable response of Eisenmenger syndrome to inhaled nitric oxide during pregnancy. *Am J Obstet Gynecol* 1999 Jan, 180 (1 Pt 1): 64-7.

22 Snabes MC, Poindexter AN: Laparoscopic tubal sterilization under local anesthesia in women with cyanotic heart disease. *Obstet Gynecol* 1991 Sep, 78 (3 Pt 1): 437-40.

23 Centers for Disease Control: Ectopic Pregnancy: United States, 1981 – 1983. *MMWR* 35: 289, 1986.

24 Stock, RJ: The changing spectrum of ectopic pregnancy. *Obstet Gynecol* 71: 885, 1988.

25 Westrom L, Bengtsson LPH, Mardh P-A: Incidence, trends and risks of ectopic pregnancy in a population of women. *BMJ* 282: 15, 1981.

26 Dorfman SF: Epidemiology of ectopic pregnancy. *Clin Obstet Gynecol* 30: 173-190, 1987.

27 Centers for Disease Control: Current trends: Ectopic pregnancies: United States, 1979-1980. *MMWR* 33: 201, 1984.

28 *Vital Statistics 1980-1998*. Department of Health Vital Statistics Unit.

29 Stock RJ: Tubal pregnancy; associated histopathology. *Ob Gyn Clin North Am* 18 (1): 73-94, 1991.

30 Tait RL: Five cases of extrauterine pregnancy operated upon at the time of rupture. *BMJ* 1: 1250, 1884.

31 Vancaille TG: Salpingectomy. *Ob Gyn Clin North Am* 18 (1): 111-122, 1991.

32 Stromme WB: Salpingotomy for tubal pregnancy. *Obstet Gynecol* 1: 472, 1953.

33 Thornton KL, Diamond MP, DeCherney AH: Linear salpingostomy for ectopic pregnancy. *Ob Gyn Clin North Am* 18 (1): 95-109, 1991.

34 Tanaka T, Hayashi H, Kutsuzawa T, et al: Treatment of interstitial ectopic pregnancy with methotrexate: Report of a successful case. *Fertil Steril* 37: 851, 1982.

35 Ory SJ: Chemotherapy for ectopic pregnancy. *Ob Gyn Clin North Am* 18 (1): 123-134, 1991.

36 Ory S, Villanueva A, Sand P, Tamura R: Conservative treatment of ectopic pregnancy with methotrexate. *Am J Obstet Gynecol* 154: 1229, 1986.

37 Sauer M, Gorrill M, Rodi I, et al: Nonsurgical management of unruptured ectopic pregnancy: an extended clinical trial. *Fertil Steril* 48: 752, 1987.

38 Stovall T, Ling F, Smith W, et al: Successful non-surgical treatment of cervical pregnancy with methotrexate. *Fertil Steril* 50: 672, 1988.

32% of all ectopic pregnancies fulfil these criteria.[39, 40] Salpingocentesis is also confined to those situations where the ectopic is small and unruptured.[41] It may be associated with systemic side-effects and the effects of local injection of some substances on the delicate endosalpinx is unknown[42, 43, 44] and questions about future fertility remain unresolved.

Preliminary studies have shown that fertility potential following systemic chemotherapy is only comparable to that of patients treated laparoscopically.[45] Only one-third of women with ectopic pregnancies later deliver children[46] and results have not improved significantly over the last thirty years. The rate of repeat ectopic pregnancy remains high (16%) and the live birth rate relatively low (30-40%). A tendency towards a higher live birth rate in those treated conservatively is paired to a clearly higher rate of repeated ectopic pregnancy.[47]

Conceptually, and clinically, the management of ectopic pregnancy does not impact on the debate on induced abortion. The International Classification of Diseases (ICD-10) classifies the diagnosis and management of ectopic pregnancy quite disjunctively from issues in relation to induced abortion. Some of the so-called 'newer techniques' for the treatment of ectopic pregnancy have been in use for up to a generation. In no other jurisdiction in the world has the issue of the treatment of ectopic pregnancies been raised in the debate on induced abortion. To do so now is, at the very least, novel and, at worst, disingenuous. In this regard, it is apposite to note that, in Britain, where an abortion on request regime operates, deaths continue to occur as a result of ectopic pregnancy. And, as noted, there has not been a death from ectopic pregnancy in this jurisdiction for nearly 20 years – notwithstanding (or perhaps because of) the absence of legal induced abortion here. Nor is there any evidence that Irish women have travelled to Britain to avail of the legal abortion regime there because they require treatment for ectopic pregnancy that is not available here. Indeed, this would not be possible, given the emergency nature of the intervention that is required, and that is available in this country. Furthermore, the availability of induced abortion has in some instances been directly linked to deaths for ectopic pregnancies. In one study 24 women who underwent induced abortion died as a result of a concurrent ectopic pregnancy and the death-to-case rate was 1.3 times higher than that for women not undergoing abortion.[48]

Eclampsia

As already noted, termination of pregnancy is, in many instances, a standard part of the treatment of eclampsia and pre-eclampsia, usually resulting in the birth of a live premature infant. In the rare cases of early severe eclampsia, pre-eclampsia, HELLP or antiphospholipid syndrome there is a high incidence of intrauterine death. Effective management of the maternal condition is the major determinant of foetal outcome. Not surprisingly, neonatal outcome is improved if the pregnancy can be safely prolonged and recent studies have confirmed the success of conservative management in many of these patients remote from term.[49, 50] It is to be strongly recommended that such patients should be managed in tertiary referral centres.

Other conditions

Again the Green Paper uses the term 'termination of pregnancy' in an inconsistent and confusing manner when dealing with other conditions in pregnancy. Obviously in a country where induced abortion is legal and widely practised, medical practitioners will more readily and easily opt for this course of action when faced with serious maternal illness. Yet, as has been demonstrated time and again, other options are available. Recent advances in drug therapy and the use of intravenous immunoglobulin for pre-eclampsia associated with lupus anticoagulant and antiphospholipid syndrome,[51, 52] liver transplantation in cases of severe acute fatty liver of pregnancy,[53] as well as advances in intensive care have all improved the outcome for patients affected by these exceedingly rare conditions.

Suicide and pregnancy

This is an issue that merits particular consideration, given that the Supreme Court in *Attorney General v. X & ors* [1992] IR 1 and the High Court in *A & B v. Eastern Health Board & ors* [1998] 1 IR 464 found that a threat of self-destruction on the part of a young pregnant girl constituted sufficient justification for induced abortion. The Green Paper rightly points out that notwithstanding the difficulty

39 Ory S, Villanueva A, Sand P, Tamura R: Conservative treatment of ectopic pregnancy with methotrexate. *Am J Obstet Gynecol* 154: 1229, 1986.

40 Stovall T, Ling F, Buster JE: Outpatient chemotherapy of unruptured ectopic pregnancy. *Fertil Steril* 51: 435-438, 1989.

41 Sanders NJ: Non-surgical treatment of ectopic pregnancy. B*r J Obstet Gynecol* 97: 972-3, 1990.

42 Lang PF, Honigl W: Hyperosmolar glucose solution or prostaglandin F-2 alpha for ectopic pregnancy. *Lancet* 336: 685, 1990.

43 Ory SJ: Chemotherapy for ectopic pregnancy. *Ob Gyn Clin North Am* 18 (1): 123-134, 1991.

44 Thompsom GR: Hyperosmolar glucose solution or prostaglandin F-2 alpha for ectopic pregnancy. *Lancet* 336: 685, 1990.

45 Stovall T, Ling F, Buster JE: Reproductive performance after methotrexate treatment of ectopic pregnancy. *Am J Obstet Gynecol* 162: 1620, 1990.

46 Oelsner G, Tarlatzis BC: Radical surgery for extra-uterine pregnancy. In DeCherney AH (ed): *Ectopic Pregnancy*. Rockville, MD, Aspen Publishers, 1986.

47 Vancaille TG: Salpingectomy. *Ob Gyn Clin North Am* 18 (1): 111-122, 1991.

48 Atrash HK, MacKay MPH, Hogue CJR: Ectopic pregnancy concurrent with induced abortion: Incidence and mortality. *Am J Obstet Gynecol* 1990; 162: 726-30.

49 Schiff E, Friedman SA, Sibai BM: Conservative management of severe preeclampsia remote from term. *Obstet Gynecol* 1994; 84: 626-30.

50 Abramovici D, et al: Neonatal outcome in severe preeclampsia at 24 to 36 weeks' gestation: Does the HELLP syndrome matter? *Am J Obstet Gynecol* 1999; 180: 221-5.

51 Katz VL, et al: Human immunoglobulin therapy for pre-eclampsia associated with lupus anticoagulant and anticardiolopin antibody. *Obstet Gynecol* 1990 Nov; 76 (5 Pt 2): 986-8.

52 Spinnato JA et al: Intravenous immunoglobulin therapy for the antiphospholipid syndrome in pregnancy. *Am J Obstet Gynecol* 1995 Feb; 172 (2 Pt 1): 690-4.

53 Pereira SP et al: Maternal and perinatal outcome in severe pregnancy-related liver disease. *Hepatology* 1997 Nov; 26 (5): 1258-62.

of predicting suicide, pregnancy appears to have a protective effect against suicide. What the Green Paper fails to point out is that induced abortion itself appears to be a significant risk factor for suicide.[54]

Omissions

While the Green Paper is thorough in its treatment of Pregnancy and Maternal Health it is somewhat surprising that it fails to address the effects of induced abortion on maternal health. This, in our view, is a significant omission. The attached, Appendix H, entitled *Abortion Sequelae: general and psychological* is of interest in this regard.

CHAPTER TWO
THE LEGAL CONTEXT

Constitutional Protection Before Eighth Amendment

In this chapter we analyse the Green Paper's presentation of the present legal position. This is set out in Chapter 2 of the Green Paper. Our analysis is necessarily critical in some respects. This should not take away from the fact that the Green Paper contains much in the way of helpful elucidation of the issues.

Paragraphs 2.09 and 2.11, in our view, are an inadequate statement of law in two respects. First, the statement in paragraph 2.09 that 'the courts' judgements' in a number of cases suggest that the Constitution (prior to the Eighth Amendment) 'implicitly prohibited abortion' is hard to sustain, since none of the four decisions so held. Three of them *McGee v. Attorney General* [55], *G v. An Bord Uchtala*[56] and *Norris v. Attorney General* [57] contained *obiter dicta* to this general effect by individual judges. In *Finn v. Attorney General* [58], the Supreme Court said nothing on the issue; Barrington J. in the High Court was faced with a situation where the Attorney General had adopted the strategy of neither disputing nor agreeing with the plaintiff's submission that the Constitution protects the life of the unborn child. Barrington J. observed that, on the basis of the authorities offered to him by counsel for the plaintiff and in the light of the reasoning he set out earlier in the judgement, he would 'have no hesitation in holding that the unborn child has a right to life and that it is protected by the Constitution.' It is to be noted that Barrington J. did not seek to express the scope of that protection. He concluded, however, that counsel for the plaintiff 'has failed to convince me that the present proposed amendment, if accepted by the people, will not change or vary the constitutional protection of the unborn child and I have attempted to describe it earlier in this judgment'. Since Barrington J. did not enlarge on this conclusion, we can only speculate as to the nature of that change or variation.

The proposition that there was judicial authority that the Constitution 'implicitly prohibited abortion' needs closer examination. One can speak of a 'prohibition' on induced abortion which is qualified, for example, by exceptions. Although McCarthy J., in one of the *obiter dicta* in *Norris*, observed that 'the right to life is a sacred trust to which all the organs of Government' must lend their support, it seems clear from his later judgment in *Attorney General v. X* [59] that, even when he made his statement in *Norris*, he envisaged that the prohibition was less than a complete one. An examination of his analysis of the issue, which, of course, had the Eighth Amendment as its focus, indicates that he regarded it as axiomatic that a prohibition on abortion could never be a total one.

A second inadequacy in the analysis of paragraphs 2.09 to 2.11 relates to the concerns of those who sought explicit constitutional protection for the unborn. Paragraph 2.11 might suggest that the primary and immediate purpose was to prevent the judicial acceptance in Irish law of the reasoning of the Supreme Court in the United States in *Roe v. Wade*.[60] The real concerns were more immediate. The Constitution in Article 40.3.2 included a guarantee by the State to protect and vindicate the right to life of 'every citizen'. On its face, this excluded the unborn, who are not citizens. Even if that protection were to be judicially interpreted as extending as far as the unborn, it was a matter of complete uncertainty as to how extensive that protection might be. There was, moreover, evidence that the Irish courts were likely to transform the right of marital privacy into a more generalised right of uncertain parameters. Against the background of this opaque and uncertain protection for the right to life of the unborn, it was considered prudent to ensure that the Constitution should afford transparent protection to the lives of everyone, born and unborn, on the principle of equality. The purpose was to give full legal protection against the introduction of an induced abortion regime, judicially or legislatively.

Attorney General v. *X*

In paragraph 2.15, the account of the decision in *Attorney General v. X*[59] refers to the Supreme Court's 'accept[ance]' of the evidence that had been adduced in the case. In fact, little evidence on the crucial issues came before the High Court, as Hederman J's dissenting judgment makes plain. No evidence was received from a psychiatrist. No obstetrical evidence was adduced on the wider subject of the medical treatment of women during pregnancy. The majority judgments reveal the detrimental effect on their analysis which these omissions caused.

Paragraph 2.17 fails to state the concern of those who opposed the Supreme Court's decision in *Attorney General v. X*[59], on the basis that it misunderstood and misinterpreted the Eighth Amendment. The effect of the Eighth Amendment is to prohibit the direct termination of the life of anyone – whether born or unborn. It was the contention of those who opposed the decision on this basis that such a direct termination is both unnecessary and unjust. So far as the risk of suicide as a ground for abortion was recognised by the decision, the concern was not that there might be 'possible abuse' of this ground but, more radically, that a risk of suicide simply *is not* a ground for abortion.

54 Gissler M, Hemminki E, Lonnqvist J: Suicides after pregnancy in Finland, 1987-1994: register linkage study. *BMJ* 1996: 313 (7070): 1431-4.
55 *McGee v. Attorney General* [1974] IR 284.
56 *G v. An Bord Uchtala* [1980] IR 32.
57 *Norris v. Attorney General* [1984] IR 36.
58 *Finn v. Attorney General* [1983] IR 154.
59 *Attorney General v. X* [1992] IR 1.
60 *Roe v. Wade* 410 U.S. 113 (1973).

Information and Travel Amendments

Paragraph 2.20 misrepresents the purpose and effect of the Information Amendment. This Amendment has been interpreted by the Supreme Court as going far beyond a *clarification* of the previous position. It gives constitutional legitimacy to the provision of specific information that the Supreme Court, in two earlier judgments, had identified as amounting to *assistance* in the destruction of the life of unborn children.

The brief reference in paragraph 2.21 to the Supreme Court's decision in the Abortion Information case might give readers the impression that this decision was uncontroversial. In fact it has been subjected to stringent criticism from legal experts with widely varying views on the abortion issue. The failure by the Green Paper to bring this criticism to the attention of the reader contrasts with its willingness to engage in criticism (from a different standpoint) of Geoghegan J's judgment in *A and B v. Eastern Health Board* [61] in paragraph 2.26. That criticism is based on a premise that appears to regard the freedom to travel as involving a *right to abortion outside the jurisdiction*. Geoghegan J. was perfectly correct in repudiating such an interpretation of the Travel Amendment.

Medical ethics – direct and indirect effects

The discussion in paragraphs 2.27-2.30 of the divergence between medical ethics and the judgment of the Supreme Court in *The Attorney General v. X* [59], is striking in its failure to comment on the fact that the Court reached its conclusions without regard to expert obstetric and psychiatric evidence and on the basis of a mistaken assertion by counsel for the Attorney General that the Eighth Amendment permitted abortion in certain circumstances. A further weakness in the Green Paper's discussion in this context is its complete failure to examine the philosophical and legal basis for the distinction between a direct attack on the life of a person, born or unborn, and the death of that person as an unintended side-effect.

The Green Paper deals with the distinction mistakenly in paragraph 1.09 and in a hostile manner in paragraph 7.20. In failing to inform the readers of the philosophical and legal basis for this distinction, the Green Paper in paragraphs 2.27-2.30 gives the false impression that the divergence between the Supreme Court judgment in *Attorney General v. X* [59] and medical ethics raises problems for medical ethics. In fact the problems are with the judgment itself.

Finally, the apparent suggestion in paragraph 2.30 that particular constitutional and legislative approaches 'might require some adjustment' in the ethical norms enunciated by the Medical Council is a cause of serious concern. The idea that medical ethics should change because the particular content of a positive law changes reveals a complete misunderstanding of the relationship between ethics and law. The whole point about ethics is that normative values are not subsidiary to and dependent on positive law.

61 *A & B v. Eastern Health Board* [1997] Unreported High Court Judgement.

CHAPTER THREE
THE STATE'S OBLIGATIONS UNDER INTERNATIONAL, EUROPEAN UNION AND COMMUNITY LAW

Some criticisms

The Green Paper discussed Ireland's obligations under international and European Union and Community law in Chapter 3. As with Chapter 2, it contains much useful material. Our comments, which include specific criticisms should not detract from this.

An overall weakness of Chapter 3 is its failure to address aspects of the international conventions and other human rights agreements which have a significant impact on the issue of the protection of life. The reader is given almost no guidance as to probable future developments at an international level. Since there are strong reasons for apprehending that the present momentum in the law will lead to further changes that augur badly for the unborn, the failure to refer to this dimension is regrettable. It is, of course, true that no one can predict the future with any degree of certainty but it is equally true that particular legal concepts, once received into a legal system, national or international, have a strong potential for growth, to the detriment of other concepts. To ignore that potential is to fail to give a fully meaningful assessment of the law.

A preliminary observation may be made concerning the language adopted in the Green Paper in this context. In paragraph 3.09, the comment is made that states that are parties to the European Convention on Human Rights enjoy a very wide margin of discretion in regulating induced abortion. The following sentence appears:

> However, it is not clear what limitation there may be to their discretion at both the liberal and restrictive ends of the spectrum.

The context suggests that 'liberal' connotes an induced abortion regime in which the unborn child receives diminished protection from having its life terminated and that 'restrictive' connotes a legal system where more extensive protection is assured. The use of labels is important and significant. Most people would prefer to support liberal rather than restrictive policies. A 'liberal' induced abortion regime, as envisaged in the Green Paper, is one in which there is very restricted protection for the right to life of the unborn child. The authors of the Green Paper may seek to defend the use of these partisan labels on the basis that they are no more than sociological descriptions, devoid of value-endorsement. This may, perhaps, have been the motivation for their use, but the effect is to adopt the campaigning language of one particular political perspective, which supports a wide-ranging abortion regime.

The Green Paper analysis of the right to life of the unborn under the European Convention on Human Rights is helpful so far as it goes. It can, however, be criticised for its failure to address the issue in greater detail.

It makes no criticism of the strategy of the majority of the European Court of Human Rights in the case of *Open Door Counselling v. Ireland* [62] to avoid the formidable argument made by the Irish Government that there is an obligation to protect the right to life of the unborn under

62 *Open Door Counselling v. Ireland* 15. E.HRR. 2 44 (1992).

Article 2 and that Article 10 justifies laws that have this goal. Nor does the Green Paper seek to consider the protection that Article 60 of the Convention gives to Article 40.3.3 of the Constitution. Article 60 provides that:

> Nothing in this Convention shall be construed as limiting or derogating from any of the human rights and fundamental freedoms which may be ensured under the laws of every High Contracting Party or under any other agreement to which it is a party.

A strong argument can be made that Article 60 confers effective protection on Article 40.3.3. (See Blayney J.'s dissenting judgment in *Open Door Counselling v. Ireland* [62] at the European Court of Human Rights).

In assessing how the new European Court of Human Rights may determine the issue of the protection of the life of the unborn child from induced abortion, one has to be conscious of social and practical realities. The Court will be sensitive to the fact that wide-ranging abortion regimes exist in many contracting states and that a decision to the effect that the unborn child is an equal member of the human community who is entitled to equal protection from a direct attack on his or her life would cause huge controversy and opposition from countries whose laws do not provide that protection.

There is clear evidence that, in the cases in which the issue of induced abortion came before the Commission or Court, a strong element of political pragmatism played a role in their determination.

Legal commentators continue to debate the question of the scope of protection afforded the unborn child in Article 2: see e.g. Freeman, 'The Unborn Child and the European Convention of Human Rights: To Whom Does Everyone's Right to Life Belong?', 8 *Emory International Law Review* 615 (1994) and Thompson 'International Protection of Women's Rights: An Analysis of Open Door Counselling Ltd. & Dublin Well Woman Centre versus Ireland', 12 *Boston University International Law Journal* 371 (1994). The truth of the matter is that future decisions by the Court in this area will inevitably be affected by international political considerations. No one can tell what lies ahead. All that one can say is that the Convention is a legal instrument which has potential danger for the legal protection of the right to life of unborn children. How great that danger may be is not possible to assess with certainty but, all the evidence suggests that the legal protection of unborn children that extends to direct attacks on their lives will not be consistent with how the new Court is likely to interpret the Convention. The Green Paper goes much of the way in conceding that in paragraph 7.27.

Incorporating convention into domestic law

At present the Convention is not part of Irish domestic law. The effect of the Maastricht Treaty is to require the European Union to respect the fundamental rights guaranteed *inter alia* by the Convention and general principles of community law: see paragraph 3.04. Inevitably debates will take place as to the impact of Protocol No. 17 on this development. The Government is also considering the possibility of incorporating the Convention as part of our domestic law.

If it were to be done, the manner of its implementation would be crucial. A constitutional amendment baldly incorporating the Convention without providing effective protection would be strongly opposed by the Pro-Life Campaign as the Convention does not provide adequate and just protection for the right to life of unborn children. The new European Court of Human Rights is most unlikely to act on the philosophical acknowledgement of the human status and rights of the unborn child that underlies Article 40.3.3 properly interpreted.

CHAPTER FOUR
POSSIBLE CONSTITUTIONAL AND LEGISLATIVE APPROACHES

Pro-Life Campaign supports Option One

In this chapter we discuss the seven possible approaches that the Green Paper canvasses in Chapter 7. The Pro-Life Campaign supports the first option, which is a complete constitutional ban on induced abortion. We do so because this is the just and workable solution. It respects the crucial principle that everyone – whether born or unborn – is entitled to have his or her life protected from direct attack. It is in harmony with medical ethics. It leads to doctors treating pregnant women in a unique situation that involves two patients and ensuring that the best of medical care is given to the mother and her unborn child. It is one of the reasons why Ireland is the safest place in the world for pregnant mothers – safer than countries that have greater resources and have wide-ranging availability of induced abortion.

The first option

The first option represents what the Eighth Amendment was intended to achieve and universally understood to have achieved. The wording of the majority in *Attorney General v. X* was contrary to the understanding of all who had debated the issue prior to the Eighth Amendment. Mr Justice Hamilton, the Chief Justice, in a lecture delivered at Fordham University School of Law on 28 March 1996 (*Matters of Life and Death*, 65 Fordham Law Review 543, at 551) observed that 'no party, of any persuasion, foresaw the manner in which the Supreme Court would interpret those words in *Attorney General v. X* [59]).

The first option has the further advantage of being clear. There is no uncertainty as to what it envisages. Induced abortion is a direct attack on the life of the unborn. Other procedures which may impact indirectly on the unborn child in a harmful – even fatal – way are not what is sought to be restricted. Pregnant women are perfectly entitled to receive all necessary medical treatment even where this detrimentally affects the unborn child as an unintended side-effect.

The Ethical Guidelines of the Medical Council are based on this distinction, which is well recognised as a grounding medical and legal principle. The law relating to the palliative care of the dying patient cannot be properly understood without regard to this distinction, which is not dependent on any religious doctrine. Cf. *Vacco v. Quill* 521 U.S. 793 (1997)[63] and *R v. Cox* 12 BMLR 38.

Those who rely on the distinction are perfectly willing to explain how it translates into practice in the context of

63 *Vacco v. Quill* 521. U.S. 793 (1992).

medical treatment of pregnant women. If anyone is in any doubt as to what this involves, all that he or she need do is see what medical practitioners do every day in our maternity hospitals. The practice on the ground is entirely harmonious with medical ethics. There is no mystery, no complicated abstraction. Unborn children are not exposed to the risk of having their lives subjected to a direct attack.

Since the Green Paper makes much of the difficulty which it perceives in finding an acceptable wording for a constitutional protection on abortion, it must be emphasised that the position which the Pro-Life Campaign supports is one that has no ambiguity. It is based on a coherent philosophical and ethical grounding (which incidentally is not the case in relation to any of the other options). If detail is considered necessary or desirable, this can be prescribed. There is no objection in legal principle to a Constitutional Amendment with a high degree of detail. So, for example, if anyone professes to be in doubt as to whether, with a complete ban on induced abortion, it would be lawful for a pregnant woman with cancer to receive radiation treatment, the answer can be elaborated that it is indeed lawful.

The Green Paper in paragraph 7.25, makes the following curious argument:

> It is possible that the ethical guidelines currently in force may be changed in the future, for example to reflect a different, more liberal, ethical approach or to take account of developments in medical practice. An explicit constitutional prohibition on direct termination of pregnancy would circumscribe the Medical Council's freedom to draw up guidelines as it considered appropriate, if it sought to adopt a more liberal approach.

The fact is that *at present,* as a result of the Supreme Court's decision in *Attorney General v. X* [59], the law has been stated in a way which conflicts with the Ethical Guidelines of the Medical Council. The authors of the Green Paper express no concern for the difficulties for medical practitioners that the present law has created. Instead, it puts forward as a criticism of the option of bringing the law back into harmony with medical ethics, a hypothesis that, if at some future time the Medical Council wanted to change the ethical guidelines 'to adopt a more liberal approach' (i.e. to favour the direct attack on the life of the unborn child), the law would be at variance with the Medical Council's wishes. Why the authors of the Green Paper should base a criticism on a hypothetical development and not make a similar and far stronger criticism of the *present* position is a mystery.

The Green Paper, in paragraph 7.27, expresses concern as to whether a complete prohibition on induced abortion is compatible with 'the State's obligations under the European Convention on Human Rights'. The Pro-Life Campaign regards any such potential incompatibility as being an added reason why the Constitution should prescribe such a prohibition. In our submission, the protection of the lives of unborn children is a pre-eminent requirement of justice. The State's obligations to protect the lives of human beings, born and unborn, are clearly more important than any obligations deriving from international treaties, to which the State may be party at any particular time.

Moreover, the Constitution should give effect to the democratic wishes of the People. It is essential that the electorate be given the opportunity to reject induced abortion if that is their wish. The first option is the only one that offers this opportunity.

Pro-Life Campaign opposes all other options

The Pro-Life Campaign is opposed to the other options canvassed in the Green Paper.

The second option

The second option, of amending the Constitution to provide for the Supreme Court ruling in *Attorney General v. X* but removing suicide risk as a ground for abortion is objectionable from the standpoint of justice. It would subject the unborn child to a direct attack on his or her life. This violates the principle of equality of human beings. As we have stated above, it is inconsistent with medical ethics and practice.

If the Constitution were to be amended in terms consistent with the second option, and abortion were to become lawful by virtue of democratic endorsement, the likelihood is that a wide-ranging abortion regime would, in due course, become established. This has been the general experience in other jurisdictions. While it is true that levels of abortion differ from jurisdiction to jurisdiction, one thing is certain. No jurisdiction in which abortion is lawful on the grounds of so-called life-threatening conditions has an abortion regime that is, in practice, as restrictive as that envisaged by the Green Paper in its discussion of the medical dimension in Chapter 1. Even if legislation accompanying the proposal for a constitutional amendment were drafted narrowly, the Oireachtas would be free, in the future, to amend the legislation to introduce a less restrictive regime which would be consistent with the Amendment.

Paragraph 7.35 gives rise to serious concern. It appears to involve a subdued reiteration of the threat by the then Minister for Justice, Mr Padraig Flynn, in November 1992, that if the electorate rejected the proposed constitutional amendment on the substantive issue (which was identical to the second option listed in the Green Paper), the Government would introduce legislation on the lines of the Supreme Court decision in *Attorney General v. X* [59]. That threat was antidemocratic and intimidating. It was designed to frighten those who were opposed to the Supreme Court's holding on the ground that it removed the complete prohibition on abortion. Such people were placed in an illegitimate dilemma: to vote against the proposed amendment and by so doing give full effect to the Supreme Court holding or vote in favour of it, thus reducing the effect of that holding.

The Pro-Life Campaign strenuously opposed that threat and advised those who opposed induced abortion to vote against the proposed amendment. Paragraph 7.35 speaks in terms of the *possibility* of reviving this threat. This is totally unacceptable from a democratic standpoint. The electorate must be given the democratic opportunity to re-iterate its complete opposition to induced abortion. A strategy designed to intimidate voters into voting for some induced abortion in fear of something worse is profoundly violative of democratic principles.

The third option

The third ootion, of leaving the Supreme Court's holding

in *Attorney General v. X* in place, is unacceptable. Under this holding abortions may be carried out at all stages of pregnancy, including the period where the unborn child is viable. The Pro-Life Campaign opposes this option on the grounds that it violates the principle of equality of human beings and subjects unborn children to the direct termination of their lives, which subverts their most important human right.

The fourth option

The fourth option is equally unacceptable, for the same reasons. The discussion of this option in the Green Paper may be criticised on the ground that, in contrast to the first option, which is subjected to hostile analysis, the discussion of the fourth option is strongly supportive, using rhetoric that amounts to partisan advocacy. Referring to the establishment of an authorisation process by an expert committee, the Green Paper asserts in paragraph 7.44 that:

> Such a provision would act as a 'double lock' against the possibility feared by many people that 'suicide risk' justification could provide a back door to abortion on demand.

In paragraph 7.46, the Green Paper states:

> Whichever approach was taken in such legislation to suicide risk-related termination of pregnancy, the legislation would guarantee that it did not become a 'back door' to the availability of abortion on demand in Ireland.

International experience completely contradicts this advocacy. In England, the *Abortion Act 1967* provided for procedures by the medical profession before an abortion could be carried out. These were represented as establishing a significant barrier to widespread abortion. In fact they gave no protection to unborn children from abortion. The English legislation extended to abortion on the ground of a purported risk to the mother's health, which is not what the fourth option envisages, but the disparity between what was promised and what turned out to be the case is worth noting.

The Green Paper, in its consideration of the fourth option, fails to take account of the profound cultural transformation which the establishment of expert committees with the power of authorising induced abortions in hospitals in this country would involve. The basis of authorising induced abortion is that the unborn child's life is an inferior one, which may be directly attacked. Once that basis is accepted, there is likely to be a tendency to weaken one's concern for that life. If it is possible to terminate a life in some cases, what reason, in principle, is there for not doing so in other cases? The international experience of the past thirty years could not be clearer: once abortion is legalised in some instances there is a momentum for further extension with no principle of justice available to create a coherent barrier.

It is important to address, and refute, the argument in paragraph 7.47 of the Green Paper that legislation is 'capable of being more comprehensive and detailed than general provisions set out in the Constitution, and more capable of discriminating between desired and undesired consequences'. If the reader is being invited to prefer a legislative solution to a constitutional amendment, for this reason, the argument is seriously misleading. The protection of the right to life of unborn children is a constitutional matter (and was even before the passage of the Eighth Amendment). The precise nature and extent of this protection is also a constitutional matter. If it is considered necessary for the purposes of clarity to elaborate in respect of any matter, this can and should be done, not by legislation *per se*, but at the constitutional level. As things stand, legislation, in order to be constitutionally valid, would have to harmonise with the Supreme Court's holding in *Attorney General v. X*[59]. This would be quite unacceptable from the standpoint of justice and of the protection of the unborn child's right to life.

The fifth option

The fifth option set out in the Green Paper is very close – if not in substance identical – to the fourth option and equally unacceptable for the same reasons.

The sixth option

The sixth option, of reverting to the pre-1983 position, is also unacceptable. The Green Paper is to be commended for making it clear that, far from providing an easy solution, this would create a range of uncertainties for the unborn child. These uncertainties would concern the scope of abortion that would be lawful. At a minimum it would go as far as the ground stated in *Attorney General v. X*[59] but there is a real prospect that it would range wider, possibly far wider. As is pointed out in paragraph 7.57, in cases such as *R. v. Newton and Stungo*[64] it has been suggested that section 58 of *Offences Against the Person Act 1861* may be interpreted as permitting abortion on grounds of physical and mental health. This would be likely to escalate, in practice, into induced abortion on demand.

The Green Paper might with benefit have addressed in detail how a future court after Article 40.3.3's removal would be likely to address issues of privacy, health, autonomy and equality in the context of induced abortion. There is a real prospect that the court would come to a conclusion that would be seriously detrimental to the interests of the unborn child. The act of the electorate in removing the protection afforded by Article 40.3.3 might be generally interpreted as implying a decision that the unborn child receive less protection under the Constitution than Article 40.3.3 provides.

The seventh option

The seventh option, of permitting abortion on grounds beyond those specified in *Attorney General v. X*, is obviously unacceptable to anyone who is concerned to protect the right to life of unborn children as equal members of the human community.

CHAPTER FIVE
THE SOCIAL CONTEXT

Introduction

While calling on the government to restore the fullest possible protection to the unborn, the Pro-Life Campaign also calls upon the Government to tackle, in a creative

64 *R. v. Newton & Stungo* [1958].

and sensitive manner, the disturbing and growing number of crisis pregnancies. In a recent poll conducted by Irish Marketing Surveys (June 1999) on behalf of the Pro-Life Campaign, 80% of respondents who expressed an opinion favoured the Government mounting a campaign to offer women in crisis pregnancy positive alternatives to abortion. What is singularly lacking is a coherent Government strategy for addressing what everyone agrees is the very disturbing rise in the number of Irish women seeking abortions in Britain. However, the rising trend of abortion is not inevitable. Statistics from Poland and certain areas in the USA show, when the conditions that pressurise women to opt for abortion are addressed, the trend can be slowed down and even reversed.

Some pointers as to how this might be done can be gleaned from the recently published report Women and Crisis Pregnancy. A Report Presented to the Department of Health and Children. The report, compiled by Evelyn Mahon, Catherine Conlon and Lucy Dillon, was commissioned by the Government in 1995. It sought to identify factors which contribute to the incidence of crisis pregnancies and the issues which resulted in women choosing the option of abortion.

In their analysis of 88 women who chose abortion the researchers point out that only 17 women used 'right to choose' language to explain or justify their decision. The main themes related to the abortion decision were:

Themes Related to Abortion Decision	Number who mentioned themes (Total is 88; More than one theme per woman)
Career/job concerns	36
Stigma of lone parenthood	30
Child needs	30
Financial concerns	28
Not ready for a child now	27
Could not cope	24
'My body, my right'	17

Providing real alternatives to abortion

As can be seen from the above table most of the factors which could be said to pressurise a woman into choosing abortion are amenable to social and/or financial support. We suggest the Government should review again the funding it gives to the voluntary organisations that help women with crisis pregnancies to continue with the pregnancy. With more funds at their disposal these organisations would be able to provide more support and counselling, appropriate accommodation and other practical help including financial assistance where needed. It seems essential that the Government would back up its commitment to the right to life of the unborn by giving funding ***only*** to organisations that fully respect that life. To do otherwise leaves the government open to the accusation of hypocrisy. A woman with a crisis pregnancy should be given all the support and help she needs to cope during the pregnancy and until she can make an informed decision regarding her child's future.

The fact that some women chose abortion because they did not think they would be able to provide the sort of good quality care they thought the child was entitled to is a challenge to policy makers to see that adequate practical help is available. This has great significance also for the handicapped and people with multiple special needs. A health education policy that encourages and supports women in nurturing and protecting their unborn children should also challenge society to recognise the value of all life and the need to meaningfully respond to the actual concerns of women with crisis pregnancy.

Rising abortion trend is not inevitable

One of the key factors that drives women to choose abortion is the dread that having a child will wreck her life and career, her whole identity, that she will effectively lose control of her life. Sophisticated research pioneered by the Caring Foundation (USA) has identified the underlying emotional and psychological motives prompting women to opt for abortion. This research has led to the development of effective strategies to address the concerns of women with crisis pregnancies. The work of the Caring Foundation originated in Missouri, where ads have been airing for a number of years, and that state has the fastest dropping abortion rate in the United States – almost six times the national average. From 1988 to 1992 the abortion rate dropped just 5 per cent nationally, but 29% in Missouri. If the Government here committed itself to making the necessary resources available, similar programmes could be adapted to work in Ireland and would substantially enhance the work of existing caring agencies offering positive alternatives to abortion.

Redefining adoption

The recent Women and Crisis Pregnancy report points out that whereas 71% of non-marital births were adopted in 1971 only 7% of non-marital births were adopted in 1991. In their analysis of the women who actually chose adoption rather than lone-parenthood or abortion, the report mentions that the women

> see adoptive parents as people who would be made extremely happy with the opportunity to rear their child, an experience they would otherwise be deprived of …

and this was a factor which helped make the decision to opt for adoption. Given that a conservative estimate of infertility is 1 in every 10 couples, this is an aspect that should receive much more attention.

Of the 88 women in the study who chose abortion some did in fact consider the option of adoption. Yet they ultimately rejected this option because they felt they would not be able to go through the pregnancy and then part with the baby.

The study suggests that changing attitudes to lone parenting and the availability of legalised abortion in Britain have been the main factors in the declining number of adoptions. While we cannot change the fact that abortion is legal and readily available in Britain, positive health education policies directed at promoting and facilitating adoption would encourage and reassure more women to avail of this option, thus helping to reduce the abortion rate and minimise the physical and emotional harm endured by women following abortion.

Recently, much criticism has been levelled at some social workers for showing ideological opposition to adoption. There is need for the public to be better informed about the changes that have taken place in adoption

procedures in recent decades. Negative media coverage of now abandoned procedures may have coloured peoples perception against adoption. While the negative attitudes of some social workers towards adoption is hopefully being addressed, there is a responsibility for the social services as a whole, to take a more proactive role in lessening the trauma for birth mothers and would-be-adoptive parents by encouraging and promoting contemporary procedures of adoption with the degree of commitment and dedication they deserve.

The Green Paper's discussion of this developing area deserves further consideration and research on possible new models of 'open adoption' is desirable.

Respite care for babies with multiple special needs

The failure on the part of successive governments to provide adequate respite care for families with multiple special needs is inexcusable and demands to be addressed as a matter of priority.

Zöe's Place is the first baby hospice of its kind caring for babies who have multiple special needs. All of the babies have life threatening or life shortening conditions.

The hospice is run by the Life Health Centre in Liverpool and offers respite and palliative care to babies and their families from birth. Zöe's is dedicated to providing a loving, supportive environment for babies and families, ensuring that pain and other symptoms which can cause acute distress and anxiety are controlled or prevented.

As well as caring for babies with multiple special needs, under the supervision of fully qualified children's nurses, Zöe's provides support and encouragement to families in relieving some of the stresses and strains by sharing the task of caring for the babies, thus giving parents the space to devote time to their other children and engage in normal everyday pursuits.

The Pro-Life Campaign strongly urges the All-Party Committee on the Constitution to reject abortion on the grounds of disability as incompatible with the equal dignity and respect for all human life, and to urge the Government to take immediate action in providing the necessary respite care and supports for people with disability and their families.

CONCLUSION

The Pro-Life Campaign proposes that the All-Party Oireachtas Committee on the Constitution base its approach to the resolution of the abortion issue on the principle that all human beings possess an equal and inherent worth by virtue of their humanity, not on condition of possessing certain other qualifications of size, level of physical, emotional or mental capacity or development, dependence, race, ethnic origin, financial status, age, sex, or capacity for interpersonal relationships.

It makes this proposal because it believes that 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 equal and inherent dignity and worth of the unborn, treating them unequally before the law. A fully inclusive society committed to treating everyone equally before the law cannot endorse the legalisation of abortion.

A balanced and even-handed approach – support for women and protection for the child

The woman facing crisis pregnancy, and the unborn child within her, are members of society, equal to the rest of us, equally entitled to whatever social support they need to be able to enjoy equal life-opportunities.

The Pro-Life Campaign recommends to the All-Party Oireachtas Committee on the Constitution the approach of the medical profession which sees every pregnancy as involving not one patient but two, and acknowledges that it has an ethical and professional responsibility of best care towards the lives and health of both. The Pro-Life Campaign urges the All-Party Oireachtas Committee on the Constitution to adopt this even-handed approach – support for women and protection for the child.

Support for women who have been through abortion

The woman who has been through abortion, and the child she has lost, are victims. The woman who has been through abortion is a woman at risk of physical and emotional harm in need of personal support, but surrounded by social silence and denial that makes it harder for her to recover – a woman at risk of social exclusion. The Pro-Life Campaign urges the All-Party Oireachtas Committee on the Constitution to make the provision of adequate support and counselling for women who have been through abortion another priority in its recommendations.

Only a constitutional amendment to ban abortion is compatible with an ethos of social inclusiveness and equal respect

This Submission has reviewed the medical legal and social issues raised in the Green Paper on Abortion and evaluated the seven options it presented in terms of their compatibility with social inclusiveness and equality before the law.

A balanced and even-handed approach requires that we commit ourselves to building a society where there is adequate and appropriate support for women in crisis pregnancy, and where all the children of the nation, born and unborn, are cherished equally.

As the recent Pro-Life Campaign/IMS poll found, there is a huge groundswell of public backing for the provision of an ample range of professional, practical and personal supports for them, and a consistent majority supports a referendum offering the electorate a clear opportunity to ban abortion.

We believe that a referendum restoring adequate legal protection to the unborn will strengthen public commitment to putting in place the supports women in crisis pregnancy need to give them real alternatives to abortion.

Having considered carefully the seven options set out in the Green Paper on Abortion the Pro-Life Campaign believes that only the first option, a constitutional amendment banning induced abortion, is compatible with respect for the inherent dignity of all human lives, and the equality of all before the law. Only this option would seek to ban induced abortion entirely. None of the other six options is compatible with these principles and each would allow a different level of legal abortion.

This Submission has shown, in its response to the Green

Paper on Abortion's review of the medical issues, that the legalisation of induced abortion is not needed to safeguard medical treatment of women. And in our review of its discussion of the legal issues, we have answered the objections to Option One, a constitutional amendment to ban induced abortion.

In conclusion, the Pro-Life Campaign sees legalised abortion as fundamentally incompatible both with the acknowledgement of the equal inherent value of each and every human life and with the commitment to building an ethos of equal respect and social inclusiveness.

We invite the All-Party Oireachtas Committee on the Constitution:

- to recommend the restoration of full legal protection to the unborn.
- to recommend a Constitutional Referendum to reverse the effects of the *X* decision.
- to urge that this referendum be held at the earliest possible date.
- to urge the implementation of measures to give women in crisis pregnancies positive alternatives to abortion.
- to provide more support for counselling agencies who advise women on alternatives to abortion.

APPENDIX A
THE GREEN PAPER OPTIONS ON ABORTION

OPTION ONE:	Absolute constitutional ban.
OPTION TWO:	Amend Constitution to restrict *X* case.
OPTION THREE:	Leave things as they are.
OPTION FOUR:	Do not amend Constitution but legislate to restate abortion ban.
OPTION FIVE:	Legislate according to *X* case.
OPTION SIX:	Revert to pre-1983 position.
OPTION SEVEN:	Allow abortion on wider grounds than *X* case.

APPENDIX B
EQUAL RESPECT, EXTRACT FROM PLC

Green Paper submission

The subject of abortion raises issues across a wide range of disciplines, including law, medicine, sociology and politics. These issues are important and need to be addressed by the Interdepartmental Working Group on the Green Paper on Abortion, but they can only be adequately considered when certain underlying issues have been identified and reflected upon. The position adopted by the Working Group on these underlying issues will already point the way towards the conclusion it will reach on the question of how to deal with abortion.

The value of the human individual These prior issues concern the value of the individual human life. Public discussion has tended to shy away from these issues, tending to regard them as exclusively religious matters not relevant to discussions and decisions of policy and law in a secular civic society. The question of the value of the human being as such, however, goes right to the heart of the most important issues on which we can reflect, relating to the meaning and significance of human existence, to the inherent value of each and every human life, to the rights that derive from the very fact of human existence, to the relationship between rights and responsibilities, and to human freedom.

Not an exclusively religious question These issues have been addressed by the various religions, but that does not mean that they are in any sense exclusively restricted or relevant only to religious debate. Implicitly or explicitly, they underpin the common life of secular society also, and inform all public policy and law. It is our intention in these opening remarks to draw out the underlying attitude towards the individual human life and its dignity, and the protection which society should adopt towards it in public policy and law, that underlies and informs Irish society today, and to suggest to the Working Group that it is this attitude that should inform and guide its work and recommendations on abortion and the legal protection of the unborn, because it is the approach that alone corresponds to the inherent dignity and worth of every human individual, on which democracy is ultimately based, and because it is the animating principle of Irish society and public life today.

The State and the law cannot be 'neutral' on this question For individuals or society as a whole to refuse to address these questions overtly would, we submit, be mistaken. After all, the attitude taken on how one leads one's life follows from the prior attitude one adopts to the value and dignity of that life. And how a society gives or denies protection to human beings and their acts depends in the last resort on how human beings are valued and respected.

Nor can the facing of these prior issues be evaded by holding that society should adopt a neutral stance with regard to them. Where society and the law adopt a 'neutral' stance towards a right which up until that moment had enjoyed social support and legal protection, they are in effect transferring the weight of social endorsement and legal protection from actions which uphold it to actions which undermine, transgress or destroy it.

What public policy had heretofore sought to discourage by the enactment and enforcement of laws is from now on no longer to be discouraged. What hitherto had been prohibited by law and punished by law is henceforth no longer to be prohibited and punished but rather positively to be allowed by law, and indeed is even itself declared to be a right to be supported by public policy and law. The rhetoric of state and legal 'neutrality' cloaks a reversal of social policy, a removal of social disapproval, a lifting of social and legal protection.

The value of every human being is inherent in their humanity We propose that the Working Group adopt explicitly as its foundation the view that underlies the status of the Irish Republic as a constitutional democracy, namely, the view that perceives human existence as of profound significance.

According to this view, people are inherently valuable and their value therefore does not derive from the external estimate of their fellow human beings. Because they are inherently of value, they must be respected. What is of value must be respected and should never logically be

treated with disrespect.

In this view, human beings are recognised as inherently valuable by virtue of their very humanity, rather than by virtue of their size, physical, emotional or mental capacity, autonomy or dependence, level of bodily, emotional or mental development, race, ethnic origin, wealth or poverty, age, sex or capacity for interpersonal relationship.

An inclusive approach based on human equality This is an inclusive approach based on human equality. All, it recognises, are equal, as human beings. On this approach, the human family is composed of all its members and no further conditions are appropriate for recognition and acceptance as a fellow-member by society. As history and contemporary experience show, societies all too often single out some individuals and categories of people for unjust treatment, sometimes treating some as non-members of the human family or as second-class citizens. By explicitly adopting this inclusive approach, the Pro-Life Campaign believes that the Working Group will be aligning itself clearly and strongly against such exclusion and with the positive inclusive thrust of Irish society, and of humane and enlightened international opinion, at this moment in history.

Since every human life has inherent value, no innocent human life should be damaged, let alone directly and intentionally taken. It is this approach which seeks to incorporate the fundamental values on which contemporary Irish society as a secular democracy is presently based, that the Pro-Life Campaign respectfully recommends to the Working Group.

Building an ethos of equal respect When one looks critically at the Republic of Ireland today, one cannot help being struck by the commitment to building an ethos of equal respect. There is a growing sense of justice, an aspiration towards inclusiveness and mutual respect. There is a sense of shared responsibility, and a desire to offer help and support to those in difficult and painful situations that arises from an awareness of social solidarity.

Above all, there is a healthy and mature concern for honesty, generosity and compassion in acknowledging difficult realities and addressing them in a way that does not sweep them under the carpet or try to deal with them in a short-sighted manner that involves hurt to the weaker members of our society.

The Pro-Life Campaign invites the Working Group to see the restoration of adequate legal protection for the right to life of the unborn as part of this drive towards building an ethos of equal respect. Modern Ireland is trying to be a society where problems are faced honestly rather than being denied and hidden away. Bitter experience teaches that injustices done to vulnerable people and innocent lives taken cast long shadows and old wrongs and hurts return to haunt later generations.

This search for greater frankness, fairness and kindness is part of the historic wider struggle to take the violence out of every aspect of Irish society. More and more it is becoming clear that 'solutions' which seem convenient and appealing in the short-term, even though they involve hurt or wrong to some marginalised members of society, not only fail truly to solve the problems but also store up additional problems for tomorrow.

The Pro-Life Campaign sees the question of the legal protection to be given to mother and unborn as situated within the overall struggle of contemporary Irish society for equality, for equal respect for all human beings, regardless of age or size, power or gender, for equality of life-opportunities, for equal treatment.

The Pro-Life Campaign sees the woman with a crisis or unexpected pregnancy, and the unborn child within her, as members of society, equal to the rest of us, equally entitled to whatever social support they need to be able to enjoy equal life-opportunities.

It recommends to the Working Group the attitude of the medical profession which sees every pregnancy as involving not one patient but two, the mother and the unborn, and acknowledges that it has an ethical and professional responsibility of best care towards the lives and health of both.

The Pro-Life Campaign sees the woman pushed towards abortion by the lack of practical assistance and personal warmth and reassurance, and her unborn child, as members of society who are singularly vulnerable and voiceless, singularly at risk of social exclusion or marginalisation, singularly in need of, and entitled to, support and help from society.

The Pro-Life Campaign sees the woman who has been through abortion, and the child she has lost, as victims of violence. The women who has been through abortion is a woman at risk of physical and emotional harm and heartbreak, in need of personal support, but surrounded by social silence and denial that makes it harder for her to recover from the violation she has been through, a woman at risk of social exclusion.

The Pro-Life Campaign sees legalised abortion as fundamentally incompatible both with the acknowledgement of the equal inherent value of each and every human life and with the commitment to building an ethos of equal respect. From this starting point of commitment to building an ethos of equal respect, and following its imperative of equal recognition, support and protection and equality before the law, equal treatment and equal life opportunity, the Pro-Life Campaign concludes that the option which is most suited to deal with abortion is the holding of a referendum which would give the people a clear opportunity to restore the protection of the right to life of the unborn which the people intended in 1983.

APPENDIX C
EXTRACT FROM PLC GREEN PAPER SUBMISSION

Rejection of the proposed Twelfth Amendment of the Constitution in November 1992

Anxious to respond to the changed legal situation after the *X* case, the then Government decided upon the route of Constitutional referendum. However, its Amendment did not allow for a full reversal of the Supreme Court judgment and, if approved, would only have removed the threat of suicide as a ground for legal abortion. The Government argued that it was necessary to leave the option of legal abortion open because medical circumstances could arise in which direct abortion might be necessary to save the life of a pregnant woman. The Amendment which the Government asked the electorate to support, therefore, would have allowed 'limited' abortion i.e. abortion on the grounds of a real and substantial

risk to the life of the mother (not including the risk of her suicide) and the Government stated that if its proposal was rejected it would then bring in laws to give effect to the full decision of the Supreme Court in the *X* case, i.e. allowing abortion in even wider circumstances, including threatened suicide of the mother.

The Government's proposed 1992 Amendment was:

> It shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother, where there is an illness of the mother giving rise to a real and substantive risk to her life, not being a risk of self-destruction.

The Pro-Life Campaign rejected these arguments, pointing out that the medical evidence did not support the view that abortion was a necessary part of any treatment, and that rates of maternal mortality in Ireland were in fact lower than in countries with liberal abortion laws. The Campaign opposed the Government's Amendment on the basis that it would have meant legalised abortion.

Many in the medical profession also opposed the Amendment. In a letter to *The Irish Times*[65] signed by over thirty consultant obstetricians and gynaecologists, the point was made that 'the wording allows for abortion on a wider scale than that acknowledged by the Government', and that, 'The question of what constitutes a substantial risk will always be highly subjective.' The consultants concluded: 'The choice now offered to the electorate is, therefore, not a reasonable one nor, on the basis of Irish obstetric practice, can it be said to have any medical justification or scientific merit.'

The holding of the referendum coincided with the (unrelated) fall of the Government, and the subsequent general election campaign seriously affected the amount of debate on the abortion issue. Three comments might be made about the Government's campaign for a 'Yes' vote in that 1992 referendum:

- The Government spent a large sum of public money on its campaign, a practice subsequently found illegal by the Courts in the McKenna case;
- The ballot papers were misleadingly entitled 'Right to life', despite the fact that the proposal was to provide for abortion, on so-called 'limited' grounds;
- The Government's advertising campaign promoted a 'Yes' vote for the 'Right to Life';
- Pressure was put on people who were anti-abortion by the oft-stated threat that if they rejected the proposal before them for 'limited' abortion, they would be faced with legislation allowing much more abortion.

Even in these circumstances, which created widespread confusion, the Government's proposal was defeated by 65% to 35%. The national distribution of the votes makes it clear that those who voted against the Amendment were mainly those who opposed abortion and that among the 'Yes' voters were many who opposed abortion but who wished to prevent legislation for still-more wide-ranging abortion.

It is beyond argument that the electorate rejected the proposal to allow for induced abortion in limited circumstances. Any future referendum should give the opportunity to prohibit induced abortion in all circumstances, thus returning to the situation which existed in law before the *X* case.

Future options The Pro-Life Campaign advocates a complete prohibition on induced abortion, similar to the situation that existed prior to 1992. This would, of course, necessitate a constitutional amendment.

How best can abortion be constitutionally prohibited? Several different wordings could advance the purpose in a perfectly satisfactory way. This purpose is clear: to restore the legal position to what it was understood to be prior to the Supreme Court decision in the *X* case. The Constitution should protect current practice in every Irish hospital as regards medical treatment and care afforded mothers and their unborn children during pregnancy. Fortunately Irish doctors and nurses have held firm to medical ethics and consequently abortions do not take place in Irish hospitals, in spite of the mistaken Supreme Court judgment.

While including a formula which we believe would achieve the stated objective, we are not in any way suggesting that there are not other forms of words which could be used. However, as an example of what *could* be included in Article 40.3.3º we suggest that a single sentence be added to the first sentence of the sub-section. The first two sentences would thus read as follows:

> 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.
>
> No law shall be enacted, and no provision of this Constitution shall be interpreted, to render induced abortion lawful in the State.

This formula aims to be as plain and as easily understood as possible. The term 'induced abortion' has a clear meaning in medicine, and is clearly understood and recognised by clinicians. An induced abortion is in contrast to a spontaneous abortion or miscarriage, and refers to a procedure or intervention which is directed at, and has as its primary or predominant or sole object, the death of an unborn child.

It is equivalent to a procured abortion, as contemplated and prohibited by the provisions of the Health (Family Planning) Act 1979, a termination of pregnancy, pursuant to the provisions of the British Abortion Act 1967 and a procuring of a miscarriage, pursuant to the provisions of the Offences Against the Person Act 1861.

There is a legal dictum, 'ordinary words have ordinary meanings'. The words 'induced abortion' are ordinary words, with an ordinary meaning which is readily understood and which does not lend itself easily to misinterpretation.

The effect of this change would be to protect the excellent standard of medical care in Irish hospitals. Irish mothers would continue to receive all the medical treatment that they need during pregnancy, even when this may impact detrimentally on the unborn as an injurious or even potentially fatal side effect. Abortions would not be carried out. That is what the electorate voted for in 1983. There is a democratic obligation to give the electorate the opportunity now to exercise that choice.

As already mentioned, it is possible to achieve this purpose by a wide variety of wordings. For example, a

65 *The Irish Times*, 16 November 1992.

wording published by the Pro-Life Campaign in October 1992 adds to Article 40.3.3° as follows:

> 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.
>
> It shall be unlawful to terminate the life of an unborn unless such termination is the unsought side-effect of medical treatment necessary to save the life of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life.

The effect of this wording would again be to render abortion unlawful, while making it clear that necessary medical treatment impacting detrimentally on the unborn as an unsought side-effect is not illegal. Again, the wording captures the reality of the present medical practice in Irish hospitals.

APPENDIX D
EXTRACT FROM PLC GREEN PAPER SUBMISSION

The medical questions[66]

The provision or prohibition of abortion is not a medical issue In pregnancy, a doctor uniquely has a simultaneous duty to two patients. In general the promotion of maternal well-being enhances that of her unborn child. Conversely, enhancing the well-being of the unborn child must not endanger his/her mother's life. If the mother does not survive neither will the child (save in very exceptional circumstances) .

Despite the Medical Council's statement to the contrary, the idea that abortion is a 'medical treatment' and may be necessary to save a mother's life has been frequently expressed in media comment and in two judgments, one from the High Court and another from the Supreme Court. The vast body of evidence that contradicts this statement was not considered in either case before the Courts and has received little comment in the media.

The Pro-Life Campaign contends that:

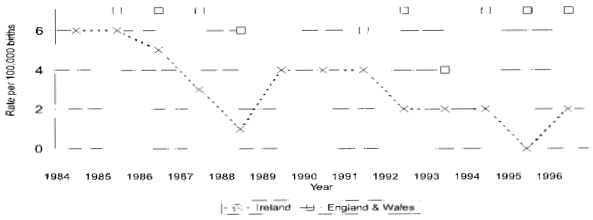
- abortion is never necessary to solve complications in pregnancy;
- there is a real distinction between treatments presently regarded as ethical which may lead indirectly to damage or death to the unborn baby, and induced abortion;
- abortion is not a necessary part of the treatment of cancer in pregnant women;
- abortion is not necessary to prevent a women with an unwanted pregnancy from committing suicide;
- abortion is not a compassionate way forward in cases of rape;
- abortion should not be contemplated as a way of preventing the birth of a handicapped child.

66 This section draws upon the work done by Doctors For Life, an affiliate of the Pro-Life Campaign. A more detailed examination of the medical issues is contained in the submission made by Doctors for Life to the Green Paper Group.

Maternal mortality Irish maternal mortality figures are excellent. They compare more than favourably with those of England and Wales, Scotland and Northern Ireland.[67]

Between 1984 (the year after the passing of the Eighth Amendment) and 1996 (the last full year for which figures are available) Irish maternal mortality figures have been consistently better than those in England and Wales (Table 1). In 1996, for instance, there were 50,390 births in Ireland and there was 1 maternal death.[68]

Table 1: Maternal Mortality Rates Ireland v England/ Wales – 1984-1998.



In 1982, a review of all maternal deaths in the National Maternity Hospital, Dublin over a ten-year period revealed that there were 21 maternal deaths from a total of 74,317 births.[69] Analysis of the cause of death in each case led the authors of the study to conclude that the availability of induced abortion would not, in any way, have reduced the number of maternal deaths over the study period. A more recently published 1996 countrywide study of maternal mortality in Ireland between 1989 and 1991 revealed five direct maternal deaths arising from 157,752 births giving a rate of 3.2 per 100,000. The authors commented:

> The Republic of Ireland is unusual in the developed world in that termination of pregnancy is not available. This does not appear to have influenced these figures significantly, the maternal mortality rate directly due to obstetric causes being half that in the nearest European neighbour, i.e. England and Wales.[70]

Independent United Nations figures further re-inforce this finding and confirm that Ireland has the lowest maternal mortality rate in the world. Britain and the United States, where abortion on demand is freely available, rank joint 14th on the league table for industrialised countries.[71] The excellent Irish maternal mortality figures owe nothing to the fact that some Irish women travel to the UK for abortions. Analysis of the stated reasons for abortions in non-residents shows that in no case was the abortion sought to save the life of the mother.[72]

67 *Vital Statistics 1984 -1996*, Central Statistics Office, Cork. One death that occurred in 1993 was not registered until 1995. There were no maternal deaths recorded for 1995.

68 *Vital Statistics 1996 Yearly Summary*, Central Statistics Office, Cork.

69 Murphy J, O'Driscoll K: Therapeutic Abortion: The Medical Argument. *Ir Med J* 75: 304-6, 1982.

70 Jenkins, DM, Carr C, Stanley J, O'Dwyer T: Maternal Mortality in the Irish Republic 1989-1991. *Ir Med J* 89: 140-141, 1996.

71 *The Progress of Nations* 1993, 33-39, UNICEF, New York, USA.

72 *Abortion Statistics 1974-1996*, (Series AB) Office of Population Census and Surveys, HMSO, London.

Because of a countrywide hospital confinement rate in excess of 99% of total births and the publication of annual reports by the three Dublin Maternity Hospitals (which together, account for nearly half of all births in the country), the published figures suggest that Irish maternal mortality figures are complete and that the data are accurate. In Britain, however, there appears to be some discrepancy between official figures published by the Central Statistics Office and those compiled by the Committee of Inquiry into Maternal Deaths in the United Kingdom, reporting every three years, which suggests a degree of under-reporting. Such is not the case in Ireland.[73] Accordingly, a recent United Nations publication[74] which suggests an alarmingly high Irish maternal mortality rate and which is based on mathematical models related to the fertility rate and 'sisterhood surveys' – rather than actual collection and collation of data – does not reflect either the reality of the situation or the excellence of Irish obstetric care for mothers and their babies.[75]

Abortion trends

General Given that the majority of abortions carried out on Irish women are carried out in England and Wales, it is apposite to consider the abortion regime operating in that jurisdiction. Furthermore, it is clear from British statistics, that abortions on Irish women account for the majority of abortions carried out there on non-resident women. There is no evidence to suggest that Irish, or Irish resident, women avail of abortion regimes in other European jurisdictions.

Great Britain Abortion on demand was not the intention of abortion legislation introduced in Britain in 1967. Rather it was sought to help the 'hard cases'. In the House of Commons it was stated that the Act would benefit mothers 'broken down physically and emotionally with the continual bearing of children.'[76]

The Abortion Act 1967, which came into effect on the 27th April, 1968 permitted abortion by a registered medical practitioner on any or a combination of six statutory grounds, i.e. where it was certified as justified by two medical practitioners on the grounds that:

1 the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;
2 the continuance of the pregnancy would involve risks of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated;
3 the continuance of the pregnancy would involve risk of injury to the physical or mental health of any existing child(ren) in the family of the pregnant woman greater than if the pregnancy were terminated;
4 there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped;

or, in an emergency, certified by the operating practitioner as being immediately necessary –

5 to save the life of the pregnant woman; or
6 to prevent grave permanent injury to the physical or mental health of the pregnant woman.[77]

The Abortion Act 1967 was amended by the Human Fertilisation and Embryology Act 1990[78] with effect from 1st April 1991 and the statutory grounds were re-defined as follows:

A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated; (previously **Ground 1**)
B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; (**'new' Ground**)
C the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman; (previously **Ground 2**)
D the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child-(ren) in the family of the pregnant woman; (previously **Ground 3**)
E there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped; (previously **Ground 4**)

or, in an emergency, certified by the operating practitioner as being immediately necessary –

F to save the life of the pregnant woman; (previously **Ground 5**) or
G to prevent grave permanent injury to the physical or mental health of the pregnant woman (previously **Ground 6**).[79]

In addition to creating the new **Ground B** – essentially a subset of the old Ground 2 – the 1990 act also:

i) reduced the 28 week presumption of foetal viability in the English Infant Life Preservation Act 1929 to 24 weeks in respect of Grounds C and D;
ii) removed all time limits in respect of Grounds A and E; and
iii) allowed for the selective reduction of a multiple pregnancy.

Since 1968 the number of total abortions has nearly quadrupled with one in five pregnancies ending in induced abortion.

Analysis of the stated grounds for abortions carried out on residents of England and Wales for the years 1974[80] to 1996[81] reveals that Ground 1/A is relied upon in less than 0.25% of abortions (from a high of 1% in 1974). That is not to say that these abortions were even necessary to save the life of the mother. Analysis of the stated grounds

73 See: Jenkins DM, Carr C, Stanley J, O'Dwyer, T: Maternal Mortality in the Irish republic 1989-1991. *Ir Med J* 89: 140-141, 1996 at 140.
74 *The Progress of Nations* 1996, UNICEF, New York.
75 In contrast, see: *The State of the World's Children* 1996, UNICEF, New York, which records an Irish maternal mortality rate closer to the national calculation.
76 Hansard: *House of Commons Debates*, 22 July 1966.
77 Abortion Act, 1967, s. 2.
78 Human Fertilisation and Embryology Act, 1990, s. 37.
79 Abortion Act, 1967, s. 2 as amended by the Human Fertilisation and Embryology Act, 1990, s. 37.
80 When the current AB Series was first published by the Office of Population Census and Surveys (OPCS), HMSO, London.
81 The last full year for which figures are available.

(in terms of the underlying conditions) indicates that none were suffering from conditions in which an abortion would improve the prognosis or outcome. Ground 2/BC alone accounts for between 80% and 90% of all abortions, with the other grounds making up the remainder. Suspected congenital malformation in the unborn child accounts for less than 1 % of all abortions.[82] (Table 2) The reclassification of the grounds in 1991 has not altered this trend.

Table 2: Abortion grounds residents of England & Wales –1989-1996.

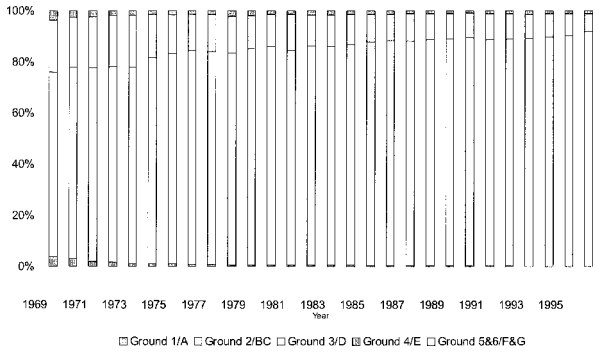
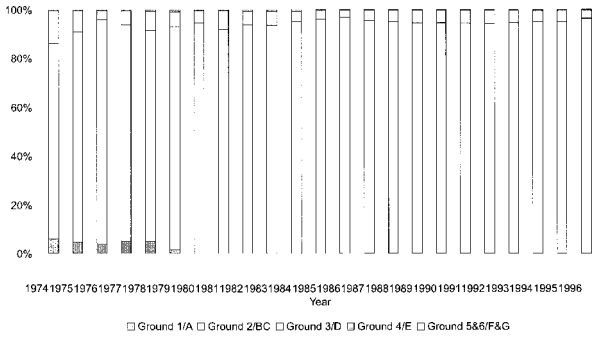


Table 3: Abortion grounds non-residents of England & Wales – 1974-1998.



Out of a total of 3,613,605 abortions performed on residents of England and Wales between 1969 and 1996, 3,094,056 (over 86%) were performed on Ground 2/BC alone, with increasing reliance on psychological grounds. Three conditions account for 99% of all psychological disorders relied upon: personality disorder, depression not elsewhere classified and neurotic disorders.

The stated ground profile for non-residents shows a similar but more marked trend i.e. ground 1 is relied upon in 0.02% of cases (from a high of 5.7% in 1974) and ground 2/BC alone accounts for approximately 95% of all abortions. Suspected congenital malformation in the foetus accounts for less than 0.2% of all abortions (Table 3). Again, this trend has not altered following the reclassification of grounds in 1991.

Out of 213,178 abortions performed on non-residents of England and Wales between 1984 and 1996, there was not a single case of Eisenmenger's complex, significant heart disease or cancer of the breast; other cases of unspecified neoplasia accounted for 0.003%. Ground 2/BC accounted for 203,112 (95%) cases. Overall, psychological reasons account for over 98% of all stated reasons. Although it has not been possible since 1994 to ascertain from the published data the clinical condition stated as the reason for abortion in non-residents, because of the manner in which the data is compiled, there are no indications whatsoever to suggest that Irish women seek abortions in Great Britain because they suffer from life-threatening conditions that are not treated, or treatable, in this country, because of the non-availability of induced abortion. Indeed, the recently (February 1998) published study *Women and Crisis Pregnancy – a report presented to the Department of Health and Children*, similarly confirmed that Irish women who seek abortions in Great Britain do so for social/personal reasons rather than because they suffer from medical conditions which are not being treated here because of the non-availability of induced abortion.

Comparative Abortion Rates The present Irish abortion rate is approximately one in eleven. This compares to a British rate of approximately one in five. On occasion, those who support making abortion available in Irish hospitals have argued that there is not a direct link between the legal availability of abortion, and the actual numbers of women who have abortions. The Dutch experience has been cited to support this: allegedly, the abortion rate in the Netherlands is similar to the Irish rate, despite the easy availability of abortion in Holland.

The Dutch figure does not stand up to closer examination. According to the Dutch State statistical agency, 'Figures on abortion, though available from the early 1970s, are not complete. The data refers mostly to abortions performed in abortion clinics. Therefore, data such as age, nationality, parity of most women who have abortion in a hospital are not known. Moreover, not all reports are available to us.'[83]

Moreover, it appears that the Dutch figure does not include what are officially classified as 'menstrual extractions', which are carried out from 16 to 44 days after the missed period. This procedure may account for many early abortions.

In short, the Dutch abortion figures do not include all abortions carried out in Holland and therefore are not comparable to the Irish or British figures.

Existing medical practice In the world of clinical practice, the professional and legal prohibition on induced abortion did not inhibit medical practitioners from providing the best and most appropriate treatment and care for pregnant mothers.

The medical profession's approach to the issue of such treatment is outlined in the 1994 edition of the Medical Council's Guide to Ethical Conduct and Behaviour and to Fitness to Practise:

> It has always been the tradition of the medical profession to preserve life and health. Situations arise in medical practice where the life and/or health of the mother or of the unborn, or both, are endangered. In these situations it is imperative ethically that doctors shall endeavour to preserve life and health …

82 *Abortion Statistics 1974-1996*, Series AB, Office of Population Census and Surveyos (OPCS), HMSO, London.

83 Letter from the Centraal Bureau voor de Statistiek, Prinses Beatrixlaan 428, Postbus 4000, 2270 JM Voorburg. 21 March 1997.

> While the necessity for abortion to preserve the life and health of the sick mother remains to be proved, it is unethical always to withhold treatment beneficial to a pregnant woman, by reason of her pregnancy.

Foreseeability ('direct' and 'indirect') Foreseeability is not the test of intention in a complete prohibition on induced abortion. In everyday clinical practice, harm or injury to a patient can be readily foreseen as a consequence of some types of medical intervention. Nevertheless, especially in instances of life-threatening conditions, it is perfectly permissible to use treatments that are associated with serious or even life threatening side effects. In such circumstances, the doctor's judgment may well be that it is proper to incur grave risks in the management of grave conditions.[84]

This is an essential component of ethical practice but does not, of itself, preclude running serious risks in grave conditions. In summary, the risks of treatment must be proportionate to the condition being treated and the expected benefits. In pregnancy, where uniquely, there is a simultaneous duty to two patients, *a fortiori*, these considerations apply – with due regard to side effects not alone to the mother but also to her unborn child. In no circumstances, however, is it permissible to compromise the therapeutic objective merely by virtue of the mother's pregnancy. In this regard, the Medical Council's position on induced abortion as a therapeutic option reflects the reality of such an approach and ought to be reflected in the law on abortion.

A clear judicial expression of the underlying principle, in a case involving a charge of attempted murder of a patient by her consultant physician, which encapsulates the essentials of ethical (and lawful) treatment was stated thus:

> We all appreciate … that some medical treatment, whether of a positive, therapeutic character or solely of an analgesic kind … designed solely to alleviate pain and suffering, carries with it a serious risk to the health or even the life of the patient. Doctors … are frequently confronted with, no doubt, distressing dilemmas. They have to make up their minds as to whether the risk, even to the life of their patient, attendant upon their contemplated form of treatment, is such that the risk is or is not medically justified. Of course, if a doctor genuinely believes that a certain course is beneficial to his patient, either therapeutically or analgesically, even though he recognises that that course carries with it a risk to life, he is fully entitled, nonetheless to pursue it. If sadly, and in those circumstances the patient dies, nobody could possibly suggest that in that situation the doctor was guilty of murder or attempted murder. …
>
> There can be no doubt that the use of drugs to reduce pain and suffering will often be fully justified notwithstanding that it will, in fact, hasten the moment of death, but … what can never be lawful is the use of drugs with the primary purpose of hastening the moment of death.… It matters not by how much or by how little [a] death is hastened or intended to be hastened … even if [it be the case that death was only hours or minutes away] no doctor can lawfully take any step deliberately designed to hasten that death by however short a period of time. … Alleviation of suffering means the easing of it for so long as the patient survives, not the easing of it in the throes of and because of deliberate purposed killing.[85]

Even more recently, the High Court in London reiterated the principle that high doses of pain-killers which were necessary to relieve pain can be given, even when – as an indirect and unintended (but foreseeable) side effect – they shorten life.[86] There is no reason to suggest that the courts in this jurisdiction would differ from this statement of the law in its articulation of the underlying principles in relation to the death of an unborn child during the course of the treatment of an ill mother.

Abortion and the treatment of cancer The simultaneous occurrence of cancer and pregnancy is uncommon with a reported incidence of 0.07% to 0.1%.[87, 88]

Numerous studies have shown over and over again that the outcome for pregnant women with cancer is no different than that of women who are not pregnant, when matched for age, stage and cancer type.

Cancer treatment involves the following modalities either singly or in combination

- surgery
- chemotherapy
- radiotherapy

Surgery can, and frequently is, performed without undue difficulty on pregnant women. Excluding caesarean sections, approximately 50,000 pregnant women per year in the United States will undergo a surgical procedure.[89]

The unborn child has developed all its organs and limbs by the 12th week of pregnancy. Hence chemotherapy can be given to a women in the second and third trimester without causing any abnormality in the unborn child. With judicious selection of chemotherapeutic agents pregnant women can be treated even in the first trimester. Some drugs cannot cross the placental barrier, some others appear not to cause malformations. If the folic acid antagonists are excluded the incidence of congenital malformation is 6% for single agents.[90] Fortunately, methotrexate, the principal folic acid antagonist used, is not part of any curative regimen for which a therapeutically equivalent substitute is lacking.[91]

84 For example, in the treatment of leukaemia, induced myelosuppression exposes the patient to the risks of overwhelming sepsis and severe haemorrhage. Nevertheless, in the circumstances, such risks are assessed as acceptable in terms of the desired outcome of cure. However, the medical and ethical principle governing such decisions is that the therapeutic option chosen must be the most effective and least toxic. Thus, if there are two treatments, Treatment A and Treatment B, of equivalent therapeutic efficacy, the ethical obligation is to choose that which is associated with the last severe side effects.

85 *R v Cox* 12 BMLR 38 (Winchester Crown Court per Ognall J and approxded in *Airedale NHS Trust v. Bland* 1993 1 All ER 821 (HL).

86 *Irish Independent*, 29 October 1997.

87 Mulvihill JJ, McKeen EA, Rosner F, Zarrabi MH: Pregnancy outcome in cancer patients. *Cancer* 60: 1143, 1987.

88 Doll DC, Ringberg QS, Yarbo JS.: Antineoplastic agents and pregnancy. *Seminars in Oncology* 16 (5): 337, 1989.

89 Barron W: The pregnant surgical patient: Medical evaluation and management, *Ann Intern Med* 101: 683-691, 1984.

90 Mulvihill JJ, McKeen EA, Rosner F, Zarrabi MH: Pregnancy outcome in cancer patients. *Cancer* 60: 1143, 1987.

91 Mulvihill JJ, McKeen EA, Rosner F, Zarrabi MH: Pregnancy outcome in cancer patients. *Cancer* 60: 1143, 1987.

To optimise the efficacy of radiotherapy for cancer patents who are pregnant, the following factors must be considered: the potential effects of the therapy on the unborn child, the stage and prognosis of the mother's disease and the possible risks to the patient of restricting cancer treatment. The risk to the unborn is negligible if the foetal exposure does not exceed 0.1Gy.[92]

Where cure is a realistic goal, therapy should not be modified in such a way as to compromise its achievement. If there is no hope for cure or even significant palliation, the primary goal may become the protection of the foetus from any harmful effects of anticancer therapy and the delivery of a healthy infant. Therapy should be individualised for each patient and patient choice must be respected.

Abortion and suicide Pregnancy reduces the overall risk of suicide compared with a population that is not pregnant.[93] This has been confirmed over and over again in studies in the U.K., the U.S and most recently in Finland. In a study in the U.S. the estimated suicide rate for pregnant women is 0.6 per 100,000 compared to 3.5 per 100,000 for non-pregnant women and 16 per 100,000 for men.[94]

A study in the U.S. found that the number of suicides of pregnant women was only one third of that expected.[95]

Suicidal thoughts are relatively common in normal adolescent girls occurring in up to 16.5%, while in girls referred for psychiatric treatment suicidal thoughts occurred in 36%.[96, 97] Actual suicide rates for teenage girls were 0.0003% for those aged 10-14 and 0.0034% for those aged 15-19 years.[98]

Prediction of suicide is at the basis of the decisions in Irish Courts relating to abortion. Numerous studies have attempted to predict suicide in high risk populations. The most thorough assessment showed that the prediction of suicide was wrong 97 times out of 100.[99] There is no literature on the association between threats and completion of the act since threats are so common and completed suicide is so rare. Thus, extrapolating clinically or statistically from threats to complete suicide would be impossible.

All studies on suicide concur that depression is the most closely associated factor with suicide. Depression should be looked for and treated in any pregnant woman with suicidal ideation.

Abortion and sexual assault Sexual assault is a crime of violence. Post-traumatic symptoms which occur immediately may not be integrated for a number of years. A distinct sub-category of post-traumatic symptoms experienced by victims of sexual assault includes shame, feeling dehumanized and reduced capacity for intimacy. Long term effects include anxiety, depression and impaired social adjustment[100, 101]

Social support is the most important single factor influencing rehabilitation after sexual assault. The social support network provides an atmosphere for feeling loved, valued and esteemed. The goal of treatment is: '*to regain a sense of safety … a sense of self and (to) reestablish sharing … relationships with men, women and society*'.[102]

It is difficult to estimate the incidence of pregnancy due to sexual assault: studies have defined sexual assault differently, and assaulted women may be sexually active and hence the pregnancy may not have resulted from the assault. Different studies give estimates varying from 0.6% to 5%. The relative rarity of rape-induced pregnancy coupled with the fact that women traumatised by rape need to be treated with great sensitivity and hence are not often suitable subjects for research explains why there are few studies on the management of pregnancy resulting from sexual assault.

Abortion is freely available on demand in the U.S. Hence any woman pregnant as a result of rape can get an abortion without difficulty. The fact that so many do *not* choose this option in these circumstances seriously challenges the assumption made by so many that abortion is somehow beneficial to a woman who has been raped. In one study in 1996 of the prevalence and incidence of rape there were 34 cases of rape-related pregnancy. Only 17 women chose abortion and of the women who did not choose abortion 10 actually kept the baby after delivery.[103]

In a study of 37 pregnant rape victims in the USA in 1979[104] identified through a social welfare agency, 28 chose to continue the pregnancy, five had an abortion and four were lost to follow up. Of this 28, 17 chose adoption and 3 kept the child themselves and the placement of the remaining eight was undetermined.

Several reasons were given for not having an abortion. First, many women expressed the feeling that abortion was another act of violence. Secondly, some saw an intrinsic meaning or purpose in the child. Thirdly, at a subconscious level, some victims felt that by continuing the pregnancy, they would in some way conquer the rape. Issues relating to the rape experience, not the pregnancy, were the primary concern for over 80% of the pregnant rape victims. The remaining 20% placed primary emphasis on their need to confront their feelings about pregnancy. In the group (28 of 37) who carried their pregnancies to

92 Nakagawa K, Aoki Y, Kusama T, Ban N, Nagawa S, Sasaki Y: Radiotherapy during pregnancy: effects on fetuses and neonates. *Clin Ther* 19 (4), 770-8, 1997.
93 Sim M: Abortion and the psychiatrist. *BMJ* 2: 145, 1963
94 Minnesota Maternal Mortality Committee. *Am J Obstet Gynecol* 6: 1, 1967.
95 Marzuk PM, et al: Lower risk of suicide in pregnancy. *Am J Psychiatry* 154 (1): 122-3, 1997.
96 Achenbach & Edelbrock: Manual for youth self-report and profile. *B J Psychiatr* 158: 776-781, 1991.
98 Eisenberg L: Adolescent suicide: On taking arms against a sea of troubles. *Paediatrics* 315-320, 1980.
99 Pokorney AD: Prediction of suicide in psychiatric patients. *Arch Gen Psychiatr* 40: 249-257, 1983.
100 Bownes T, O'Gorman EC, Sayers A: Assault characteristics and post-traumatic stress disorder in rape victims. *Acta Psychiatr Scand* 83: 27-30, 1991.
101 Moscarello R: Psychological management of victims of sexual assault. *Can J* Psychiatry 35: 25-30, 1990.
102 Bassuck EL: Crisis theory perspective on rape. In McCombie SL (ed): *The rape crisis intervention handbook.* Plenum Press, New York, 1980.
103 Holms MM, Resnick HS, Kilpatrick DG, Best CL: Rape related pregnancy: estimates and descriptive characteristics from a national sample of women. *Am J Obstet Gynecol* 175 (2): 320-4, 1996.
104 Mahkorn S: Pregnancy and Sexual Assault. *Psychological Aspects of Abortion*, Mall and Watts (eds) 5: 1979.

term, the majority saw their attitude toward the child improve consistently throughout the pregnancy.[105]

Abortion and heart disease The incidence of heart disease in pregnancy is extremely low.

The spectrum of heart disease in pregnancy has been changing over the last thirty years with a fall in the incidence of rheumatic heart disease and a relative increase in the numbers of pregnant women with congenital heart disease (both corrected and uncorrected). The balance comprises miscellaneous cardiac problems and acquired conditions.[106]

With early detection and successful correction of congenital heart defects, Eisenmenger's syndrome has become increasingly rare in developed countries in recent decades. The incidence of Eisenmenger's syndrome in pregnancy is very low.[107] By 1992 there had been less than 150 reported cases in the world literature over the previous 45 years. One case has been reported in Ireland since 1969. There is not a single reported case of the condition among the 115,567 abortions performed on non-residents in England and Wales between 1984 and 1990.[108]

The most recent review of pregnancy in women with Eisenmenger's syndrome is from the Heart Institute of the University of São Paulo, Brazil. It reviewed the outcome of 13 pregnancies in 12 women with Eisenmenger's. Three women in the series died: one had refused hospitalization, another died at home unexpectedly and the cause of death was unclear, and the third woman died in the puerperium of a femoral artery thrombosis having discontinued anticoagulant therapy.[109] This confirms other case reports that show that with intensive pre-, intra- and post-partum care these women can be taken safely through pregnancy and labour and even through caesarian section.[110, 111] With advances in intensive care and in the critical understanding of the pathophysiology of this condition over the last 10 to 15 years pregnancy and labour have become safer for these patients.

Other cardiac conditions can be safely managed in pregnancy. There were no maternal deaths in a review of 214 pregnancies in 182 women with valve prostheses.[112]

Numerous reports of cardiovascular surgery during pregnancy include successful correction of most types of congenital and acquired cardiac disease. Maternal mortality is dependent on the specific nature of the procedure being performed and is not increased by pregnancy.[113] Successful pregnancy following heart transplantation has also been reported.[114, 115]

Consequences of abortion Notwithstanding some high profile cases of abortion survivals the mortality rate for the unborn child in abortion is effectively 100%. While the introduction of so-called 'lunch-time' or 'quickie' abortion would seem to emphasise the safety of the procedure for the mother yet there is significant maternal morbidity and even mortality.

Maternal mortality following abortion The Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1991-1993 reports 5 deaths directly related to abortion, a further 2 deaths due to suicide within 42 days of the abortion and another 2 deaths in women known to be substance abusers who died of injecting substance abuse overdose within 1 year of an abortion.[116]

A surveillance of pregnancy related deaths carried out by the U.S. Centres for Disease Control and Prevention found that 1 in every 20 maternal deaths was due to induced abortion.[117]

A study of maternal mortality in Finland found the suicide rate following abortion was much higher than that associated with birth. The mean annual suicide rate was 11.3 per 100,000; the rate associated with birth was 5.9; the rate associated with induced abortion was 34.7.[118]

Abortion begets abortion A study of 2,925 women in Norway showed that the incidence of repeat induced abortion doubled from the second to the third abortion, indicating that the likelihood of choosing an abortion is increased by having done so before.[119] In a review of women having abortions in 1938 59% were under 25 years of age and 42% had had a previous abortion[120] and in a review of 2,001 women seeking abortion in Wichita, Kansas in 1991-1992 34% had had a previous abortion.[121] In a study of 163 patients seeking abortions who attended Irish Family Planning Association clinics in a 1 year period 10 of the women had had an abortion in the past with 4 of these having had 2 abortions. One teenager had 2 abortions during the study period of 1 year and returned for a third abortion one month after the study ended.[122]

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105 Mahkorn S: Pregnancy and Sexual Assault. *Psychological Aspects of Abortion*, Mall and Watts (eds) 5: 1979.

106 Clark SL: Cardiac disease in pregnancy. *Ob Gyn Clin North Am* 18 (2): 237-256, 1991.

107 Cleicher N, Midwall J, Hockberger D, Jaffin H: Eisenmenger's syndrome in pregnancy. *Ob Gyn Surv* 34 (10): 721-741, 1979.

108 Office of Population Census and Surveys (OPCS): Abortion Statistics 1984-1990, HMSo, London.

109 Avila WS, Grinberg R, et al: Maternal and fetal outcome in pregnant women with Eisenmenger's syndrome. *Europ Heart J* 16: 460-464, 1995.

110 Spinnato JA, Kraynack BJ, Cooper MW: Eisenmenger's syndrome in pregnancy: epidural anaesthesia for elective caesarean section. *N Eng J Med* 304 (20): 1215-1217, 1981.

111 Atanassoff P, Alon E, Schmid ER, Pasch T: Epidural anaesthesia for caesarean section in a patient with severe pulmonary hypertension. *Acta Anaesthesiol Scand* 34 (1): 75-77, 1990.

112 Sbarouni E, Oakley CM: Outcome of pregnancy in women with valve prostheses. *Br Heart J* 71: 196-201, 1994.

113 Bernal JM, Miralles PJ: Cardiac surgery with cardiopulmonary bypass during pregnancy. *Obstet Gynecol Surv* 41: 1, 1986.

114 Hedon B: Heart Transplant Patient gives Birth to Twins. *Ob Gyn News* 26: 30, 1990.

115 Eskander M, Gader S, Ong BY: Two successful vaginal deliveries in a heart transplant patient. *Obstet Gynecol* 87 (5): 880, 1996.

116 Report on Confidential Enquiries into Maternal deaths in the United Kingdom 1991-1993.

117 *CDC Obstet Gynecol* 88: 161-167, 1996.

118 Gissler M, Hemminki, E, Lonnqvist J: Suicides after pregnancy in Finland 1987-94: register linkage study. *BMJ* 313 (7070): 1431-4, 1996.

119 Skjeldestad FE: The incidence of repeat induced abortion – a prospective cohort study. *Acta Obstetricia et Gynecologica Scandinavica* 73 (9): 706-10, 1994.

120 Henshaw SK, Koonin LM, Smith JC: Characteristics of U.S. women having abortions, 1987. *Family Planning Perspectives* 23 (2): 75-81, 1991.

121 Westfall JM, Kallail KJ: Repeat abortion and use of primary care health services. *Family Planning Perspectives* 27 (4): 162-5, 1995.

122 *Irish Medical Times* April 18, 1997, page 5.

Medical complications following abortion Incidence of postabortal upper genital tract infections varies across populations. Incidence rates range at 5-20%. Infecting organisms include Chlamydia trachomatis, Neisseria gonorrhoeae, Mycoplasma hominis, Ureaplasma urealyticum, Group B streptococci and Human Papillomavirus. Long term sequelae of postabortal infection include chronic pelvic pain, ectopic pregnancy, dyspareunia and infertility.[123, 124]

Previous induced abortion has also been shown to be associated with clinically significant neurotic disturbances in subsequent pregnancy and it is postulated that this phenomenon may reflect a reactivation of mourning which was previously suppressed.[125]

A number of studies have suggested that induced abortion may be a risk factor for developing breast cancer. One study suggested that women aged 45 or younger who have had induced abortions have a relative risk of 1.5 (50% increased risk) for breast cancer compared to women who had been pregnant but never had an induced abortion. The highest risk was for women who had an abortion younger than age 18 or older than 30.[126] A meta-analysis of 28 papers concludes that even one abortion significantly increases the risk and that overall the relative risk of breast cancer for women who have had an abortion is 1.3.[127]

APPENDIX E
EXTRACT FROM PLC GREEN PAPER SUBMISSION

Democracy

Introduction The Pro-Life Campaign based this Submission to the Interdepartmental Working Group on the Green Paper on Abortion on the view that all human beings possess an equal and inherent worth simply in virtue of their humanity, and not on condition of their possessing certain other qualifications of size, physical, emotional or mental capacity, autonomy or dependence, level of bodily, emotional or mental development, race, ethnic origin, wealth or poverty, age, sex or capacity for interpersonal relationship.

The Pro-Life Campaign adopted this view and proposes it to the Working Group because it believes that this view alone adequately acknowledges and respects the equal dignity of all human beings, because this view of equal and inherent worth is the foundation of the Republic's constitutional democracy, and because this view is the animating spirit behind the contemporary drive in Irish society to build an ethos of equal respect.

123 Sawaya GF, Grady D, Kerlikowska K: Antibiotics at the time of induced abortion: the case of universal prophylaxis based on meta-analysis. *Obstet Gynecol* 87 (5): 884-90, 1996.

124 Stray-Pedersen B, et al: Induced abortion: micrological screening and medical complications. *Infection* 19 (5): 305-8, 1991.

125 Kumar R, Robson K: Previous induced abortion and antenatal depression in primiparae: preliminary report of a survey of mental health in pregnancy. *Psychological Medicine* 8 (4): 711-5, 1978.

126 Daling JR, Malone KE, Voigt LF, White E, Weiss NS. *J Natl Cancer Inst* 1994, 2.

127 *Journal of Epidemiology and Community Health* 50: 486-96, 1996.

Having examined the legal and medical issues indicated by the advertisement inviting submissions, it is now proposed to evaluate the key point in each issue in the light of the principle of equal respect and to draw some conclusions from this evaluative review of the issues, which are proposed to the Working Group as the Pro-Life Campaign's recommendations.

Morality and the law in a secular democracy It is sometimes argued that laws in a secular democracy should not embody morality because to do so would be to impose the religious or moral values of some, whether a majority or a minority, on others. It is undoubtedly true that in a secular democracy, religious freedom is a basic civil right, that one should not be forced to accept religious beliefs and practices. Muslims should not be forced by the civil law to recite the Angelus, nor should Catholics be forced by the civil law to observe Ramadan.

It does not follow from this, however, that a secular democracy has to exclude every moral principle and precept that is taught by every religion – if it did, the result would be social anarchy. In order to have a society at all, certain minimal moral conditions have to be met by most of the members most of the time, and these are required of their adherents by the main religions. For example, the Bible enjoins respect for the civil authorities, payment of taxes, the requirement of corroborative evidence in legal proceedings on serious charges. A secular democracy is quite entitled to enact laws requiring obedience of lawful civil authorities, payment of taxes and corroborative evidence on serious charges, notwithstanding the fact that these moral requirements are also enjoined on their adherents by religions, *because it needs them in order to exist and function properly as a secular society*.

If this is true for all societies, it is especially true for constitutional democracy. A democracy is a society governed by the whole population through elected representatives, in accordance with laws that reflect the will of the people. The Concise Oxford Dictionary (9th edition) defines democratic as 'favouring social equality.' What makes a society truly democratic, therefore, is a spirit of respect for social equality. Take that away and even though the structures and procedures may remain, the ethos, the spirit, of democracy is gone.

Democracy is government according to the rule of law, where the law is the fabric of rights and responsibilities, entitlements and liberties, ordering human interaction. Human rights are just and reasonable claims on others to do or refrain from doing actions which impede the natural human existence, life and development of each human being. The minimum moral condition for having a democratic society at all, therefore, is a shared respect for social equality.

The fundamental human right is the right to life. It is only if one is alive, if one's life is respected and protected, that one can possess and exercise all the other rights such as the right to rational self-determination which are so important in a democratic society.

The foundation of democracy, in the literal sense of that upon which the rest of the edifice is based and built, is equality before the law. And since life is the fundamental good, the right to life, and to the protection of the law for one's life, is the fundamental human right and protection

on which the rule of law in a democracy is grounded. Take that away and the rest is undermined, weakened and unbalanced.

It is appropriate and legitimate, and indeed, necessary, for the laws in a democratic society to recognise and protect the right to life, especially of the weaker members of society, the voiceless and powerless. It is for this reason that abortion should not be legalised.

The advertisement seeking submissions to the Working Group invited interested parties to address the 'constitutional, legal, medical, moral, social and ethical issues which arise regarding abortion.' On the basis of the view presented of the equal and inherent worth of every human life, the Pro-Life Campaign submits that in a secular democracy abortion is wrong on each and every one of these grounds.

Abortion is morally wrong Abortion is wrong *morally* because it is the direct and deliberate taking of an innocent human life.

Abortion is legally and constitutionally wrong It is wrong in terms of *legal ethics* because the purpose of law in a democracy is to protect and vindicate the rights of the members in a just and equal manner, but abortion legalises the treating of some human lives unequally and unfairly under the law.

Abortion is wrong *legally* because in a democracy, the law exercises, in addition to its regulative function, a declarative, educative and normative role. What the law forbids, the society as a whole thereby declares, in the most formal, authoritative and official manner, to be impermissible.

When the law prohibits abortion, the society as a whole thereby declares in the most formal, authoritative and official manner that it throws the full moral weight of its backing behind the humanity of the unborn and its equal right to life as a human being equal in inherent worth to every other member of society.

When a society which hitherto has made abortion unlawful turns around and legalises abortion, it is declaring the dislodging of the old norm of recognition, equal respect, social support, and the protection of the law for the humanity and right to life of the unborn. The legalisation of abortion is the denial by society as a whole in the most authoritative and official manner of the equal humanity and inherent worth of the unborn as a fellow member of the human family and fellow member of society. It is the revoking of equal respect from the unborn as a human being, and the formal withdrawal of society's support and the law's protection for his or her life and right to life.

And in place of equal recognition, respect, support and protection, by legalising abortion, the society as a whole is declaring permissible what hitherto it had declared to be impermissible, namely, the direct and intentional killing of that innocent and defenceless human life by another member of society.

Small wonder, then, that when the law declares permissible what hitherto it had declared to be the unlawful taking of innocent human life, an ever increasing number of the members of the society come to believe that this killing of the unborn actually is morally permissible.

For this reason, Article 40.3.3º should be retained, and the people should be offered an opportunity to amend it along the lines suggested in this Submission so as to reverse the effect of the Supreme Court ruling in the *X* case and to restore the protection to the right to life of the unborn which the people intended in enacting Article 40.3.3º to ban completely abortion in the Republic.

As regards a legislative approach, legislation is at all stages secondary to the basic constitutional provisions. Sections 58 and 59 of the 1861 Act harmonise with a constitutional approach which prohibits abortion, and the Pro-Life Campaign has no objection in principle to any legislative model which would harmonise with such a constitutional provision.

As made clear in the discussion above of the decision of the people in the referendum of 25th November 1992 to reject the amendment that would have inserted into the Constitution a right to abortion in certain instances, that amendment was unacceptable to the majority because it did not offer them the opportunity they wished to have to decide whether or not they want to ban abortion here altogether.

It is clear from the submission to this Working Group by the Irish Family Planning Association, the Irish affiliate of the International Planned Parenthood Federation, the most powerful international pro-abortion body in the world, that what the proponents of legalised abortion want is for abortion no longer to be regarded as a criminal matter at all but simply a matter of 'women's health.' This involves a complete denial of the humanity and equal and inherent worth of the unborn and is a view only held by a minuscule and entirely unrepresentative handful of people. The Irish Family Planning Association's proposal would require two referenda to be implemented, and in terms of realistic politics in the Republic today, given the balance of opinion among the general public on abortion, there is not the remotest chance that such referenda would pass.

Democracy, in Lincoln's memorable phrase from the Gettysburg Address, is government of the people, by the people for the people. It is that form of government in which the most important questions are put to the people as a whole for their decision. Article 6 of the Irish Constitution recognises explicitly the 'right' of the people 'in final appeal, to decide all questions of national policy, according to the requirements of the common good.'

If any matter is a question of national policy it is surely whether or not abortion should be legalised. This matter, more than many other issues, should be put to the people as a whole for their decision. The common good in a democracy means the fabric of key social conditions that facilitate the existence, development and well being of all the members of the society, so it should surely include a legal framework that at the very least binds the society in its laws to respect the equal and inherent worth of all its members by acknowledging and pledging itself to protect their equal right to life.

The signatories of the Easter Proclamation pledged to defend religious and civil liberty, to seek equal rights and equal opportunities for all members of the society, and to cherish all the children of the nation equally. How can the Republic today claim a true continuity of commitment to these pledges if equal and inherent worth of the unborn as members of society is denied? Will not the commitment to religious and civil liberty ring hollow if legal protection

is removed or withheld from the most elementary liberty of the unborn, the liberty to be born, to live? Surely the Republic cannot honestly claim to be respecting equal rights and equal opportunities for all as long as the unborn are denied equal legal protection for their right to life, equal opportunity to be born and to live. All the children of the nation are not being cherished equally as long as the laws of that nation withhold the protection of the law from the right to life of those children who are unborn. Abortion is wrong *constitutionally* because it is incompatible with these democratic pledges of equality.

Abortion is wrong *constitutionally* also because the purpose of the Constitution is to safeguard the most important rights of the members of society from unjust attack. In a constitutional democracy, the insertion of certain personal rights in the Constitution serves as an additional protection for them, withdrawing them from easy access in the cut and thrust of day to day politics, where otherwise they might be infringed when political expedience or a temporary social crisis seemed to require it.

But the right to life is the fundamental right; the unborn are among the most voiceless and vulnerable members of society, and abortion destroys the life of the unborn, so it is especially appropriate and imperative that the protection of the Constitution be given to the right to life of the unborn, having due regard, as Article 40.3.3° requires, to the equal right to life of the mother.

Abortion is medically wrong It is wrong in terms of *medical ethics* because it violates the first principle of medical ethics, on which the whole practice of medicine has been based down through the centuries, *primum non nocere*, first do no harm, and the Hippocratic Oath, which originated outside the Judaeo-Christian tradition, that prohibits the procuring by a doctor of an abortion. Abortion makes the medical profession a party to the deliberate shedding of innocent blood.

Abortion is wrong *medically* because, as shown above, the provision of abortion is not really a medical issue at all as abortion is never necessary to save the life of a mother; it is not a necessary part of the treatment of cancer or heart disease in pregnant women; it is not an appropriate medical response to suicidal inclinations; and it is not a truly compassionate response where pregnancy has resulted from sexual violence.

Medical treatments in which the loss of the life of the unborn follows as a foreseeable though undesired side-effect are *not* the same morally, legally or medically as induced abortion. All medical treatments involve side-effects, often foreseeable, and the practice of medicine is quite familiar with the distinction between foreseeable direct and indirect effects.

Abortion to prevent the birth of a handicapped child is medically wrong because when a doctor treats a pregnant women he or she has an ethical and professional duty of best care towards not one but two patients, the mother and the unborn child, and the fact that a patient is suffering from a disability is not a reason to seek to bring about the death of that patient. On the contrary, a human being is not any the less human or worth any less because they suffer from a disability. We are equal in worth to the other members of the human family and the society into which we are born by virtue of our humanity, and not as a result of having passed some kind of quality control test.

Abortion is socially wrong Abortion is wrong *socially* because in a democracy all the members are equal and their lives have an equal and inherent value, but abortion treats some unequally and regards their lives as of lesser or no inherent worth, but rather allows some to decide upon the value of the lives of others, and actually to dispose of those lives, according to their own wish or convenience.

It is also wrong *socially* because by allowing some to bring about the death of others, it undermines, weakens and destroys the sense of human brotherhood and sisterhood, breaking the bonds of fellowship that bind the members into a society.

When, as in this submission, we look at the grounds on which legal abortion is available in Britain, we realise that the legalisation of abortion is wrong *socially* also because it throws the weight of society's moral approbation behind the violation of its own most intimate bonds, the bonds uniting mother and unborn, father and unborn, born and unborn brothers and sisters. It signals a rejection of the handicapped. It signals a rejection of the weak. If the most vulnerable can lawfully be killed, then any lesser abuse may well be visited on the less vulnerable. The medical and legal professions are those to whom we have to turn in our moments of greatest distress and weakness. Legalised abortion involves both of these professions in the taking of innocent life, in the violation of the most fundamental right of the most voiceless members of society. Democracy is that form of society animated by a spirit of social equality. If the legislature or judiciary in a democracy make laws that deny the equal humanity and inherent worth of some of the members of the society, as happens when abortion is legalised, they thereby render the society entrusted to them ever more undemocratic, less suffused by a spirit of respect for equality, and they alienate ever more radically those who are affronted by this attack on the fundamental rights of the innocent and defenceless. Legalising abortion saws away the very branch on which democracy rests, the respect for social equality.

Proponents of legalising abortion argue that, because of the tragic fact that several thousand women go to Britain for abortions, abortion should be legalised in the Republic. This is a false and hypocritical argument. What is tragic is that those women undergo abortion, not that the abortions happen in Britain. They would be just as tragic if they happened in the Republic.

Abortion is only tragic because it is the taking of the life of an unborn child, and for that reason is profoundly distressing for the women. If it were a medical operation like having an appendix removed, it would not be tragic. It is gross insensitivity and hypocrisy for the proponents of abortion to trade on the tragedy by suggesting that it constitutes a reason for legalising abortion in Ireland. The only way to avoid the tragedy is to avoid what makes it tragic, namely, the abortion itself. The tragedy is not any less tragic because it happens in the Republic rather than happening in Britain.

The Pro-Life Campaign is deeply concerned that so many women feel they have to have recourse to abortion and is committed to pressing for the introduction of measures that will help them to find another way to resolve

the terrible dilemma in which they find themselves, but it insists that each of these abortions is tragic, not because it happens in Britain, but because it happens at all, because it involves the taking of an innocent human life and the violation of a vulnerable woman.

The Pro-Life Campaign further points out that the clear and ineluctable lesson of international experience is that the legalisation of abortion is followed by a massive increase in the numbers having recourse to abortion. If every women going for an abortion is tragic, and it is, this is a reason for not going down the road of legalising abortion here, because were it to be legalised here, the certainly foreseeable consequence would be a huge rise in the numbers of women who would have recourse to it.

As an expression of its concern that every effective measure that will help women not to turn to abortion should be explored, the Pro-Life Campaign wishes to draw the attention of the Working Group to the findings of the opinion poll published in the *Sunday Independent* (30 November 1997), which found 87% of people in favour of Government action to make adoption easier where a single mother is unable or unwilling to care for the child, and 59% in favour of a major Government campaign to persuade single expectant mothers to allow their pregnancies to proceed to birth.

These replies point to the existence of an emphatic public desire that public policy not only ban abortion but discourage women under pressure from having abortions by positive measures, such as making other options easier, and by a social education campaign to encourage them to give birth. The Pro-Life Campaign wholeheartedly shares this desire and urges the Working Group to make the identification and implementation of such measures one of its principal recommendations.

APPENDIX F
SUBMISSION MADE BY THE PRO-LIFE CAMPAIGN TO THE ALL-PARTY OIREACHTAS COMMITTEE ON THE CONSTITUTION IN JANUARY 1997 IN RESPONSE TO THE REPORT OF THE CONSTITUTION REVIEW GROUP

Summary of submission

Constitution Review Group's proposals on definition 'The Pro-Life Campaign is of the view that the protection of the law should extend to all life from conception to natural death. Any attempt to limit this protection by way of statutory definition or otherwise is both unconstitutional and undesirable.'

Possible approaches 'The position of the Pro-Life Campaign is simple and clear. Irish medical practice has no difficulty in distinguishing between abortion and medical treatment for the mother. Irish obstetricians make the distinction every day in the hospitals. They do not carry out abortions, since they recognise that the Supreme Court was mistaken, legally and medically, in its holding in the *X* decision. The Irish electorate should be given the democratic choice, in a referendum, to restore full protection to the unborn, consistent with contemporary medical practice.

'The Pro-Life Campaign, therefore, rejects the proposal of the Review Group to legislate to allow abortion and stands by the alternative approach of a referendum to allow the electorate to constitutionally prohibit abortion.'

Introduction

The legal situation in regard to abortion has been unsatisfactory since the Supreme Court in 1992 interpreted the Eighth Amendment, inserted by the electorate into the Constitution to expressly prohibit abortion, as actually allowing abortion, potentially on wide grounds.

Since then, there have been various efforts to tackle the matter; the constitutional referenda in November 1992, the increased funding to various non-governmental agencies, and the *Regulation of Information (Services outside State for Termination of Pregnancies) Act 1995*. None of these addressed the core problem of whether abortion should be permitted or prohibited. The Pro-Life Campaign promotes the latter position, and furthermore holds that abortion raises such fundamental questions about the nature of society and respect for life that it must be left to the electorate to decide, by way of a referendum which gives a clear choice.

Proposals on definition

Before examining the various approaches by which the law might be clarified, the *Report of the Constitution Review Group* (henceforth referred to as the Review Group) raised a problem of definition, pointing out that:

> There is no definition of 'unborn' which, used as a noun, is at least odd. One would expect 'unborn human' or 'unborn human being'. Presumably, the term 'unborn child' was not chosen because of uncertainty as to when a foetus might properly be so described.[128]

The Pro-Life Campaign regards this statement with some degree of puzzlement. Article 40.3.3° is in the personal rights section of the Constitution and must therefore refer to unborn human beings. Moreover, the adjectival noun is of standard usage in the Constitution. For instance in Article 45.4.1:

> The State pledges itself to safeguard with especial care the interests of the weaker sections of the community, and, where necessary, to contribute to the support of the infirm, the widow, the orphan, and the aged.

In its discussion of Article 45.4.1, the Review Group did not suggest that the use of the adjectival nouns 'the infirm' and 'the aged' denoted any uncertainty about their humanity.[129]

The Review Group goes on to state:

> Definition is needed as to when the 'unborn' acquires the protection of the law...

and

> a definition is essential as to when pregnancy is considered to begin; the law should also specify in what circumstances a pregnancy may legitimately be terminated and by whom.

128 *Report of Constitution Review Group*, Dublin, 1996, p. 275.
129 Review group, pp. 391-4.

and finally

> If the definition of 'pregnancy' did not fully cover what is envisaged by 'unborn", the definition would need to be remedied by separate legal provisions which could also deal with other complex issues, such as those associated with the treatment of infertility and *in vitro* fertilisation.[130]

The Review Group concludes that these definitions should be introduced by way of legislation.[131]

This is a surprising recommendation as it is not within the ambit of the Legislature to define the scope of constitutional protection given to human life: that is the prerogative of the Courts. Furthermore, the Pro-Life Campaign views with grave concern any effort to limit the protection of the law so that it does not extend to all life, from conception to natural death.

The Pro-Life Campaign is of the view that the protection of the law should extend to all life from conception to natural death. Any attempt to limit this protection by way of statutory definition or otherwise is both unconstitutional and undesirable.

The possible approaches

On the substantive issue of abortion, the Review Group considered five options:

a) introduce an absolute constitutional ban on abortion
b) redraft the constitutional provisions to restrict the application of the *X* case decision
c) amend Article 40.3.3º so as to legalise abortion in constitutionally defined circumstances
d) revert, if possible, to the pre-1983 situation
e) regulate by legislation the application of Article 40.3.3º.[132]

This Submission will deal with the two primary options, 'a' and 'e'. Some comments upon the Review Group's approaches are to 'b', 'c' and 'd' are made in the appendix.

The first option, to introduce an absolute constitutional ban on abortion, is the option supported by the Pro-Life Campaign.

Of this approach, the Review Group said:

> According to a press report (*The Irish Times*, 10 September 1992), the Pro-Life Campaign considers 'a complete prohibition on abortion is legally and medically practicable and poses no threat to the lives of mothers'. Reference is made to 'the success of medical practice in protecting the lives of mothers and their babies', and it is claimed that 'a law forbidding abortion protects the unborn child against intentional attack but does not prevent the mother being fully and properly treated for any condition which may arise while she is pregnant'.[133]

The Review Group goes on to state that it would not be safe to rely on such understandings, because:

> ... if a constitutional ban were imposed on abortion, a doctor would not appear to have any legal protection for intervention or treatment to save the life of the mother if it occasioned or resulted in termination of her pregnancy.[134]

The Pro-Life Campaign believes that this conclusion is unsafe, and without grounding in either the legal and medical understanding of the treatment of mothers and their unborn babies, or the medical profession's own ethical guidelines which reflect the fact that '… the necessity for abortion to preserve the life or health of the mother remains to be proved …'[135]

There is a crucial distinction, ignored by the Review Group, between those cases where the death of the unborn may result as an indirect effect of appropriate medical treatment, and cases involving the intentional killing of the unborn child. The established medical practice of over a century has always required that mothers be fully and properly cared for during pregnancy.

It is important to realise – and this point appears to have escaped the Review Group – that a mother is not denied the appropriate treatment because of possible but undesired and unintended consequences for her baby.

Treatments directed at protecting the life of the mother, and not involving any direct attack on her unborn child, are and always have been ethically and legally proper even though the loss of her child may follow as an unsought and unwelcome side effect. Irish medical practice has it that '... it is unethical always to withhold treatment beneficial to a pregnant woman, by reason of her pregnancy'.[136]

Thus, Irish law and the ethical guidelines of the Medical Council recognise the difference between induced abortion – the direct and intentional killing of the unborn – and damage to or even the death of unborn babies arising indirectly from medical treatment. This principle was not changed by the passage of the 1983 Amendment, any more than it would change if another prohibition on induced abortion were to be inserted in the Constitution.

In treating pregnant women, doctors know that all treatments have side effects. In selecting a treatment for any patient, the doctor must have regard – not alone to the desired effects – but also to the undesired side-effects. Pregnancy presents a near unique situation for any doctor, who is then required to deal with two patients simultaneously. Here the effects on the unborn child must also be taken into consideration. However, the fact that a woman is pregnant is not a ground for refusing her appropriate treatment. Although concerns for foetal well-being may alter therapeutic approaches, in serious or life-threatening conditions, therapy should not be modified in such a way as to compromise the goal of treatment.

Where, however, there are two treatments for any given condition in the mother – and both are of comparative therapeutic efficacy – there is an obligation to use that which is least harmful to both the mother and her unborn child. The function of medicine is to preserve life and relieve suffering. It is not the function of doctors to kill: an obvious point but one that would have been well remembered by the authors of this report.

130 Review group, p. 275.
131 Review Group, p. 279.
132 Review Group, p. 276.
133 Review Group, p. 277.
134 Review Group, p. 277.
135 *A Guide to Ethical Conduct and Behaviour and to Fitness to Practise.* The Medical council, Fourth Edition, 1994, p. 36. (Henceforth cited as 'Medical Council').
136 Medical Council, p. 36.

In effect, Ireland without abortion is one of the safest countries for pregnant women. While not attempting to minimise in any way the death of any woman during pregnancy or childbirth, it is abundantly clear – and this is reflected in international reports – Ireland has one of the best records in the world,[137] which is reflected in our maternal mortality rates. The latest independent research states:

> The Republic of Ireland is unusual in the developed world in that termination of pregnancy is not available. This does not appear to have influenced these figures significantly, the maternal mortality rate due to obstetric causes being half that of the nearest European neighbour, i.e. England and Wales.[138]

This research is consonant with the major review of maternal deaths carried out in the National Maternity Hospital, Dublin in 1982, before the enactment of the Eighth Amendment. That study found that over a ten year period there were 21 maternal deaths and a total of 74,317 births. In each case the cause of death was analysed and the conclusion was that the availability of induced abortion would not, in any way, have reduced the number of maternal deaths over the study period.[139]

It might be thought that the rate of maternal death in Ireland is artificially low because of the number of Irish women who travel to Britain each year for abortions. This is not the case. Analysis of the British statistics is unequivocal. For whatever reason Irish women have recourse to abortion in England – which has one of the most liberal abortion regimes in Europe – a risk to the mother's life or health is not one of them. There is no evidence that women travel in order to obtain treatment for life-threatening conditions which could not be treated here in Ireland because of the non-availability of abortion.[140]

The Review Group's contention that a complete ban on abortion would prevent the mother being fully and properly treated for any condition which may arise while she is pregnant represents a major departure from the present legal and medical understanding of the matter, and is not supported by Irish maternal mortality statistics.

The position of the Pro-Life Campaign is simple and clear. Irish medical practice has no difficulty in distinguishing between abortion and medical treatment for the mother. Irish obstetricians make the distinction every day in the hospitals. They do not carry out abortions, since they recognise that the Supreme Court was mistaken, legally and medically, in its holding in the *X* decision. The Irish electorate should be given the democratic choice, in a referendum, to restore full protection to the unborn, consistent with contemporary medical practice.

137 1994, 1995. *The Progress of Nations*. UNICEF, New York.

138 Jenkins DM, Carr C, Stanley J, O'Dwyer T: Maternal Mortality in the Irish Republic 1989-1991, *Irish Medical Journal*, July/August 1996, Volume 89, Number 4.

139 Murphy J, O'Driscoll K: Therapeutic Abortion: The Medical Argument. *Irish Medical Journal* 75: 306-6, 1982.

140 *Abortion Statistics, England and Wales, Series AB, 1974-1994*. Office of Population, Censuses and Surveys, HMSO, London.

Option 'e', to 'regulate by legislation the application of Article 40.3.3º', is the preferred option of the Constitutional Review Group.

> Relying on legislation alone would avoid the uncertainties surrounding a referendum but the legislation would have to conform to the principles of the *X* case decision and be within the ambit of Article 40.3.3º generally.[141]

This statement forms the basis of the Group's recommendations and contains two points which cannot be left unchallenged.

1 '… the uncertainties surrounding a referendum …'. Every popular vote is subject to uncertainties, because it is never clear which way the electorate will vote. Thus 'uncertainty' is an integral part of the democratic system; to suggest that such uncertainties should be avoided is tantamount to saying that, since the electorate cannot be trusted to vote in a predictable or reliable manner, it is better to leave major decisions to the Legislature.
2 '… the legislation would have to confirm to the principles of the *X* case decision …' This analysis is quite correct, and must mean that any legislation would have to permit the creation of a domestic abortion regime. Yet this was clearly not the intention of the people in 1983 and would be contrary to what the Review Group recognised to be 'strong opposition to any extensive legalisation of abortion in the State.'[142]

Despite the acknowledgement that 'legislation would have to conform to the principles of the *X* case decision'[143], the Review Group suggests that a time-limitation be imposed to prevent a viable foetus being aborted in circumstances permitted by the *X* case. This inconsistency in the Review Group's arguments is in itself a matter of concern; moreover the contention that the Legislature could limit the scope of a constitutional interpretation of the Supreme Court is simply a legal nonsense.

The Review Group notes that legislation could 'require written certification by appropriate medical specialists of 'real and substantial risk to the life of the mother'".[144] This is presumably an effort to reduce the number of abortions that would take place under the proposed legislation. Yet the foreign experience is that any abortion law, no matter how superficially restrictive in some areas is used to create a legal culture of abortion on demand. (And the Pro-Life Campaign notes again that legislation under the terms of the *X* decision would have to be broad, rather than restrictive, if it is to give scope to the decision.)

The Review Group concludes:

> While in principle the major issues discussed above should be tackled by constitutional amendment, there is no consensus as to what that amendment should be and no certainty of success for any referendum proposal for substantive constitutional change in relation to this subsection.
>
> The Review Group, therefore, favours, as the only practical possibility at present, the introduction of legislation covering such matters as definitions,

141 Review Group, p. 279.

142 Review Group, p. 277.

143 Review Group, p. 279.

144 Review Group, p. 279.

protection for appropriate medical intervention, certifications of 'real and substantial risk to the life of the mother' and a time-limit on lawful termination of pregnancy.[145]

The Pro-Life Campaign agrees that, in principle, the abortion issue should be tackled by constitutional amendment. It also agrees with the somewhat obvious observation that there is no consensus as to what the amendment should be and no certainty of success for any referendum. It would be a bizarre situation indeed if there were to be a total consensus on abortion, or indeed a certainty of success for any constitutional referendum. None of this means that a national abortion debate, taking place at the most fundamental level of the Constitution, is impractical. The strength of our democratic system lies in its ability to confront difficult issues and reach a mature decision which will, by virtue of having such a direct mandate from the people, be infinitely more acceptable than a judicial or legislative decision.

The Pro-Life Campaign, therefore, rejects the proposal of the Review Group to legislate to allow abortion and stands by the alternative approach of a referendum to allow the electorate to constitutionally prohibit abortion.

Appendix

Comments upon the Review Group's proposals 'b', 'c' and 'd'.

(a) redraft the constitutional provisions to restrict the application of the *X* case decision

The Review Group notes the failure of this approach in 1992. The Pro-Life Campaign agrees with this analysis.

(b) amend Article 40.3.3° so as to legalise abortion in constitutionally defined circumstances

The Review Group draws attention to the fact that there 'appears to be strong opposition to any extensive legalisation of abortion in the State.' The Pro-Life Campaign endorses this view. Concerning the Group's assertion that 'There might be some disposition to concede limited permissibility in extreme cases, such, perhaps, as those of rape, incest or other grave circumstances', the PLC draws attention to the 1995 survey by the Institute of Advertising Practitioners in Ireland which put opposition to abortion in all circumstances at 52% of the electorate.[146]

(Another poll, conducted by Irish Marketing Surveys for the Pro-Life Campaign in May, 1993 asked a representative sample of the electorate whether, their personal opinions on abortion aside, they felt that a constitutional referendum was the way to deal with the issue. 60% were in favour of a referendum, 28% opposed.)

(c) revert, if possible, to the pre-1983 situation

The Review Group comments that the experience since the 1983 Amendment was 'a lesson in the wisdom of leaving well enough alone …'

This viewpoint is contested by the Pro-Life Campaign. That the Amendment was not upheld by the Supreme Court in the *X* decision can as easily be construed as a criticism of that decision rather than of the Amendment itself. And it is fair to say that without the constitutional protection for unborn life throughout the 1980's, the situation in Ireland might now be very different.

The Pro-Life Campaign would not recommend a return to the pre-1983 situation, because such would not provide adequate protection for unborn life.

145 Review Group, p. 279.

146 It might be expected that this figure would rise during a referendum campaign; the same survey indicated that opposition to divorce was 28%.

APPENDIX G
EFFECTS OF CANCER TREATMENT ON UNBORN CHILDREN

Chemotherapy

Chemotherapy is potentially curative in carcinoma of the breast and ovary, acute leukaemia, Hodgkin's lymphoma, and intermediate and high grade non-Hodgkin's lymphomas. Cytotoxic drugs produce their effects predominantly on rapidly dividing cells. Therefore, rapidly dividing foetal cells exposed to such agents may be associated with deleterious effects. The timing of the exposure is critical. Drugs administered in the first week after conception probably produce an 'all or nothing' phenomenon (i.e. either a spontaneous miscarriage or normal development). During the first trimester when organogenesis occurs, drugs can produce congenital malformations of differing severities and/or spontaneous miscarriage. Each type of malformation can occur only at specific times.[147, 148] During the second and third trimesters, drugs do not cause significant malformations but they can impair foetal growth and functional development (neurological development in particular).[1, 149] Finally towards the end of gestation, the foetus reacts like a newborn exposed to a noxious substance.

The teratogenic and mutagenic potential of chemotherapeutic agents has been clearly demonstrated in animals[150, 151, 152] but extrapolation from animal studies to humans is tenuous because of differences in species susceptibility.[1, 153] Up to 600 factors have been catalogued as teratogenic in animal experiments.[154] However teratotoxic sequelae have been documented for only some of these factors. This is partly due to the fact that the therapeutic dose used in humans is lower than the minimal

147 Ebert U, Löffler H, Kirch W: Cytotoxic therapy and pregnancy. *Pharmacol Ther* 74 (2); 207-220, 1997.

148 Beeley L: Adverse effects of drugs in the first trimester of pregnancy. *Clin Obstet Gynecol* 13: 177-195, 1986.

149 Doll DC, Ringenberg QS, Yarbro JW: Antineoplastic agents and pregnancy. *Sem Oncol* 16 (5): 337-346, 1989.

150 Cahen RL: Experimental and clinical chemoteratogenesis. *Adv Pharmacol* 4: 263-349, 1966.

151 Chaube S, Murphy ML: The teratogenic effects of the recent drugs active in cancer chemotherapy. *Adv Teratology* 3: 181-237, 1968.

152 Sieber SM, Adamson RH: Toxicity of antineoplastic agents in man: Chromosomal aberrations, antifertility effects, congenital malformations and carcinogenic potential. *Adv Cancer Res* 22: 57-155, 1975.

153 Brent RL: evaluating the alleged teratogenicity of environmental agents. *Clin Perinatol* 13: 609-613, 1986.

154 Shepard TH: *Catalog of Teratogenic agents*. 7th ed. Johns Hopkins Press, Baltimore, 1992.

teratogenic dose applied in animals. In addition, the genotype of the organism also plays an important role. Thus the absence of teratogenesis in animals is no guarantee of safety in man (e.g. thalidomide) and conversely agents that produce defects in animals appear to be harmless in humans (e.g. aspirin).[3]

Studies have confirmed that the critical phase for teratogenesis embryonic organogenesis is the first trimester.[155, 156, 157] But the risk is significantly lower than is generally appreciated because doses, dose frequency and duration of exposure are important variables. For an agent to be teratogenic, it appears necessary for the dose to lie within the narrow range between causing death of the foetus and causing no discernible effects. Synergistic teratogenesis may occur with combination chemotherapy.[158]

A large number of anti-neoplastic agents given alone or in combination may cause congenital malformations when given in early pregnancy.[3] An early review of 53 cases where antineoplastic drugs were administered during pregnancy reported a 7.5% rate of foetal malformation.[159] Another study found that 17% of foetuses exposed to chemotherapy developed congenital malformations.[160] The most recent review of 217 cases involving cytotoxic treatment during pregnancy between 1983-1995 found 9.2% of liveborn or stillborn infants had congenital abnormalities.[1]

In a review of 56 pregnancies associated with haematological malignancies (27 treated before conception and 22 while pregnant) there was only 1 major malformation.[161]

Furthermore an assessment of the rate of congenital malformation due to anti-cancer therapy should be tempered by the fact that the overall incidence of major congenital malformations is approximately 3% of all births[2, 162] and the incidence of minor malformations is as high as 9% (depending on the definition of 'minor' giving a total of 12% for all malformations).[3] Furthermore, the effects of radiation which is a well known teratogen in both humans and animals[163] are difficult to exclude from the data.[3]

If the effects of radiation and the folic acid antagonists are excluded the incidence of congenital malformation falls to 6% for single agents.[3] Fortunately, methotrexate, the principal folic acid antagonist used, is not part of any curative regimen for which a therapeutically equivalent substitute is lacking.[3] Similarly, there are reports of normal infants delivered following chemotherapy (including methotrexate[164]) during the first trimester.[17, 165, 166, 167] Long term follow-up of these children has revealed the phase of growth and development is normal.[17, 18, 20]

There is no evidence of an increased risk of teratogenesis associated with the administration of chemotherapy in the second and third trimesters.[14, 168]

In most cases the cancer and the pregnancy can be managed concurrently with a good outcome for the baby and without compromising the mother's prognosis.[169] When cure is a realistic goal, therapy should not be modified in such a way as to compromise its achievement. If there is no hope for cure or even significant palliation, the primary goal may become the protection of the foetus from the harmful effects of anticancer therapy and the delivery of a healthy infant. Therapy must be individualised for each patient.[3]

Surgery

Excluding caeserean sections, approximately 50,000 pregnant women per year in the United States will undergo a surgical procedure.[170] Surgery *per se* does not cause problems in pregnant patients. Anaesthetics given to a pregnant woman who requires surgery can be used safely and have not been shown to be teratogenic.[171, 172]

Radiotherapy

The most common tumours requiring radiotherapy are lymphomas, leukaemias and tumours of the breast, uterine cervix and thyroid. With the exception of cancer of the cervix there is no direct radiation to the foetus, instead the foetus is excluded from the radiation field and is exposed only to radiation leaking from the accelerator, collimator dispersion generated from apparatuses other than the accelerator and dispersion radiation from the mother. The most important factor is the distance of the foetus from the field edge which is the limit of the direct beam. It is possible to estimate the foetal dose as a function

155 Blatt J, Mulvihill JJ, Zieglewr JL, et al: Pregnancy outcome following cancer chemotherapy. *Am J Med* 69: 828-832, 1980.

156 Barber KRK: Foetal and neonatal effects of cytotoxic agents. *Obstet Gynecol* 58: 41S-47S, 1981 (suppl).

157 Gilliland J, Weinstein L: The effects of cancer chemotherapeutic agents on the developing fetus. *Obstet Gynecol Surv* 38: 6-13, 1983.

158 Mulvihill JJ, McKeen EA, Rossner F, et al: Pregnancy outcome in cancer patients. *Cancer* 60: 1143-1150, 1987.

159 Hicholson HO: Cytotoxic drugs in pregnancy. *J Obstet Gynecol. Br Commonw*. 75: 307-12, 1968.

160 Doll DC, Ringenberg S, Yarbro DW: Management of cancer during pregnancy. *Arch Intern Med* 148: 2058-2064, 1988.

161 Znazu J, Julia A, Sierra J, Valentin MG, Coma A, Sanz MA, Batle J, Flores A: Pregnancy outcome in haematological malignancies. *Cancer* 63 (3), 703-9, 1991.

162 Kalter H, Warkany J: Congenital malformations. *N Engl J Medi* 308: 424-431, 1983.

163 Brent RL: The effects of embryonic and fetal exposure to x-rays, microwaves and ultrasound. *Clin Perinatol* 13: 615-648, 1986.

164 Aviles A, Diaz-Maqueo JC, Talavera A, Guzman R, Garcia EL: Growth and development of children of mothers treated with chemotherapy during pregnancy: Current status of 43 children. *Am J Haematol* 36: 243-248, 1991.

165 Aviles A, Niz J: Long-term follow-up of children born to mothers with acute leukaemia during pregnancy. *Med Pediat Oncol* 16: 3-6, 1988.

166 Caliguri MA, Mayer RJ: Prgnancy and leukaemia. *Sem Oncol* 16: 388, 1989.

167 Reynoso EE, Shepherd FA, Messner HA, et al: Acute leukaemia during pregnancy: The Toronto Leukaemia Study Group experience with long-term follow-up of children exposed in utero to chemotherapeutic agents. *J Clin Oncol* 5: 1089-2106, 1987.

168 Grendys EC Jr, Barnes WA: Ovarian cancer in pregnancy. *Surg clin North Am* 75 (1): 1-14, 1995.

169 Antonelli NM, Dotters DJ, Katz VL, Juller JA: Cancer and pregnancy: a review of the literature Part I. *Obstet Gynecol surv* 51 (2): 125-34, 1996.

170 Barron W: The pregnant surgical patient: Medical evaluation and management. *Ann Intern Med* 101: 683-691, 1984.

171 Pedersen H, Finster M: Anaesthesa risks in the pregnant surgical patient. *Anaesthesiology* 51: 439-51, 1979.

172 Nunn FJ: Faulty cell replication, abortion, congenital abnormalities. In Cottrell JE, editor, *International Anesthesiology Clinics* Vol. 19: 82-3, 1981.

of the stage of pregnancy.[173] Covering the mother's abdomen with a lead shield (approx 4.5 cm thick) was effective in further reducing the radiation to the foetus.[174, 175]

To optimise the efficacy of radiotherapy for cancer patients who are pregnant, the following facts must be considered: the potential effects of the therapy on the foetus and neonate, the stage and prognosis of the mother's disease, and the possible risks to the mother of restricting or delaying treatment. Malformation and mental retardation are the most serious consequences of foetal exposure to radiation. The risk is negligible if foetal exposure does not exceed 0.1Gy.[176] With higher doses the sensitivity to radiation is high from 28 weeks after conception for malformations and from 8-15 weeks for mental retardation.

It has been well established that planned delay in therapy for patients with early squamous cell carcinoma of the cervix can improve neonatal outcome without compromising maternal outcome.[177] In cases of advanced disease, primary radiation therapy is the main treatment modality. Radiation for cancer of the cervix in the first and second trimester will result in a spontaneous abortion. Options should be fully discussed with the mother who may decide to forego treatment for the sake of her foetus if maternal outcome is likely to be poor regardless of treatment. For patients in the third trimester the baby can be delivered by ceasarian section or vaginally prior to treatment. There is no difference in outcome in pregnant and nonpregnant patients.[178]

APPENDIX H
ABORTION SEQUELAE: GENERAL AND PSYCHOLOGICAL

General

Notwithstanding some high profile cases of abortion survivals the mortality rate for the unborn child in abortion is effectively 100%.

While the introduction of so-called 'lunch-time' or 'quickie' abortion would seem to emphasise the safety of the procedure for the mother yet there is significant maternal morbidity and even mortality. The report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1991-1993 reports 5 deaths directly related to abortion, a further 2 deaths due to suicide within 42 days of the abortion and another 2 deaths in women known to be substance abusers who died of injecting substance abuse overdose within 1 year of an abortion.[179] The report for the following three years 1994-1996 reports a total of 12 deaths related to abortion: 1 direct, 1 suicide; 2 deaths from thrombosis/thromboembolism; 1 death from myocardial infarction; 1 death from a ruptured ectopic pregnancy after an induced abortion had supposedly been performed; and finally 6 deaths occurred in women who had so called medically indicated induced abortion for cardiac conditions such as primary pulmonary hypertension and Eisenmenger's.

A survey of abortion mortality in the United States from 1972-1987 found 240 maternal deaths: the main causes of death were sepsis, haemorrhage and anaesthetic complications.[180]

A study of maternal mortality in Finland found the suicide rate following abortion was much higher than that associated with birth. The mean annual suicide rate was 11.3 per 100,000; the rate associated with birth was 5.9; the rate associated with induced abortion was 34.7.[181]

Abortion begets abortion. A study of 2,925 women in Norway showed that the incidence of repeat induced abortion doubled from the second to the third abortion, indicating that the moral threshold for choosing an abortion after recognition of an unplanned pregnancy is the first induced abortion.[182] In a review of women having abortions in 1987, 59% were under 25 years of age and 42% had had a previous abortion.[183] In another review of 2,001 women seeking abortion in Wichita, Kansas in 1991-1992, 34% had had a previous abortion.[184] In a study of 163 women seeking abortions who attended Irish Family Planning Association clinics in a 1 year period 10 of the women had had an abortion in the past with 4 of these having had 2 previous abortions. One teenager had 2 abortions during the study period of 1 year and returned for a third abortion one month after the study ended.[185]

Incidence of postabortal upper genital tract infections varies across populations. Incidence rates range at 5-20%. Infecting organisms include Chlamydia Trachomatis, Neisseria gonorrhoea, Mycoplasma hominis, Ureaplasma urealyticum, Group B streptococci and Human Papillomavirus. Long term sequelae of postabortal infection include

173 Van der Giessen PH: Measurement of the peripheral dose for the tangential breast treatment technique with Co-60 gamma radiation and high energy X-rays. *Radiotherapy and Oncology* 42: 257-264, 1997.

174 Stovall M, Blackwell CR, Cundiff J, et al: Fetal dose from radiotherapy with photon beams. Report of AAPM Radiation Therapy Committee Task Group No. 36. *Am Assoc Phus Med.* 22: 63-82, 1995.

175 Woo SY, Fuller LM, Cundiff JH, et al: Radiotherapy during pregnancy for clinical stages IA-IIA Hodgkin's disease. *Int J Radiation Oncology Biol Phys.* 23: 407-412, 1992.

176 Nakagawa K, Yukimasa A, Kusama T, Ban N, Nakagawa S, Sasake Y: Radiotherapy during pregnancy: effects on fetuses and neonates. *Clin Therap* 19 (4): 770-777, 1997.

177 Soronsky J, Squatrito R, Ndubisi BU, Anderson B, Podczaski ES, Mayr N, et al: Stage I squamous cell cervical carcinoma in pregnancy: planned delay in therapy awaiting fetal maturity. *Gynecol Oncol.* 59: 207-10, 1995.

178 Sood AK, Sorosky JI, Mayr N, Krogman S, Anderson B, Buller RE, Hussey DH: Radiotherapeutic management of cervical carcinoma that complicates pregnancy. *Cancer* 80 (6): 1073-1978, 1997.

179 Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1991-1993.

180 Lawson HW, et al: Abortion Mortality, United States, 1972 through 1987. *Am J Obstet Gynecol* 171 (5), 1994.

181 Gissler M, Hemminki E, Lonnqvist J: Suicides after pregnancy in Finland 1987-94: register linkage study. *BMJ* 313 (7070): 1431-4, 1996.

182 Skjeldestad FE: The incidence of repeat induced abortion – a prospective cohort study. *Acta Obstetrical et Gynecologica Scandinavica* 73 (9): 7-6-10, 1994.

183 Henshaw SK, Koonin LM, Smith JC: Characteristics of U.S. women having abortions, 1987. *Family Planning Perspectives* 23 (2): 75-81, 1991.

184 Westfall JM, Kallail KJ: Repeat abortion and use of primary care health services. *Family Planning Perspectives* 27 (4): 162-5, 1995.

185 *Irish Medical Times*, Page 5, April 18, 1997.

chronic pelvic pain, ectopic pregnancy, dyspareunia and infertility.[186, 187]

A number of studies have suggested that induced abortion may be a risk factor for developing Breast Cancer. One study suggested that women age 45 or younger who have had induced abortions have a relative risk of 1.5 (50% increased risk) for breast cancer compared to women who had been pregnant but never had an induced abortion. The highest risk was for women who had an abortion younger than age 18 or older than 30.[188] The meta-analysis of 28 papers concludes that even one abortion significantly increases the risk and that overall the relative risk of breast cancer for women who have had an abortion is 1.3.[189]

Psychological

Short-lived adverse psychological sequelae following induced abortion occur in up to 50% of women studied. Psychiatric disturbance is marked, severe or persistent in 10-32%.[190, 191, 192]

Both women and men are severely impacted by post-abortion syndrome (PAS), according to diagnostic features developed by Rue et al[193] based on DSM-111 criteria for post-traumatic stress disorder. Certain factors predispose particular individuals to its development. Individuals at greatest risk include:

- a woman who is advised or coerced into having an abortion for medical reasons – either illness in the mother or deformity in the foetus;[13, 194, 195, 196]
- a woman who has a previous psychiatric history;[13]
- a woman who has current or past interpersonal relationship difficulties and a premorbid personality vulnerable to trauma;[15]
- a woman who intends to have further children at some stage;[197]
- teenagers;[13]
- those with a history of previous abortions;[13]
- women who have second trimester abortions.[198, 199]

Previous induced abortion has been shown to be associated with clinically significant neurotic disturbances and affective disorders in subsequent pregnancy and it is postulated that this phenomenon may reflect a reactivation of mourning which was previously suppressed.[200, 201]

186 Sawaya GF, Grady D, Kerlikowska K: Antibiotics at the time of induced abortion: the case for universal prophylaxis based on meta-analysis. *Obstet Gynecol* 87 (5): 884-90, 1996.

187 Stray-Pedersen B, et al: Induced abortion: micrological screening and medical complications. *Infection* 19 (5): 305-8, 1991.

188 Daling JR, Malone KE, Voigt LF, White E, Weiss NS: *J Natl Cancer Inst* (2), 1994.

189 *Journal of Epidemiology and Community Health* 50: 481-96, 1996.

190 Dagg: T*he psychological sequelae of induced abortion*. *Am J Psychiatr* 148: 578-585, 1991.

191 Ashton JR: Psychological outcome of induced abortion. *Br J Obstet Gyn* 87: 1115-22, 1980.

192 Wallerstein JS, et al: Psychosocial Sequelae of Therapeutic Abortion in Young Unmarried Women. *Archives of General Psychiatry* 27: 832, 1972.

193 Rue V, et al: The psychological aftermath of abortion: A white paper presented to C. Everett Koop, Surgeon General USA: A review of 225 articles, 1987.

194 Blumberg, et al: The psychological sequelae of abortion performed for a genetic indication. *Am J Obstet Gynecol*: 122-799, 1975.

195 Bracken, et al: The decision to abort and psychological Sequelae. *J Nerv Mental Dis* 158: 154-162, 1974.

196 Iles S, Gath D: Psychiatric outcome of termination of pregnancy for foetal abnormality. *Psychological Medicine* 23: 407-413, 1993.

197 Greenglass E: Therapeutic abortion, fertility plans and psychological sequelae. *Am J Ortho Psychiatr* 1: 119-126, 1977.

198 Zolese, Blacker: The psychological complications of induced abortion. *B J Psychiatr* 160: 742-749, 1992.

199 Kaltreider, et al: The impact of mid-trimester abortion techniques on patients and staff. *Am J Obstet Gynecol* 135: 235-238, 1979.

200 Kumar R, Robson K: Previous induced abortion and antenatal depression in primiparae: preliminary report of a survey of mental health in pregnancy. *Psychological Medicine* 8 (4): 711-5, 1978.

201 Kitamura, et al: Psychological and social correlates of the onset of affective disorders among pregnant women. *Psychological Medicine* 23: 967-975, 1993.

IRISH BISHOPS' CONFERENCE
29 NOVEMBER 1999
REV. MARTIN CLARKE, COMMUNICATIONS OFFICER

1 The position of the Irish Bishops' Conference regarding the issue of Abortion is clearly set out in its Submission to the Interdepartmental Working Group dated 16 March 1998, a copy of which is attached.

2 In particular, the Bishops' Conference wishes to draw attention to the following points made in its Submission to the Interdepartmental Working Group:

> The right to life is the most fundamental of all rights because it is the foundation of all other rights. The Catholic Church, in common with many Christians in other Churches and many of the great religious and moral traditions of humanity, teaches that the direct and intentional killing of innocent human life, at any stage from conception to natural death, is gravely morally wrong. … Every human life is unique and irreplaceable. No one should be treated as if he or she were of less value than any other. (Page 1)
>
> We … reaffirm our conviction that the Irish people should be offered the opportunity to restore by referendum the constitutional guarantee of the right to life of the unborn child. (Page 4)

3 (a) Having examined carefully the 'seven options' set out in Chapter 7 of the Green Paper, the Bishops' Conference is strongly and unanimously of the view that the only acceptable option is a Constitutional ban on abortion which would guarantee the right to life of the unborn child while recognising existing medical practice which permits treatment where the loss of the foetus is the indirect consequence of treatment necessary to save the life of the mother (cf. Paragraph 7.17 of the Green Paper).

(b) The Bishops' Conference believes that it is possible to formulate a Constitutional amendment so that the right to life of the unborn child will be upheld by the Courts.

4 The Bishops' Conference is opposed to options 2 to 7 set out in the Green Paper as they do not adequately protect the right to life of the unborn child.

SUBMISSION FROM THE IRISH BISHOPS' CONFERENCE TO THE INTERDEPARTMENTAL WORKING GROUP PREPARING GREEN PAPER ON ABORTION – 16 MARCH 1998

The right to life

The right to life is the most fundamental of all rights because it is the foundation of all other rights. The violation of this right is an injustice. The Catholic Church, in common with many Christians in other Churches and many of the great religious and moral traditions of humanity, teaches that the direct and intentional killing of innocent human life, at any stage from conception to natural death, is gravely morally wrong. This is the clear and universal teaching of the Catholic Church. It should not be labelled an 'extremist' or 'fundamentalist' view held by some Catholics.[1]

Every human life is unique and irreplaceable. No one should be treated as if he or she were of less value than any other. Any statement of moral principles about how human beings should treat one another, and any just legal system, must be based on a recognition of the unique dignity of each person.

Human life is at its most defenceless in the womb, and has a right to receive the protection of the law.[2] From the moment a human life begins to exist at conception it is entitled to the same respect and protection as any other human life.[3]

The destruction of a human life when it is at its most defenceless – for instance in the first or last stages of its existence – overturns the moral order. These are the times when individuals have the most pressing claim to be protected from harm.

> Even in the midst of difficulties and uncertainties, every person sincerely open to truth and goodness can, by the light of reason and the hidden action of grace, come to recognise in the natural law written in the heart (cf. Rom 2:14-15) the sacred value of human life from its beginning until its end, and can affirm the right of every human being to have this primary good respected to the highest degree. Upon the recognition of this right, every human community and the political community itself are founded'. (Pope John Paul II, encyclical, *The Gospel of Life*, 1995)

Each life is precious

In the course of prolonged debate, a number of people have experienced a growing sense of confusion about the moral issues involved. The life of the child in the mother's womb is sacred and inviolable, just as the life of the mother is sacred and inviolable. Both lives are of equal value. This is the consistent teaching of the Catholic Church. Almost half a century ago Pope Pius XII declared: 'Never and in no case has the Church taught that the life of a child must be preferred to that of the mother. It is erroneous to put the question with this alternative: either the life of the child or that of the mother. No, neither the life of the mother nor that of the child can be subjected to an act of direct suppression'.[4] We ourselves have stated: 'Concern for the mother's life must go hand in hand with concern for her unborn child. Anyone who claims to be pro-life must be emphatically pro-mother as well'.[5]

The central principle

The principle that neither the mother's life nor the unborn baby's life may be deliberately and directly terminated for any cause remains true whatever the law of the state or international law may say.[6] No court judgment, no act of legislation, can make abortion morally right. Abortion goes to the very wellsprings of human life and touches the very foundations of morality.[7]

Some kinds of choices are always immoral. This is not to say that particular events or consequences or side effects are always wrong. It is obviously not possible to say that every time a child dies in the womb a moral evil has been committed any more than one could say that every time an adult dies a moral evil has been committed. The right to life is not a right to be immortal. It is the right not to be murdered. It is the right to say, in effect, to every other human being, 'You may not take my life'.

What is always wrong is *to choose to bring about the death of an innocent human being.* This is true whether the death is chosen for its own sake of for the sake of some other objective. If a person chooses, for whatever motive, to end the life of a child in the womb that action is always immoral.

It can happen that a person acts under the pressure of panic or great fear, or under the influence of psychological forces, or under severe coercion, so that they do not carry all the blame. Such considerations do not, however, alter the fact that a person's right to life has been fundamentally violated.

Abortion is unnecessary

The life of the pregnant mother is as inviolable as the life of the child in her womb. An expectant mother with a life-threatening illness must receive the urgent medical treatment which is truly indispensable for the saving of her life, even when the treatment puts the life of the child at risk. Obstetrical practice in Ireland has an outstanding record of success in preserving the lives both of the mother and of the baby. In its annual report, *State of the World's Children* (December 1993), UNICEF recorded the fact that Ireland is the safest place in the world for women giving birth. According to the report, the Irish maternal mortality rate is only two per cent per 100,000, the lowest of the 145 countries surveyed. The excellence of maternity care in

1 Irish Episcopal Conference (IEC) statement on the Maastricht Treaty, May 1992.
2 *ibid.*
3 IEC statement, March 1992.
4 Address to doctors, November 1951.
5 IEC Statement on the Eighth Amendment, August 1983.
6 IEC statement, March 1992.
7 *ibid.*

this country indicates that recourse to abortion is not necessary to save the life of the mother and that the absence of abortion does not endanger the lives of women.[8]

Sometimes the death of a child in the womb may be the unsought and unwelcome result of a medical treatment necessary to save the life of the mother. In such a case the death of the child has not been chosen.

Pregnancy from incest and rape

Sometimes rape is cited in justification for abortion. Rape is a horrendous crime. In our pastoral letter, *Love is for Life*, we called it 'the most glaring example of the desecration of the mystery of sexuality'. We added: 'Rape is infamous and is seen to be infamous because it is a brutal assault on the dignity of women and because it totally separates sex from love'. Because it is an act of violence the victim has a right to seek medical help with a view to preventing conception.[9]

When pregnancy is the result of incest or of rape, the experience for the girl or the woman is truly horrific. She may react with resentment, anger and rejection of the pregnancy, which she can feel to be a continuation of the violation of her body.

Nevertheless, however abhorrent and degrading the circumstances of the conception, a new human life has come into existence. It is an innocent human life, a life given by God and called to live with God forever, a life which has a right to be welcomed into the human community. To end this life by abortion is a further violation of the woman's body and may in fact increase her distress.[10]

Legality of abortion in Ireland

The judgement of the Supreme Court in the case of *The Attorney General v. X* introduced into Irish law the principle that it could be legal to perform an action with the intention and purpose of killing an innocent human being.

The declaration that it is legal, at least under certain conditions, deliberately to kill an unborn child authorises the violation of a defenceless human being's most basic right. Such a decision can properly be called a corruption of law. The Supreme Court judgement in the 'X' case was, therefore, unjust.[11]

Furthermore, the Court did not enquire into, or seriously explore, what might have been done to protect the life of the child as well as that of the mother.[12]

Who judges the judges?

A wording which people consider to have a particular meaning can be given a different meaning by the Supreme Court. The Court sees itself as having the right to interpret the provisions of the Constitution 'in the light of prevailing ideas and concepts'.* The Court, therefore, claims the right to declare that a provision of the Constitution no longer means what the people intended it to mean when they enacted it. In spite of the guarantee in Article 6 that the people have the right to decide all questions of national policy, there is no machinery by which the people may challenge an assertion by the court that prevailing ideas and concepts have altered the original meaning of a constitutional provision.[16]

Another referendum needed

Since the judgment in the 'X' Case intentional abortion is now legal in Ireland.[13] Because the rights of the mother and her unborn child are so closely intertwined in pregnancy, and because they can appear to be in conflict, it is not easy to find a legal formula which will simultaneously do justice to both rights. However, unless that judgment is overturned abortion will remain legal in a potentially wide range of circumstances.[14]

It is right that at various stages of the judicial process, from a decision whether to prosecute to the sentencing of someone found guilty, there should be discretion which allows particular circumstances to be taken into account. *What is enormously damaging, however, is the kind of thinking underlying the judgments in the 'X' and 'C' cases, which attempts to deal with difficult situations by abandoning the principle that every human being has the right not to be deliberately killed.*

This is the precise point which needs to be addressed, whether by a referendum which explicitly overturns these judgments, or by one which states the principle that no human life from conception to natural death may be subjected to an act whose intention or purpose is to bring that life to an end.

We, therefore, reaffirm our conviction that the Irish people should be offered the opportunity to restore by referendum the constitutional guarantee of the right to life of the unborn child.[15]

An inescapable duty

A pregnant woman is called to respect the life within her, a human being equal in dignity to her own. But it is a call not made to her alone. It is the duty of everyone to offer the solidarity that a woman in such circumstances needs and deserves. As Pope John Paul II has observed, the reality of pregnancy 'is a permanent challenge to individuals and to all, particularly, perhaps, in our time when great proof of moral consistency is often asked of the expectant mother. Consequently, the mother who is about to give birth cannot be left alone with her doubts, difficulties and temptations. We must stand by her side, so that she will not put a burden on her conscience, so that the most fundamental bond of man's respect for man will not be destroyed'.[17]

The 15 CURA centres throughout Ireland and the centres established by the non-denominational agency LIFE offer support and understanding to women for whom the prospect of the birth of a child creates difficulties which they may feel unable to face.

8 IEC statement on the Maastricht Treaty, May 1992.
9 IEC Pastoral Letter, *Love is for Life*, 1984.
10 IEC statement on the Maastricht Treaty, May 1992.
11 IEC statement, 'Civil Law and the Right to Life', June 1995.
12 *ibid*.

* Chief Justice Finlay's judgment in the 'X' case, citing as 'correct and appropriate' a principle for interpreting the Constitution set out in other judgments by Judges Brian Walsh and C.J. O'Higgins.

13 IEC statement, Nov 1992.
14 *ibid*.
15 IEC Standing Committee statement, May 1997.
16 IEC statement 'Civil Law and the Right to Life', June 1995.
17 Address to caring professions, January 1979.

The genuineness of our convictions about the right to life of the unborn child must be measured by our willingness to give the necessary support.

The Challenge

The abortions which Irish women procure abroad can be the product of fear, anguish and isolation. Too often they are the fruit of the abandonment of responsibility or lack of responsibility of the father.

We are living in a world where abortion is widely accepted and promoted. A society founded on respect for every human life would not respond by seeking to facilitate abortion. It would be generous in ensuring that understanding and support is always available.

THE SOCIETY FOR THE PROTECTION OF UNBORN CHILDREN IRELAND
26 NOVEMBER 1999
SUBMISSION TO THE ALL-PARTY OIREACHTAS COMMITTEE ON THE CONSTITUTION ON BEHALF OF THE SOCIETY FOR THE PROTECTION OF UNBORN CHILDREN

INTRODUCTION

The All-Party Oireachtas Committee has been set up to assess the issues raised and the solutions proposed in the Green Paper on Abortion. The Committee must consider the implications of the various proposals from a constitutional point of view.

The Society for the Protection of Unborn Children is a single issue, anti-abortion organisation set up in Ireland in 1980. The Society affirms the value of human life from the moment of conception and defends the absolute right of the unborn child to legal protection from induced abortion. It aims to monitor existing or proposed legislation on human reproduction, parenthood, and abortion and to mount educational and political campaigns whenever the interests of the unborn child may be at stake.

In pursuit of its objectives, the Society has taken an active part in all the referenda on abortion, and has taken action in the High Court and in the Supreme Court against organisations which promote abortion, viz., the Well Woman Centre, Open Door Counselling, and the Union of Students in Ireland. In the course of these actions the Courts recognised that the Society has the 'locus standi' to undertake the defence of the unborn child.

For these reasons the Society feels that it is especially mandated to respond to the Green Paper on Abortion and to make the following submission.

DEFINITION OF ABORTION

For the purposes of this submission abortion is defined as the direct, intentional destruction of the unborn child.

PREGNANCY AND MATERNAL HEALTH

The absence of abortion in Ireland has not proved to be detrimental to the health of pregnant women or to have had any effect on maternal deaths in Ireland. In fact it is a matter of record that Ireland has one of the lowest maternal death rates in the world. The rate is so low that it would be almost impossible to improve on it. This makes it clear that there can be no grounds to support an argument for medical need for abortion to save the lives of pregnant women. In fact the Medical Council, the body regulating the medical profession, has made the point that no case has even been made showing that abortion is of any benefit in the treatment of pregnant women.

A study of Irish maternal mortality rates carried out by Murphy and O'Driscoll and reported in the *Irish Medical Journal* in 1982 75:304-6 bears this out and experience from that date has not changed that finding.

The Medical Council, has, in fact, repeatedly affirmed that induced abortion is medical misconduct and that a doctor has a duty to care for both the mother and her baby. The 1998 Guide to Ethical Conduct and Behaviour states that 'the deliberate and intentional destruction of the unborn child is professional misconduct'.

Eclampsia

The early delivery of a baby, say in the case of a mother suffering from severe pre-eclampsia cannot be regarded as an abortion. Rather the early delivery is intended to save both the life of the baby and the mother.

Cancer

Even a lay person will have no difficulty in comprehending that unless the child has reached a stage where he can exist outside the womb (in which case early delivery is indicated) the doctor has no option but to treat the mother for any life threatening disease or illness she may suffer from, or risk losing both his patients. This is particularly true where the mother suffers from cancer whilst pregnant. Chemotherapy and radiotherapy may have a deleterious effect on the child *in utero* but a case cannot be made for witholding such treatment. With modern methods and judicious choice of drugs the effects can be minimised and the pregnancy brought to at least a stage where the baby can be delivered alive albeit in some cases early.

Eisenmenger's Syndrome

Because of improvements in the treatment of women with congenital heart disease, they are now reaching child-bearing age and are choosing to become pregnant. There is no evidence of increased mortality associated with pregnancy in these conditions (see Schmaltz, Neudorf and Winkler, 'Outcome of Pregnancy in Women with Congenital Heart Disease', published 1999 Cardiol Young) except in the case of Eisenmenger's Syndrome.

Eisenmenger's Syndrome is a serious and generally life-shortening illness for which there is no surgical treatment, other that perhaps heart-lung, or lung transplantation. When carried out, pregnancy should not pose particular difficulties (see *J Clin. Anesth.* July-Aug 1993 and *Asia Oceania J Obstet. Gynaecol* 1994, Sep, 20 (3).

The disease is rare and carries with it a very high risk of sudden death, and death following any surgical intervention.

Pregnancy also carries a high mortality. Many studies have been carried out (e.g. Gummerus and Laasonen 'Eisenmenger Complex and Pregnancy 1981, *British Journal*

of Obstec. Gynaecol. Aug. 1998, Smedstad, Cram and Morison, reported in *Canada J. Aesth.* 1994 to name but some) and the only conclusion that can be drawn is that such cases should be treated in specialist centres. With care in these centres, patients with Eisenmenger's Syndrome will have a 60-80% chance of survival, while foetal survival is now expected to exceed 90%.

It is also clear from the studies that induced abortion is also hazardous for these patients.

The Report on Confidential Enquiries into Maternal Deaths in Britain for the triennium 1994-96 indicates that there were six deaths during or following induced abortions performed because of maternal cardiac disease in that period.

In all of the medical literature there is no evidence, on clinical or research criteria, that justifies induced abortion in pregnant women with heart disease (see also Avila, Grinberg et al. *Eur. Heart Journal* April 1995 and Chia, Yeoh et al. *J Obstet. Gynaecol.* Res.1996 Apr). Indeed annual reports from Irish Maternity hospitals indicate no evidence to suggest that the outcome in any woman with cardiac disease could have been altered by induced abortion.

Ectopic pregnancy

Patients with ectopic pregnancy usually present as an emergency because of tubal rupture or bleeding or tubal distension and must be treated immediately. Tubal gestations result in either foetal death followed by spontaneous resorption or tubal rupture/bleeding followed by foetal death. In either case the outcome of the pregnancy is the same. Therefore the imperative for the treating doctor is survival of the mother.

Actually the management of ectopic pregnancy does not impact on the abortion debate. The diagnosis and management of ectopic pregnancy has been classified quite apart from any issue in relation to abortion (International Classification of Diseases, ICD 10). In no jurisdiction in the world has the treatment of ectopic pregnancy been raised as an issue in the debate on induced abortion. To do so in Ireland today would be mischievous. There has not been one death from ectopic pregnancy in Ireland in the past 20 years, in spite of (or because of) the complete ban on induced abortion. It would be impossible to hold that Irish women travel to Britain to avail of abortion there as a result of having a tubal pregnancy due to the emergency nature of the intervention required.

Suicide and pregnancy

The issue of pregnancy and suicide is one that needs particular attention in view of the decision of the Supreme Court in the *Attorney General v. X & ors* 1992 and the High Court in *A & B v. Eastern Health Board & ors* 1998 which held that the threat of suicide on the part of a young girl was sufficient justification for induced abortion.

The Green Paper points out that pregnancy appears to have a protective effect against suicide but does not, strangely, make clear that induced abortion in itself appears to be a significant risk factor for suicide as found in international studies.

THE LEGAL CONTEXT

The Offences Against the Person Act, 1861, Sections 58 and 59

In Ireland, Sections 58 and 59 of the Offences Against the Person Act of 1861 have always been seen as a total ban on direct, intentional, abortion by the woman herself or by others. It is vital to note that the act forbids only actions done 'with intent to procure the miscarriage of any woman'. Under the Act, no pregnant woman had ever been denied medical treatment because of possible but undesired or unintended consequences for her baby, even in cases where the outcome is the death of the baby.

The Act makes a clear distinction between acts intentionally directed towards harming the unborn child and acts whose likely, or even certain, consequence is that harm will ensue to the unborn child.

The Green Paper rightly points out that this is the Act which was interpreted in England as allowing abortion in the *R v. Bourne* case in 1935 and that this decision has been relied on in other jurisdictions, although not in Ireland prior to or since the Eighth Amendment.

Without copperfastening in the Constitution the 1861 Act would prove a flimsy protection for the unborn child.

The Constitution and abortion

Prior to the Eighth Amendment to the Constitution in 1983, according to the Green Paper, the Constitution contained implicit protection for the lives of unborn children, but it is true to say that none of the judgements relied on, contain anything other than *obiter dicta*. There was no *explicit* protection in the Constitution and the existing protection afforded by the 1861 Act could have been overturned by an Act of the Oireachtas, or a Court challenge along the lines of *Bourne*. It was therefore prudent to insert an explicit guarantee into the Constitution so that the lives of unborn children were afforded the same protection as everyone else.

After protracted debate this article was inserted into the Constitution in 1983. It was understood by all to be intended as copperfastening the existing ban on abortion. Even the literature of the Anti-Amendment Campaign stated at the time 'The proposed Amendment will impede further public discussion and possible legislation on abortion'.

Therefore everyone, on all sides of the argument understood that the passage of the Eighth Amendment would mean that abortion could not be legalised in Ireland, either through the Courts or the Oireachtas, unless the people gave their consent in another referendum.

Attorney General versus X

In paragraph 2.15 of Chapter 2 the Green Paper gives an account of the decision in the *Attorney General v. X* and refers to the Supreme Court's 'acceptance of the evidence that had been adducted in the case'. In fact the Supreme Court proceeded, astonishingly, on the basis that the direct termination of the life of the unborn child was permissible, despite the State's clear obligation to protect and vindicate that life. Counsel for the Attorney General did not contest this view. The Court did not take into consideration the crucial distinction between those cases where the death of the unborn child may result as an indirect effect of appropriate medical treatment, and cases involving the

direct intentional killing of the unborn child. It appears that counsel for the Attorney General did not appreciate that distinction, which was certainly not brought to the attention of the Court. No medical evidence was heard, or sought. No evidence was received from a psychiatrist. The majority verdicts are marred by these omissions and therefore faulty in their conclusions.

Paragraph 2.17 refers to 'concerns … about the possible abuse of suicide risk as a ground for abortion'. The purpose of the Eighth Amendment was to protect the unborn child from abortion for any reason. It was the contention of those proposing that Amendment that the termination of the life of the unborn was unnecessary for any reason and unjust. In so far as the decision of the Court recognised suicide risk as a ground for the killing of the unborn child, the concern is not about 'abuse' but more radically, that suicide risk is simply not a ground for abortion.

Medical ethics – direct and indirect effects

The discussion in Chapter 2 of the divergence between medical ethics and the judgements of the Supreme Court in the *X* Case is striking in its failure to comment on the fact that the Court reached its decision without regard to expert obstetric and psychiatric evidence and on the mistaken admission by counsel for the Attorney General that the Eighth Amendment permitted abortion in certain circumstances. The paper also fails to discuss the legal and philosophical basis for the distinction between a direct attack on the life of the unborn child and the death of the child as an unintended side effect of medical treatment. In failing to inform the reader of this distinction the Paper gives the false impression that the divergence between the Supreme Court's Judgement in the *X* case and medical ethics, raises problems for medical ethics. In fact the problems are with the judgment itself.

Also in 2.30 there is an apparent suggestion that ethical norms should be adjusted in the light of the content of a positive law. Surely, the whole point about ethics is that normative values are not dependent, or subsidiary to, positive law.

THE STATE'S OBLIGATIONS UNDER INTERNATIONAL, EUROPEAN UNION AND COMMUNITY LAW

This Chapter, whilst containing much that is positive, fails to address aspects of international conventions and human rights agreements which have a significant impact on the issue of the protection of life. There is almost no guidance as to probable future development at an international level. This failure is regrettable as there are reasons to believe that there is a momentum in law which will lead to future changes which augur ill for the unborn child, although it is, of course, impossible to accurately foretell the future.

The Green Paper analysis of the right to life of the unborn child under the European Convention on Human Rights fails to address the issue in detail. It does not make any critical analysis of the strategy of the majority of the European Court of Human Rights in the case of *Open Door Counseling v. Ireland* (1992) to avoid the argument made by the Irish Government that there is an obligation to protect the right to life of the unborn child under Article 2 of the Convention and that Article 10 justifies laws that have this goal. Nor does the Green Paper consider the protection that Article 60 of the Convention gives to Article 40.3.3. A strong argument can be made that Article 60 confers effective protection on Article 40.3.3.

Incorporating the Convention into domestic law

At present the Convention is not part of domestic law. The Maastricht Treaty requires the European Union to respect fundamental rights guaranteed by the Convention and general principles of community law. No doubt debates will take place as to the impact of Protocol 17 on this development. The Government is considering incorporating the Convention as part of our domestic law. The manner in which this is done would be crucial. A referendum put to the people baldly incorporating the Convention would have to be opposed as it would not provide adequate protection for the life of the unborn child.

There has also been a strategy suggested of enacting a statute law, which would make the Convention a tool for the interpretation of domestic law, provided that it does not conflict with the Constitution. However, there are problems with this approach too, as it would make it difficult to undo the damage caused by the Supreme Court decision in *X*. Moreover, there is a possibility that the Courts, when interpreting the Constitution in this context, would be affected by the Convention.

POSSIBLE CONSTITUTIONAL AND LEGISLATIVE APPROACHES

The Society for the Protection of Unborn Children supports Option One

In this section we will briefly discuss the various options laid out by the Green Paper.

The Society supports option one as being the only fair and just option. It is the opinion of the Society for the Protection of Unborn Children that the only fair and just way to proceed on the abortion question is for the Government to allow the people to vote in an unambiguous referendum which would give a clear choice between having abortion banned or legalised in Ireland. The people in the Amendment in 1983 intended to ban direct abortion but the will of the people was subverted by the surprising judgement of the Supreme Court in the *X* case.

Under Article 6 of the Constitution the sovereign people is the court of final appeal.

Referenda have often been held previously to reverse unsatisfactory and unacceptable Supreme Court decisions, for example

1979 Referendum on Adoption

1992 Referendum on the substantive issue was an attempt to modify the *X* case decision.

The referendum on cabinet confidentiality.

The Society for the Protection of Unborn Children opposes all other options

Second option This option seeks to amend the Constitution to provide for the Supreme Court ruling in *X* but removing the risk of suicide as a ground for abortion. This is, in effect, the referendum which was put to the people in 1992 and rejected. There is no reason to think that it would be accepted now. It is objectionable because it would seek to establish, by democratic consent, an

abortion regime which would be wide ranging. It has been the experience in other jurisdictions that there is no such thing as 'limited' abortion.

The third option This is to leave the Supreme Court decision in *X* unaltered. This is unacceptable because the decision subverted the will of the people. Under this decision abortions may be carried out at all stages of pregnancy including the period where the unborn child is viable. This violates the principal of equal treatment of all humans before the law and undermines the unborn child's basic human right to life.

The fourth option This is equally unacceptable for the same reasons. International experience has shown that this approach eventually leads to abortion on demand.

The Society notices that this option is presented in a supportive manner by the Green Paper, in contrast with the presentation of the first option which was markedly hostile in tone.

The fifth option This is really the fourth option all over again and is equally unacceptable.

The sixth option This is to revert to the pre-1983 position and is also unacceptable. To do this would also need a referendum to take article 40.3.3 out of the Constitution and if this were passed would leave the unborn child open to having his right to life eroded by statute law and court decisions.

The seventh option This is to go even beyond the *X* case and is unacceptable to anyone concerned with the protection of the right to life of the unborn child.

GENERAL

The Green Paper makes much of the fact that the issue of abortion is too divisive to be dealt with by referendum. However, it would be just as divisive if it were to be dealt with by legislation. Here is an important issue on which there are diametrically opposed views. There are bound to be disagreements and differences but democracy is a way of making a decision in the face of difference and disagreement. It is important to go back to underlying principals, have a calm public debate, and then let the people decide by offering them an option that is in keeping with the principle of democracy.

The basic principles on which democracy is based are two – the equal and inherent value of every human being, regardless of age, sex, creed, bodily or mental health, or state of development, and equality for all before the law.

Abortion is not compatible with either of these two principles. It is a social question, not a medical one.

There is a democratic demand for a referendum which would give the people an opportunity to restore a total ban on direct abortion.

A simple clause inserted into Article 40.3.3 to the effect the 'no Article of this Constitution can be interpreted as allowing direct abortion' would protect the unborn child whilst allowing women to have any necessary treatment.

79% of County Councils and 65% of all local authorities have asked for such a referendum and opinion poll after opinion poll has demonstrated that people want this issue resolved by referendum.

A new unambiguous referendum is the people's right.

YOUTH DEFENCE
29 NOVEMBER 2000
WHITE PAPER ON ABORTION – SUBMISSION FROM YOUTH DEFENCE

INTRODUCTION

Of all the issues confronting the All-Party Oireactais Committee on the Constitution, the issue of abortion is undoubtedly the most emotionally charged, and, in the consequence, has the appearance of being the most difficult. Certainly it is the case that whatever recommendation is made will face significant opposition. The question of whether that opposition is substantial in the sense of being logically sound, morally just, and representative of the wishes of the Irish people, however, is quite another matter.

The Committee will be aware that the case for liberal abortion laws enjoys the support of powerful sections of the Irish media, both broadcast and print. The Committee will also be aware that a caucus of ideologically determined liberals exists within the Oireactais itself. It is possible, therefore, that the national debate may not have what we might term a perfectly 'balanced' quality if we are merely calculating the amount of noise which the supporters of abortion provision are able to make. It has been made clear however, by the submissions made to the Inter-departmental Working Group which produced the Green Paper on abortion, that the representative force of this noise is almost nil. There exists in Ireland no public, and by association no democratic, pressure for legalised abortion, regardless of whatever degree of limitation is proposed. The supporters of legalised abortion have been unable, even in their tiny numbers, to reach any meaningful agreement among themselves, and have certainly failed to impress their case on the public-at-large. This is in spite of having both considerable time, nearly eight years since the *X* judgment, and disproportionate media access.

On the other hand, the enormous response by Pro-Life organisations and individuals has revealed with equal clarity the determination of the majority to completely prohibit abortion. The recognition of this fact in the Green Paper is to be heartily welcomed. The resources available to these organisations and individuals has been limited, their media access restricted and often negative, and their members, particularly of Youth Defence, positively persecuted with clear political motivation. Their ability to maintain an effective opposition to legalised abortion has been entirely due to the support received from the overwhelming majority of ordinary Irish people. The representative character of their case has been repeatedly proved and, far from weakening in their resolve, they have grown steadily stronger, in numbers and determination, over the passing years. As such, it bears repeating that the opposition to legalised abortion comes from the Irish people, naturally and spontaneously. It needs only the opportunity, afforded by a referendum, to have that will be given concrete expression in law.

And while we might well appreciate the thoroughness of the authors of the Green Paper in outlining both the options available and the contextual background, it is unfortunate that they fail to give the kind of guidance to the Committee which it surely would have expected.

Specifically, the absence of any objective ethical framework led to the Paper outlining options in such a way as to suggest that they were morally equal and that the only questions arising were matters of practical application. We regard such methodology as unsound, and, must, with respect, regard the Paper itself as fundamentally flawed for this reason.

Bluntly stated, and without apology, abortion is murder. The circumstances are not strictly relevant to the act as such, since they may well alter the level of responsibility imputable to the participants, but cannot alter the objective character of the thing itself. It is a source of regret that the Green Paper treats the humanity of the unborn child as a subjective opinion, rather than an established scientific fact. It should be noted, however, that no serious effort was made by those persons advocating legalised abortion that the unborn child was not a human being. It may safely be concluded that they no longer believe that such a case can be made. The Committee, we hope, will, in the course of its deliberations consider the facts of foetal development which have a crucial bearing on the debate, especially insofar as much of this knowledge was not available at the time that other countries framed their liberal abortion laws. It will be clear then, that the Pro-Life case is supported by more than electoral numbers, but is also a case founded on natural justice.

The Committee will not have the luxury of moral neutrality, which was available to the Interdepartmental Working Group. The nation expects a decision and a decision cannot be divorced from its moral dimension.

Youth Defence have at all times approached the issues arising from abortion with a profound sense of the enormous responsibility involved. Aware that the matters under discussion are literally ones of life and death, it is incumbent upon all involved to understand the seriousness which goes beyond political calculation or ideological obtuseness. In this context, we awaited the publication of the Green Paper as a defining moment and we awaited it with an open mind. With all due respect to its authors, however, the defenders of the right-to-life of Mother and Child in Ireland are disappointed with the outcome, and it would be a shirking of responsibility to attempt to hide that disappointment. There is, of course, for those determined to protect the right-to-life of Mother and Child, only one real option: that of a complete constitutional ban on abortion, though, even here, the Green Paper is disappointing in its treatment of the issues arising.

The submission made here to this Committee is consequently in large measure the elaboration of that disappointment.

CERTAIN PRELIMINARY NOTES

It is important to a full understanding of Youth Defence's attitude to the various options outlined in the Green Paper, that certain preliminary matters be established:

(a) In the chapter concerning Pregnancy and Maternal Health, the Green Paper is essentially rehashing old arguments which have long since been settled. When we say settled, we do not, of course, mean politically, since the ability of the supporters of abortion to ignore established facts is notorious; rather, we mean medically, and by the only body competent to make such a settled assertion, the Medical Council. Without returning in detail to issues dealt with at length in the original submission, we recall to the attention of the Committee that the Medical Council has held that abortion is always unethical and a striking off offence. That they do so in a context which states that the with-holding of necessary medical treatment from the Mother is also unethical is the clearest endorsement of the view that the perceived conflict between the right-to-life of the Mother and, here, Child, is of purely legalistic invention, and has no basis in medical fact or practice. We would remind the Committee that those doctors making the claim that abortion is sometimes necessary to save the life of the Mother have had ample opportunity to present their case in the appropriate forums and, in failing to do so convincingly, have instead made unfounded and irresponsible statements to the media. Doctors who resort to so-called therapeutic abortions, or support such resort, are incompetent to practice medicine and to have their tiny minority views juxtaposed to the Medical Council's is a vain attempt to skew the frame of debate.

(b) The Chapter on the States Obligations under International and European Union law raises serious concerns beyond the issue at hand. The Green Paper's inability to reach any conclusions concerning the effects of Ireland's signature to various Covenants and Conventions has appalling implications. It is impossible to escape the conclusion of governmental incompetence in assuming potential obligations without being aware what those obligations might eventually amount to. This much is certain, that any obligation to legalise the crime of murder cannot be reconciled with any but the most absurd conception of 'human rights' and it follows that the solution must be to withdraw from such Covenants and Conventions as might enforce such an obligation.

(c) No sensible person can have any confidence in the legal force of the Solemn Declaration of the High Contracting Parties. It is not found in the text of the Maastrict Treaty, and it may be taken to relate to the political effort to achieve a 'Yes' vote in the referendum on the Treaty and to have no independent existence from this purpose. It must therefore be placed outside our thinking on implications of Protocol No. 17, insofar as it might restrict our ability to amend Article 40.3.3.

(d) The laws relating to abortion in other jurisdictions (excepting the U.K.) have no consequences for ourselves. When, where, how and under what circumstances other countries have resorted to the barbarity of killing their own children raises frightening questions for their peoples, and, as a revelation for what may await us, they may have the effect of dramatic warning. If, however, the implication is that we should somehow conform, this is to be entirely rejected. Rather we should serve as their example to aspire to, in efforts to recover civilized values. The availability of abortion in the UK has of course resulted in the killing of Irish children and should be the subject of objection and protest, at least as forceful as that directed against the operation of the Sellafield Plant.

(e) The statistics on quoted abortions carried out on Irish women in the U.K. are falsely represented as established fact. We would draw the Committee's attention to the method of compilation. Though an official

government body publishes the figures, the original source is the abortion clinics themselves. Is it really too much to question the honesty of organisations who kill children for profit? It is significant that all sides agree that the figures are inaccurate, though different conclusions are drawn.

(f) Reference is made to certain problems of definition arising out of the wording of Article 40.3.3 if it were to be retained. These problems arise only in a context which seeks to introduce abortion in some circumstances. A complete prohibition on abortion does not require definitions as to what is an unborn any more than it is required to define human being in the context of prohibiting ordinary murder. That such a complete prohibition would have the effect of prohibiting abortafacient drugs or interfere with embryo freezing and some current practices in IVF is not to be regretted.

(g) It is absurd to grant any weight to submissions made by supporters of legalised abortion. Their tiny number, their unrepresentative character and their barbaric logic ought to have concentrated the mind of the Inter-departmental Working Group on finding the means by which the will of the civilized majority should be enacted. We must strongly object that their views were treated with a respect undeserved.

POSSIBLE CONSTITUTIONAL AND LEGAL APPROACHES

We propose to deal with the various options on possible Constitutional and legal approaches in a reverse order to how they are found in the Green Paper since this will eliminate the most absurd options first.

Option (VII)

Permitting abortion on grounds beyond those specified in the *X* Case The Green Paper is correct in stating that all the cases considered broadly under this option would require an amendment to Article 40.3.3. As a matter of pure practicality, this places the option outside the frame of the serious consideration. The Committee will be aware just how few submissions supported this option which is, in itself, an indication of its absurdity. The fact that such submissions as did support it come from sources for which the phrase 'tiny fringe group' is an understatement of gross proportions underlines this obvious point

There is no public support whatsoever for this option and it is hard to imagine that if it were put to a referendum in any form it would achieve even a double-digit percentage. In short, it would not pass.

It should not entirely be ignored, however, since, within the parameters of this option is a clear sign post as to the direction we would be taking a nation if we seek to tolerate abortion in any degree. Strictly speaking there is no moral difference whatever between the various ideas for limited abortion and an unlimited form which this option envisages. There seems little doubt that if the door to the death culture is opened at all that it will add fuel to these currently marginalised views. The Irish people are not natural hypocrites and will easily see the hypocrisy of maintaining restrictions once the principle (of protecting human life) has been removed. Indeed, we can see, in the propositions made under this heading, just what it has done to the mindset of those few who have adopted the death ethic as their own. Abortion on any of the grounds dealt with in this section must quickly descend to abortion-on-demand sooner rather than later.

We would note especially that the proposition that abortion be allowed for congenital malformation is essentially an attempt to equate the value of human life with materially ascertainable quantities. The Committee will be aware that this philosophical view is, in reality, necessary for supporting any form of abortion, and in the nature of normal practice, matters generally reach their logical conclusions quickly. If we kill the handicapped in the womb then logically we ought to be able to kill the handicapped born alive. The definition of handicap is also problematic and open-ended.

And being quite serious, if we are to allow abortion for social reasons, can we, without irony, bring before the courts for judgment persons accused of killing their children, their spouses, their neighbors or indeed any person. Shall it become a defence for murder that the continued life of their victim was 'troublesome'? We should not therefore be surprised to find the cultures of countries adopting such Liberal regimes have grown violent in the extreme.

This option is utterly rejected by Youth Defence.

Option (VI)

Reversion to the pre-1983 position The recognition by the Green Paper that the reversion to the pre-1983 position would not of itself negate the decision in the *X* Case is to be welcomed as clear-headed and correct. It has been repeatedly and falsely stated that the *X* decision was brought about by a mistake of the Pro-Life movement in advocating the Eighth Amendment. Firstly the wording of that amendment was originally of government inspiration and specifically Fianna Fail responsibility. It was supported by many Pro-Lifers reluctantly and with hope rather than full confidence. Secondly the *X* decision flowed naturally from the 1861 Act, a fact referred to by Mr Justice Egan. The enactment of the Amendment was an attempt to forestall what otherwise would have been inevitable. The principle involved in the attempt remains valid despite subsequent events and the logic, which inspired Constitutional change, remains true.

There is the most extraordinary suggestion that the right-to-life of the unborn child may have been protected constitutionally before the enactment of the Eighth Amendment. While this assertion, based on the *obiter dicta* of several cases, was always flimsy, the *X* Case itself puts it finally away. In the course of the judgment, reference is made to Justices' view (quoted from *McGee v. The Attorney General* and otherwise supported) that, 'no interpretation of the Constitution is intended to be final for all time. It is given in light of prevailing ideas and concepts.' How a right vaguely referred to in non-binding sections of previous judgments is supposed to survive such logic is unstated. We may safely conclude that no such implied right would have any standing.

It is quite clear, therefore, that the removal of Article 40.3.3 would almost certainly result in legalised abortion in the context of a purely Irish reading of the law, certainly on grounds as wide as those provided for in the *X* decision, and conceivably on grounds even wider since the unborn would not now have any explicit rights at all.

The removal of Article 40.3.3 and significant amendments to the 1861 Act with a view to using it as a legislative vehicle to completely prohibit abortion encounters a number of objections. Firstly, a purely legislative prohibition on abortion may well prove unconstitutional under the logic employed in the *X* case or other more extensive propositions. Secondly, any removal of 40.3.3 certainly removes the protection of Protocol 17 of the Maastrict Treaty from subsequent legislation and leaves such laws as may be enacted vulnerable to European law. Thirdly, the right of the Irish people to decide the issue is removed.

During the course of deliberating on the options available in 1983, it was proposed and rejected that a purely legislative prohibition be introduced, even with the provision by Constitutional amendment that such legislation could be placed outside the remit of the Courts. It was rejected because, quite correctly, the issue of abortion was held by the majority to be a question of such paramount significance that it was for *the people*, not the legislature or the courts, to decide. This is the essential purpose of Constitutional law, to place certain rights above politics in the ordinary sense and thus protected by society in concert. It has been stated by some that the Constitution is not the appropriate vehicle and that it is, rather, the place for declarations of broad principle. As such, the Constitution would serve no real purpose at all and the fact that some Constitutional lawyers have expressed this view does not alter the inanity of the notion. We would remind the Committee that the abortion issue only becomes legally complex when attempts are made to allow some but not all abortions.

Reverting to the pre-1983 position, regardless of what might be proposed by way of legislation, would be rejected by all Pro-Life groups of any standing, and since it would require a referendum the Committee may confidently expect that it would fail.

This option is strongly rejected by Youth Defence.

Option (V)

Legislation to regulate abortion in circumstances defined by the *X* case The Committee will be aware that there is a considerable degree of party political support for this option within the Dail. They will also be aware that whatever is stated in various submissions it is the real and only practically possible objective of the pro-abortion forces. The reason, and, indeed, the motivation are the same. Firstly, this option does not require a referendum, and thus, not being subject to the peoples judgment, it does not have to encounter the overwhelming rejection of legalised abortion which is their will. Moreover it is a fact that while the *X* decision superficially restricts abortion it would be impossible to implement those restrictions in real situations. They, whose avowed aim is to have abortion-on-demand, know that legislation for the *X* decision, while not employing their rhetoric, must enact their agenda. Fortunately for the unborn child so does everyone else.

Those politicians who are opposed to a referendum are afraid that their unpopular views on this issue will be rejected by the Irish people and that any campaign on behalf of their pro-abortion views would fix their names in the public mind in association with this abhorrent practice.

Some suggestions have been made as to the possibility of referring such legislation to a referendum. While this might serve to underscore, once and for all, that the rejection of the so-called 'substantive issue' amendment in 1992 was a rejection of the *X* judgment in its entirety, this can hardly amount to a justification for a national referendum. It is salient to note that while pro-abortion figures in the media and elsewhere have implied that the Irish people rejected the restriction of that judgment, by removing the threat of suicide as grounds for abortion, and have thus claimed it as a victory, there is a veritable panic at the mention of testing that assertion. On the other hand, while we would not welcome a pointless ballot, Youth Defence would nonetheless meet such a prospect confident of success.

To legislate without recourse to a referendum, the approach apparently favoured by most supporters of this option must prove to be a positively dangerous course of action. There is in this country already a growing disenchantment with the ordinary workings of the democratic process, a feeling that voting serves no purpose and achieves nothing. It may well be that this feeling is largely one of apathy, yet it should not be discounted either that a growing number of electors are concerned that decisions made by 'consensus' are deliberately designed by the political establishment to exclude the wishes of the people. On an issue of such emotional force as abortion, any legislation which sought to bypass the people would undoubtedly fuel the belief that the system is in fact corrupt. We would strongly urge the Committee to understand that withdrawal in disgust is not the same thing as apathy.

The threat of suicide as grounds for abortion is in practice impossible to regulate no matter what legislation is employed. It would, for example, be impossible to impose a certification process since psychiatric professionals are the first to admit that identifying those seriously at risk of suicide is largely a process of estimating probabilities, and this is without the added motivation for false claims that providing abortion on these grounds would create. Moreover, any certification process would itself be open to manipulation by unscrupulous abortion providers.

It is not possible to implement any meaningful regulation of the decision in the *X* case which would differentiate it in practice from Option VII.

As such Option V is utterly rejected by Youth Defence.

Option (IV)

Retention of the constitutional *status quo* with legislative restatement of the prohibition on abortion We are at a loss to understand why this idea has been presented as a separate option. There is nothing whatever to differentiate it from legislation Option V except the descriptive language of the Green Paper itself. Phrases such as 'double lock' and how it would not become a 'back door' are misleadingly forceful and have no substance in reality. In fact, it would be a matter of serious concern if the Interdepartmental Working Group should suppose that strong terminology could replace sound law, or at least replace it in the popular imagination.

As stated, there is an extreme difficulty and probably a practical impossibility involved in regulating the *X* decision to conform to the limits set out in the judgment as the

Justices would have understood it. There is as a matter of certain fact no possibility of restricting the judgment to any extent by means of legislation without a Constitutional Amendment. It is dishonest to claim otherwise.

This pseudo-option is strongly rejected by Youth Defence and moreover it is to be objected that it was included as a distinct option at all.

Option (III)

Retention of the *status quo* In preface it should be remarked that there is no substantial reason why the existing situation should continue as the Green Paper states, 'if it is not possible to reach consensus on constitutional and/or legislative reform.' If such were the case, then it is difficult to understand why the Working Group was set up, or indeed, why the Committee has been given the task of presenting a recommendation. There never was any serious possibility of achieving a consensus if we are to take this to mean anything like an agreement between persons representing diametrically opposed views on the moral implications of the abortion debate. It ought to be obvious that the priority in this process is to arrive at the right decision in the broadest sense of that word rather than find the path of least resistance.

It is worth reminding the Committee that the mania for consensus is entirely confined to supporters of legalised abortion and betrays, again, that fear of the judgment of the Irish people. No one understands better than ourselves the stresses and strains involved in what is pejoratively termed 'a divisive referendum,' yet we are forced to note that no such concern was evidenced in the previous administration's decision to hold a referendum on the divisive issue of Divorce. In fact, such divisions as exist in Ireland on abortion are present regardless of whether a referendum is held or not. A referendum represents, therefore, a means by which the issue may be settled by the Constitutional means of settling such divisions within a democracy. To refuse a referendum on the grounds that a consensus cannot be reached is consequently absurd. Moreover, it is difficult to conceive of an issue on which a greater number of Irish people are in perfect agreement. If it were not for powerful allies within the media, the pro-abortion lobby would be unable, by its numbers, to feature on the national agenda at all. We would refer the Committee to the number of submissions favouring a complete prohibition on abortion juxtaposed to those favouring various forms of abortion provision.

Aside from this, however, it is to be welcomed that the Green Paper has recognised that the current position is unsatisfactory to every point of view and completely unworkable in the longer term. The law cannot forever remain in a state of suspended animation and while there exists the remote possibility that a future Supreme Court might give a Pro-Life interpretation to Article 40.3.3 this would only underline the weakness of a provision which rightly, or wrongly, would be seen as being in a judicial flux.

It was, in part, a distrust of judicial activism which prompted the original Amendment to the Constitution and nothing in the years which have followed could lead the sensible person to any other conclusion than that this distrust was abundantly justified. The Courts have in fact shown themselves to be capricious to a degree bordering on, if not crossing over the line of impeachable 'stated misbehaviour.' To leave the matter of life and death, which is abortion within their discretionary power would be negligent in the extreme.

Youth Defence are pleased to concur, albeit under somewhat different reasoning, with the Green Papers rejection of this option.

Option (II)

Amendment of the constitutional provisions so as to restrict the application of the *X* case In considering this option, the Green paper is approaching the core of the real controversy about abortion in Ireland. This is the only form in which the legalisation of abortion commands any measurable degree of public support and the only one which ever had any possibility of being accepted by the people in a referendum. The reason is, that it purports to juxtapose two equal rights (the life of the Mother and the life of the Child), supposedly in conflict, and therefore, catches the uninformed in an apparent quandary. Its appeal is based on its seeming to be framed in terms of the respect for and protection of human life, which is almost universally agreed. Clearly the government in office in 1992 sought to capitalise on this perception by going so far as to call its proposal on the so-called 'substantive issue' the Right to Life Amendment.

The Committee does not need reminding that the proposal was roundly defeated at the ballot and that the wording then proposed, is, as the Green Paper suggests, probably the only one which achieves the aim sought under this heading. It was not defeated because of some technical difficulty with the terms that might easily be corrected. It was not defeated (as the Committee can at least admit to itself privately) because the restriction on the *X* decision was rejected. It was defeated because it was founded on a false appreciation of the facts; it would have proved dangerous in practice and was opposed by every Pro-Life organisation of any standing. If presented again it will be defeated again.

The perceived conflict between the right-to-life of the Mother and her Child is of purely legalistic invention and exists only in the propaganda for legalised abortion. Even here, the physical argument is rarely cited since they are aware that the ruling of the Medical Council is far too well-known by the general public to have any plausibility. That certain doctors have been irresponsible enough to lend the weight of their status to what is essentially a political opinion is to be regretted, and insofar as it has mislead some and frightened others it is to be positively condemned. Their unfounded and unsupported statements should not, however, be allowed to hold the law of the State in thrall.

Stating international examples of instances where abortion was and is employed for so-called therapeutic purposes is worse than useless, since in countries where abortion-on-demand is the norm, the motivation to seek and find alternative treatments is not present. Indeed, if medical practitioners in these countries are unable to employ such alternatives they present us with an example of the general value of the Pro-Life ethic as expressed in medical care, since the care of Mother and Child is clearly proven as superior in this country because abortion is not available. There is no evidence whatever that life threatening situations for Irish women are being dealt with in English clinics and it is specious to cite the possibility.

It has been claimed, however, that since abortion is never necessary to save the life of the Mother, that the Pro-Life movement should not oppose the legalisation of abortion when it is provided only to save her life. In practice, the argument contends that no actual abortions would take place. This would certainly be true if it were not for the malicious and dishonest character of individuals involved in the abortion industry.

However, the rule that would almost certainly have been employed if the amendment had been passed in 1992 is that of *Rex v. Bourne* (in fact referred to by Mr Justice Egan in X). Under this ruling, it is not required that a doctor performing an abortion prove that it was performed to save the life of the Mother, rather it is for the prosecution to prove that he did not. The test is that the abortion was carried out in 'good faith'. To place unborn children in peril of their lives on the good faith of doctors whose own claim is an incompetence not shared by the vast majority of their profession is not acceptable. In any case, we might well refer here to international examples as to the type of doctors who are willing to perform abortions.

We cannot expect the law to use any other rule than that of the 'good faith' of individuals. If it did, this proposed amendment would not be presented at all given that the Working Group would have accepted the competent body's ruling on the matter, i.e. the Medical Council, and proposed a complete prohibition on abortion.

At this point we are compelled to raise the most vehement objection to the suggestion that this amendment might be proposed again with the threat of a more severe abortion regime if it is rejected by the people. It is not appropriate for any government body, howsoever formed, nor indeed for the government itself, to threaten and coerce the Irish people into a course of action which is at profound variance with their conscience.

As to the option itself, it is rejected by Youth Defence as unsafe.

Option (1)

Absolute constitutional ban on abortion The Green Paper is very clear in its appreciation of the fact that this is the option favoured by all but a minuscule number of submissions made to it. There seems little doubt that the same will be the case for the White Paper. You will undoubtedly also be aware of the many opinion polls conducted over successive years which prove conclusively that this ratio of submissions is in line with the feelings of the nation at-large. In any case, as incumbent Oireactais members you cannot fail but to be aware of the attitudes of your constituents on this point.

In the consequence, this is the only option which if referred to the people has the possibility of being enacted. We are not unaware of the problems associated with this, but are nonetheless confident, that, if the Committee recommends and the Dail accepts a properly worded Pro-Life referendum, then the campaigning has the wherewithal to explain it, argue for it and have it endorsed by the same overwhelming majority which supports the principle.

It is particularly unfortunate then that the Green Paper should set out to so comprehensively repudiate this option. It is chosen to make much of the distinction between 'direct' and 'indirect' abortion and the contention that these terms create legal difficulties. We can only agree. These terms do have a common usage and as such are widely understood by those engaged on both sides of the abortion debate. Youth Defence have always opposed their use even in this context, regarding them to be highly misleading to those not intimately familiar with the issues involved and obviously quite useless in formulating a Constitutional amendment. It is not, however, proposed that an amendment would be framed using these words, and it is somewhat disingenuous to reject the concept of a Constitutional ban on abortion based on the notion that these words may be imprecise.

Youth Defence proposes an amendment to Bunreact na hEireann which would read:

> No law shall be enacted, nor shall any provision of the Constitution be interpreted to render induced abortion, or the procurement of induced abortion, lawful in the State.

The amendment would be inserted as Article 40.3.4 of the Constitution. It is not proposed to delete, amend, or modify Article 40.3.3 in any way. The sentiments expressed in that provision are entirely supported by Youth Defence, though the judgment in *X* has effected a skewing of their application.

We would be vehemently opposed to any attempt to delete the Eighth Amendment on two principle grounds. Firstly the right-to-life of the Mother is not a secondary thought for us but of paramount and absolutely equal concern with the protection of the unborn child. Since no conflict exists there seems no purpose in removing a perfectly valid provision. Moreover, we would be concerned in the context of the social questions arising from the abortion debate that the State would fulfill its duty to comprehensively 'by its laws … defend and vindicate' the right-to-life. It is now universally agreed that this is an extensive obligation.

Secondly, any sensible reading of the Protocol 17 of the Treaty of Maastrict would recognise that it is only the original provision in its original wording that is afforded immunity of European law. While a conflict between European law and the additions concerning travel and information are highly improbable, it is nonetheless true that these additions cannot be covered, since, if they were, Ireland could put any provision it wished under the heading of Article 40.3.3 including the whole of the Constitution and render it immune to European law. This is clearly absurd and cannot be the case.

Article 40.3.4 as envisaged by Youth Defence would compel the Supreme Court to re-interpret the preceding subsection in light of a absolute prohibition on abortion while not amending the subsection as such. In point of fact, we are adding a clarifying subsection which does not change the original intention and meaning of the Eighth Amendment, but rather returns it to fitness for purpose. Since the immunity applies to this original wording, the immunity extends to its meaning. It surprises us that this possibility was not considered either in 1992 or in the Green Papers treatment of the potential effects of Protocol 17.

Altogether it is unfortunate that the Working Group, in seeking to denigrate its own first option, avoided dealing specifically with any wording as such. They make several references to the problems that might be associated with finding a suitable wording yet fail to address any of the

examples which were provided by the various organisations. In the consequence, their treatment of the option of a Constitutional ban is extremely vague and not of much salience to this Committee. In light of the fact that this option comprised almost all of its public submissions the Working Group was seriously remiss in not dealing more extensively with it.

Nonetheless, with those reservations concerning the manner in which it is addressed in the Green Paper noted, Youth Defence strongly recommends the first option as the singular morally just and popularly acceptable choice for the Committees consideration.

CONCLUSION

Youth Defence are acutely aware that there exists for the Committee a great temptation to base its recommendation concerning abortion on short-term political considerations, such as the calculation of numbers in the current Oireactais. You may also have the inclination to pay excessive attention to the kind of media coverage that the recommendation may receive. There is, further, the tendency to found the decision on the precedent of laws in other jurisdictions, to be like everyone else. While these things are understandable pressures, they cannot, however, be acceptable ones.

It is not possible to stress too strongly that the act of abortion is a crime so heinous as to beggar belief, and yet, believe it we must because it happens every day, legally sanctioned by otherwise civilised countries around the world. We could elaborate at length on the damage it is doing to those countries by spreading the culture of disposable humanity and violent problem solving throughout their societies. This however is sociological and vague. Abortion, on the other hand, is very personal, unique even, in the serious violence it is committing against the women who suffer it and the children who are butchered by it. It is always really about one woman and one baby, no matter how many times that is multiplied. Our own Gaelic language is not circumspect or evasive on what is involved, it has no words to describe it clinically cleansed of its enormity; it is ginmhilleadh.

The responsibility the Committee bears is similarly personal and unique. For in the end it comes down to this: when a woman becomes pregnant whatever the circumstances, she becomes a mother to a child, which became a child at the very moment of conception. And the question before us is whether we are willing to walk down that road to the death culture, whether we are willing for the sake of some false notion of freedom, or just because it is easier, to say to these women in crisis pregnancy, that it is your choice and therefore your problem, that we are willing to let loose the madness of abortion which reaches into the womb to tear limb-from-limb a living baby. Whether in an attempt to crush conservatism or Catholicism the Liberal mind has become so warped as to permit crushing the skull of a child with the fiendish blessing of corrupted law. It is as simple as that. It is not as easy as that, as there is much more to be done than just passing a Constitutional amendment to restore the respect for life and the dignity of the human person, but it is that simple, because, somewhere, a beginning must be made.

It is not possible to adopt the pro-choice position here, as if somehow by saying that in leaving it to individual women to bear the burden and consequences of the decision we are thereby cleansed of responsibility as a society. The law is necessarily a statement of who we are as a people and what we believe as a nation. Legalised abortion says we are cowards, unable to bear the responsibilities of freedom without descending to barbarity. Legalised abortion says that as a nation we believe that those who have no power have no rights.

The position we have taken is straightforward and, whatever the media may say, without extremism. Youth Defence wants our children protected, our women safe, and the soul and conscience of the nation preserved, that we may stand before the world not as a perfect people but at least as a people determined not to do the worst thing because it is by way of the path of least resistance. We are not submitting a document for your consideration so much as submitting the fragility of life for your decision.

Can your conscience bear the blood of the innocents?

PUBLIC POLICY INSTITUTE OF IRELAND
11 APRIL 2000
SUBMISSION TO JOINT COMMITTEE ON THE CONSTITUTION
TOM TROY, CHAIRMAN

PART 1
KEY ISSUES RAISED IN SUBMISSION TO GREEN PAPER WORKING GROUP

Constitutional rights

A Constitution is not only a legal document but also a social and political one and is (inter alia) the means whereby the people control the State. Where certain rights are specifically recognised or provided for in the Constitution, the aim is (inter alia) to prevent action by the State against these rights whether by laws or by decisions of judges. For this aim to be effective, the constitutional provisions should be clear and definite, without ambiguity. Obviously, the State will not normally mount an all-out attack on a basic right. What happens is that marginal changes are sought to meet exceptional cases or classes of cases favoured by particular lobbies or political groups. Exceptions once made tend to multiply – hence the need to stand on principle.

There is general acceptance of the view that within the hierarchy of rights there are a small number of rights that may never be infringed. John Finnis, for example, in his book 'Natural Law' (page 225) specifies his selection and sets out the right to life as the first. He defines it as an absolute human right 'not to have ones life taken directly as a means to any further end'.

We submit that the right to life is the most fundamental human right because all other rights presuppose it. Logically, protection of this right should extend from conception to natural death. Obviously, no State will attack such a right per se but may, as indicated above, seek changes at the margin (or what the State considers the margin). The relevant area of difficulty in this country at present is the attempt to introduce abortion.

Abortion: recent developments

We should recall that in the early 1980s fears grew – fed by the experience elsewhere – that court decisions might open the door to abortion. In consequence an amendment by referendum inserted an express right to life of the unborn in the Constitution. This seemed to be the position until the judgement in the *X* case opened the door to abortion (quite widely, on some interpretations). In response to widespread public agitation, the Government brought forward three proposals to amend the Constitution. Two of these (relating to information and travel) in effect were not opposed and were passed (although there were substantial votes against). The remaining proposal related to the substantive issues and disappointingly, the Oireachtas did not give the people the opportunity to reverse the court's judgement but sought, for the first time in Irish law to formally legalise abortion, although on a more limited basis than the court had envisaged. A Government spokesperson at the time indicated that if the proposal were rejected no further proposal would be put and therefore the more widespread range of abortion envisaged by the Supreme Court would apply. The dilemma facing the pro-life voters is obvious but nevertheless the people voted to reject the proposal. From a study of the votes against in the three referenda and taking account of the different circumstances in each case, it is clear that the people stood on principle and voted against abortion. This was confirmed by subsequent opinion polls at the time (in particular the 1995 Survey by the Institution of Advertising Executives).

Democratic deficit

We have recalled at some length in the previous paragraphs the steps that have led to the present position. We consider that it is clear that the will of the people, (who have the right of final appeal to decide all matters of policy under Article 6 of the Constitution) has been ignored. The people have sought by referendum to prevent the courts from introducing abortion but their amendment has been largely nullified by the interpretation put on it by a court. The Oireachtas, in effect the political parties, refused to put the original issue again to the people to enable them to put this right. We now have a serious democratic deficit and in consequence widespread alienation among a substantial section of people, an alienation that can be expected to grow if and when legislation to pave the way for abortion is introduced, and even more so if and when abortion clinics appear on the scene. People will sense that such developments, which will tend to change drastically the whole nature of our society, have been forced on them without their consent and therefore lack legitimacy.

Some proposals have been floated to the effect that the matter should now be wrapped up by ordinary legislation to pave the way for abortion on a limited scale (more limited than envisaged by the judgement in the *X* case). Apart from the fact that there are strong doubts as to whether this is constitutionally possible, it evades the issue of the democratic deficit. Similarly any proposal to insert a compromise amendment (in effect limited abortion) without the option of the choice clearly preferred by the people would be clearly undemocratic. A critical issue of this kind must be faced and debated and decided by the people.

Moral deficit

The 'moral deficit' is even more important. Morality is a matter of doing the good. Natural law, which has a strong influence on our Constitution, asserts that morality is based on reality and therefore stands, on the one hand, in opposition to legal positivism (which makes something right because it is commanded) and, on the other hand, against a morality of personal whim. Natural law morality is based on the order of reason. The moral person and moral community must discover and recognise the moral good and in the case of the religious person this process is helped and confirmed by one's beliefs.

When considered according to reason all moral principles are not equally clear to everyone but there are some on which all agree and the first of these is the right to life. To be defended logically and coherently as universally valid, the right must be seen as applying to every innocent human being from conception to natural death. In regard to the part of life before birth, modern scientific advances have shown more and more clearly that there is, as it were, a continuum from conception onwards, a continuing identity of a particular human being, and there is no point at which an abortion is justifiable. The informed moral conscience of mankind has judged abortion to be evil, not only because it is repelled by the notion of a medical programme of killing unborn babies (however hidden from public view) and the casual brutality of it all but also because of an intuitive understanding of the implications for society as a whole.

The higher religions have opposed abortion on moral grounds. In the case of Christianity, the whole Christian family, East and West, Catholic and Protestant opposed abortion from the beginning, right down to the present century (c.f. Vatican II's reference to abortion as an 'unspeakable crime'). This view informed the laws of Christian countries until the present century. Russia was the first to break ranks (after the Bolshevik Revolution), then Germany and other countries one by one either by court decisions in 'hard cases' or by legislation aimed initially at exceptional cases only. Of course, once the principle was conceded, the floodgates opened. In Britain, for example, some of the framers of the Abortion Act in the 1960s have since expressed regret at the outcome. Similarly, in the USA, many who originally supported abortion (including, remarkably, the woman at the centre of the *Wade v. Roe* case, which legalised abortion) have expressed alarm at the turn of events.

Laws teach people about values and when the law legalises some practice that tends to count with people and to affect their views. When particular groups (as part of a wider agenda) actively support abortion over a period, this also has an effect especially in the public presentation of the issue. (The rulebook of the NUJ in Britain enjoins support for abortion on its members). Public perceptions are also affected by a tendency to focus debate entirely on the mother in some hypothetical and exceptional case (which, we hold, never arises in actual fact) while ignoring the vast number of unborn babies who will actually be killed in pain.

It may be said that a departure from morality is not so

serious if confined to a small number of exceptional cases. However all experience shows that in such matters these 'exceptional' cases multiply over time, for various reasons eg. the inner logic of case law interpretations of 'hard cases', the pressures on individual doctors working under conflicting imperatives with no public principled moral position etc. Moreover, irrespective of the numbers involved, to formally introduce legislation for abortion would change drastically the nature of our society. It would associate the State formally with abortion in various ways: by legislation enabling abortion to take place, by initiating moves within the professions to change ethical standards and training, by overseeing new standards by health boards and/or private interest, by incurring some public expenditure on abortions and thus involving all taxpayers in complicity.

We submit that, as a minimum, the people should be given the option of voting for (or against) the maintenance of a principled moral position in relation to the right to life such as existed (or was thought to exist) before the *X* case. This would guarantee the right to life of the unborn, subject to the equal right to life of the mother, and in addition (as proposed by the pro-life movement) there would be a specific prohibition of induced abortion (to offset the judgement in the *X* case). It is important to remember that this involves no leap in the dark but a reversion to the status quo ante the *X* case, to a system that has served us well over many years. If there is any doubt that this is not so, a removal of doubt declaration could be added saying in effect that for avoidance of doubt no medical procedure in general use in Irish hospitals before the *X* case would be prohibited.

Abortion is advocated in Ireland from two positions. First, in the case of some highly committed groups, abortion is seen simply as a second line of defence in contraception and as such to be widely available. However this position is not widely publicised. The second position is that there may be a medical problem in some cases which endangers the mothers' life which can only be saved by (induced) abortion of the unborn baby. The view of the medical profession appears to be that no such problem has come up under the existing system of medical ethics (pre *X* case) with its emphasis on the distinction between direct and indirect and its provision for medical procedures to save the mother even when this has the indirect and unintended effect of the death of the baby.

If the issue turns on the question of conflicting views about the life of the mother versus the life of the child, a primary consideration is that the experience of the medical profession over many years shows that there is in fact no problem.

We submit that as moral persons and as a moral community we should seek to oppose the introduction of abortion.

PART 2
KEY ISSUES ARISING IN RESPONSE TO GREEN PAPER ON ABORTION

In the light of the options set out in the Green Paper we would strongly urge the Joint Committee to consider the following points in particular.

- Under Article 6.1 of the Constitution 'the people' have the right 'in final appeal to decide all questions of national policy, according to the requirements of the common good'. Hamilton P. described the enactment of the Eighth Amendment as the exercise of this right by the people so as to ensure that there could be no doubt that abortion was contrary to national policy and public morality (in the case of *SPUC v. Open Door Counselling* (1988) IR593; (1987) ILRM 477. However, after the *X* case it became clear that the people had not obtained what they thought they had voted for. The Oireachtas subsequently proposed in a referendum, in effect, a limited form of abortion, which was opposed by the people. Ever since then there has been a growing consciousness of a gulf between rulers and ruled, with a substantial section of the electorate feeling that democratic principles are being flouted. It is essential for the integrity of the constitutional process that the people be given the option to vote for or against a complete ban on abortion. If the people then vote for such a ban, the matter is settled, democratic principles are satisfied and the medical practice universally followed in Irish hospitals up to now can continue. If the people reject the ban then a new situation arises, but the Oireachtas will have discharged their constitutional obligations. In our view, the Oireachtas cannot countenance any of the pro-abortion options in the Green Paper without first giving the people the option of restoring the status quo which was upset by the *X* case ruling.
- There is a tendency here and abroad, while acknowledging universally held rights to seek exclusions of particular categories of people (based on race, nationality, class, age, health status, unborn etc.). In order to protect the right to life of all, there is a need to uphold the moral principle that one can never justify the taking of an innocent human life (no exceptions), and hence the principle that abortion should not be permitted in any circumstances. The only counter argument of a moral nature is based on a supposition that this practice could cause the death of the mother. But the reply to this, that such an eventuality has never arisen over the decades (when abortion has been banned) is conclusive (assuming that the wording of the ban permits existing medical practice to continue). In any event, this evaluation of the matter should be made by the people.
- One should not be too attached to the style of wording in the Constitution. While simple expressions of rights are attractive, practical politics may dictate the need for awkward phraseology. The insertion of a complete ban on abortion, while recognising existing medical practice, may not result in pretty wording, but if it serves to save countless unborn lives, and helps protect against future judicial misinterpretation then it would be a very welcome addition.

DOCTORS FOR LIFE
RESPONSE TO GREEN PAPER ON ABORTION FOR THE ALL-PARTY OIREACHTAS COMMITTEE ON THE CONSTITUTION

Induced abortion is not a medical matter. However, because the medical profession is intimately involved in the induced abortion process – from the initial decision

to the ultimate execution of that decision – it is widely considered that it is mainly a matter for doctors and their patients. It is not. It is far more important than that. It is an issue of human rights. Nevertheless, political, legislative and judicial decisions about abortion are invariably influenced by the advice of the medical profession and the medical perspective on abortion. That advice should always be based upon solid factual information. That it has not been so in the past, is abundantly clear from the decision of the Supreme Court in the case of *Attorney General v. X & ors* ([1992] IR 1) and the decision of the High Court in *A & B v. Eastern Health Board, Judge Mary Fahy and C & Attorney General (Notice Party)* [1998] I IR 464.

Thus, in *X*, evidence as to alleged suicide risk was sought only from a clinical psychologist, who was not a medical practitioner. No medical evidence was sought, notwithstanding that the psychologist, on examination in the High Court, expressed himself as not being in a position to give evidence as to *X*'s clinical state – a state to which had had averred in the course of his testifying. Furthermore, his evidence was accepted, even though untested. Notwithstanding the objectively empirical weakness of that evidence, and the absence of any expert medical view in relation to the condition of *X*, in the Supreme Court, the Chief Justice was nevertheless able to conclude:

> If a physical condition emanating from a pregnancy occurs in a mother, it may be that a decision to terminate the pregnancy in order to save her life can be postponed for a significant period in order to monitor the progress of the physical condition, and that there are diagnostic warning signs which can readily be relied upon during such postponement.
>
> In my view, it is common sense that a threat of self-destruction such as is outlined in the evidence in this case, which the psychologist clearly believes to be a very real threat, cannot be monitored in that sense and that it is almost impossible to prevent self-destruction in a young girl in the situation in which this defendant is if she were to decide to carry out her threat of suicide.

The medical profession is gravely concerned at the groundless presumptions, the critical lack of understanding of the reality of clinical practice and the confusion as to that reality that underlies the Chief Justice's stated view.

In *C*, however, there was evidence before the district court from a consultant child psychiatrist. Although it has been reported that *C* was assessed by two consultant psychiatrists, it is worth noting what actually occurred, as noted in the judgement of the High Court. Thus, the High court stated:

> [The second psychiatrist] had carried out an assessment which was largely directed at competency and was never directed at the question of whether the girl had suicidal intentions.

It is further worth noting that the evidence of the psychiatrist – who was called on behalf of the parties seeking to procure an abortion for *C* – was untested in the District Court. The district Judge had refused to allow an assessment of *C* on behalf of her parents, or even to allow an adjournment for the purpose of obtaining expert assistance in order that the psychiatrist might be properly cross-examined on his evidence and the grounds upon which it was based might be challenged. The conclusions of the psychiatrist in that case, on the basis of any objective assessment of the available evidence, do not accord with the empirical clinical reality in relation to suicide in pregnancy. Thus, as in *X* the conclusion of the court was based on untested evidence.

However, what is further disturbing about the High Court decision in *C* is the confusion about the nature of induced abortion and its groundless classification as 'medical treatment'. Thus, it was stated:

> [W]here a psychiatrist as in this case gives strong evidence to the effect that a child is likely to commit suicide unless she has a termination of pregnancy, that termination of pregnancy which is a medical procedure is clearly in my view also a medical treatment for her mental condition.

The available evidence rebuts completely the presumptions inherent in this assertion. It demonstrates that it has no objective basis – either generally or specifically – and it confirms that an induced abortion is not a 'treatment' of any condition in a mother.

Doctors for Life has considered the discussion of medical issues as they arise in the debate on induced abortion as set out in the Green Paper of the Inter-Departmental Working Group on Abortion. While largely concurring both with the evidence as set out therein and with the conclusions at which the authors of the Green Paper arrived, nevertheless, Doctors for Life wishes to record some important reservations. These have already been set out, and form part of, the Submission of the Pro-Life Campaign to the All Party Oireachtas Committee on the Constitution. Briefly put, Doctors for Life re-iterates that there is no empirical evidence that justifies on ordinary clinical or research criteria the necessity for induced abortion in the treatment or management of any condition, whether physical or psychological, in an ill mother.

Judicial consideration of induced abortion has been characterised by rampant confusion and an extraordinary failure to assess the issue from a standpoint of objective necessity. There has been no considered legislative assessment of the matter. Notwithstanding the involvement of the medical profession, this is not an issue that should be left to be decided by the medical profession on an *ad hoc* individualised basis. Human rights are far too important for that. The People, and the People along, should decide.

Accordingly, Doctors for Life wish to record their opposition to the adopting of any option set out in the Green Paper, other than the first option, i.e. a complete constitutional prohibition on induced abortion. Adopting such an approach, Doctors for Life contends, is the only legal mechanism that can realistically protect the lives of unborn children and adherence to best ethical medical practice.

Doctors should not create an implied serious hazard to the mother's life that is not justified by the medical facts in order to solve social, psychological or legal problems. If a medical reason can be found for aborting over 3 million children in Great Britain since 1968, then a medical reason can be found for aborting anyone.

That said, because of concerns that have been raised in relation to the situation whereby an unborn child dies, or is injured, as a consequence of treatment – whether surgical or medical – of a pregnant mother, it is necessary to briefly consider the ethical, clinical and legal nature of medical treatment.

No treatment is devoid of side-effects. In all decisions regarding the appropriate modality or type of treatment in any given situation, the most efficacious and least toxic must be chosen. The underlying ethical principles are those of doing good and avoiding unnecessary harm. Nevertheless, in very serious or critical illness, some harm, actual or potential, incidental to the primary aim or goal of treatment, may be acceptable. So, in cases of chemotherapy, the serious side-effects of lowered immunity and poor clotting (with the actual or potential risks of serious infection and bleeding) may be acceptable in the risk/benefit analysis, whereas they would fail to pass such a test if a treatment for a less serious condition, e.g. tonsillitis, involved such serious side-effects.

In pregnancy, a doctor, almost uniquely, has a simultaneous duty to two patients. Therefore *a fortiori* these principles apply. In general, the promotion of maternal well-being enhances that of her unborn child. Conversely, enhancing the well-being of the unborn child must not endanger the mother's life. In preserving the mother's life, consideration must be given to treatment side-effects on both the mother and her unborn child. However, maternal treatment should not be modified in such a way as to compromise the mother's chance of survival. For if the mother does not survive, then neither will the child (save in very exceptional circumstances).

Respect for the principle of maternal autonomy dictates that the ultimate choice regarding treatment is the mother's. She is the final arbiter of which option is chosen but such a decision is contingent upon full disclosure of all available therapies, their relative efficacies and effects and side-effects –for both mother and her unborn child.

A mother may elect to forego life-saving treatment (or even significant palliation) for the sake of preserving the life and integrity of her unborn child. Such a situation might arise, for example, in the case of an early mid-trimester pregnancy associated with advanced invasive cancer of the cervix. Here, a mother might decide to forego radiotherapy (and thus damage to her unborn child) until viability is reached, if her prognosis is poor. Conversely, if the mother elects curative treatment that might have the foreseen but unintended effect of damaging her unborn child, then this similarly must be respected and curative treatment instituted. If the child does, in fact, die or is congenitally malformed because of the treatment, no liability attaches to the doctor for such effects as he has a *prima facie* duty to treat the mother and the effects on the child are neither intended nor the result of negligence. Such treatment is both ethically and legally justifiable. By contrast, failure to provide such treatment or to inform the mother of the attendant risks and benefits could be unjustifiable if it amounts to a breach of duty on the part of the doctor or to a denial of proper and full consent by the mother. However, in medical practice, induced abortion – the direct and intentional killing of an unborn child – has no role in the treatment of any condition, physical or psychological, in the mother. And, it can never constitute 'medical treatment' irrespective of what the High Court might determine.

These are principles that are capable of constitutional expression and should, in the submission of Doctors for Life, be incorporated by way of Constitutional amendment completely prohibiting induced abortion.

THOMAS MORE MEDICAL ASSOCIATION
NOVEMBER 1999
SUBMISSION TO THE ALL-PARTY OIREACHTAS COMMITTEE ON THE CONSTITUTION WITH REFERENCE TO THE GREEN PAPER ON ABORTION

Having considered the Green Paper and the options set out, the Thomas More Medical Association urges resolution of the issue of induced abortion by way of the First Option recommended by the Green Paper, i.e. an absolute constitutional ban on abortion. No other option is capable of protecting the life of the unborn and the integrity of current medical practice.

INTRODUCTION

We are very glad to have the opportunity to present our position on the equal right to life for all, and on the constitutional issues which arise regarding induced abortion.

We believe that in recent years the approach to the abortion issue of the legislature and the judiciary has lacked a proper philosophical basis, and has shown a lack of regard for the equal right to life of the unborn in particular, and consequently the weakest section of the human family, the unborn baby, has suffered.

If the legal or medical approach to the right to life of the unborn lacks a proper philosophical basis, the lack of respect for that life which is evident in so much of the world today, will dominate in Ireland as it has done in other countries.

AN ETHICAL COMMENTARY

The Courts and the paramedical personnel involved in the *X* case, and the Courts together with officers of the Eastern Health Board and medical personnel involved in the C case, did not it seems to us consider the nature of what is involved in induced abortion, that is the deliberate killing of another human being, nor did they appear to consider the constitutional pledge to protect the dignity of the individual.

Our responsibility as citizens is to respect and in so far as one can to protect the right to life and dignity of every human being. We cannot see any circumstance which would entitle anybody to set aside the right to life of another. Accordingly it is not permissible for any person to take the life of another as a means to an end irrespective of how desirable that end might appear to be. To choose against the universal right to life for all can only harm the weak and breaches the principle of the equal right to life. The concept of the equal right to life for all implies a community in which nobody has superior rights of a moral or political kind over any one else. Any custom or enactment which persistently or in isolated cases allows one race or one group in society to lord it over other groups or individuals breaches this principle of equality. At the present time it is clear that the unborn child is at great risk despite the 1983 Amendment. The bizarre judgements in both *X* and *C* and the Thirteenth and Fourteenth Amendments of 1992 have left us in a situation whereby judges, doctors, fathers, mothers and counsellors are now entitled to treat the unborn child as a second-class member of human society.

Unless the right to life is inviolable, no other right can be enjoyed. Nobody could be sure that their life, their health, their freedom of conscience and religion are secure if the right to life can be arbitrarily denied.

If the law permits a denial of the right to life of any human being, irrespective of how controlled the circumstances might be the foundations of justice are in jeopardy. In a just society, everyone's right to life is protected on the basis of the equality of its members. If the State permits the deliberate killing of a child at any stage before birth how can a just society exist?

The basis of human rights is that all human beings are equal and because of this equality all are obliged to respect the rights of others. The right of autonomy of the person does not extend to prizing autonomy above all other rights. An anarchic exaltation of human freedom such as is involved in induced abortion means that human equality will not be valued.

Personal choice must be guided by moral principles. Mothers, fathers, doctors, nurses, scientists, judges and politicians, indeed all are obliged not to do anything which would jeopardise the right to life of the unborn. Clearly the act of induced abortion violates this principle as does a Court decision which countenances killing an unborn child, and an Act of the Oireachtas such as The Abortion Information Act, 1995, which condones promotional propaganda, and effectively permits for referral for abortion.

SUPPORT FROM FEMINISM

One of the most significant movements in recent times has been that of the demand for equality for women. The basic tenet of feminism is that being human, a living member of the species Homo Sapiens entitles that being to certain rights, regardless of sex or other criteria. If any class of human beings is treated as less than equal and this practice is condoned by the State, the very foundations of feminism are undermined. In this regard it is worth noting that the American feminist Rachel McNair has pointed out, that the attitude that leads to placing the ending of a child's life by abortion as a right, is 'toxic' for the feminist cause. 'Promoting abortion as necessary for the equality of women implies that women require surgery to achieve equality with men, and that the whole premise of male domination, women's biological inferiority is correct', McNair argues.

Those who work with the second victim of abortion, i.e. the mother of the aborted child, feel great frustration that induced abortion is treated as a minor surgical procedure by many in the abortion industry, and by supporters of abortion.

As has been pointed out by many feminists, a baby is not only the responsibility of the mother but also that of the father. The father who has an equal part in the procreation of the baby is freed of his obligation towards the mother by a decision of one or both to kill their baby in utero. If an abortion is carried out, the father cannot be required to give child support. If the mother decides to keep their child, the father may be tempted, such is the pervasiveness of the 'health through death' mentality which induced abortion promotes, to see 'it' i.e. the baby, as resulting from the failure of the mother to abort. 'Why inconvenience me when it is only a matter of a visit to an abortion centre?' the father may ask. A trivialisation of induced abortion follows from such an approach.

However induced abortion as well as killing the child, also places the mother at risk. It beggars belief that abortion centres are allowed to advertise and promote their wares in Ireland, a country that has provided and continues to provide unequalled maternity care for women.

Making induced abortion legal does not make it safe. Even in countries which operated legalised abortion regimes, infection and haemorrhage are not uncommon, uterine perforations may lead to hysterectomies and other surgical procedures. An incompetent cervix or scarring of the uterine tissue may lead to miscarriages of subsequent 'wanted' pregnancies, ectopic pregnancies and premature births. These facts are not highlighted when induced abortion is being promoted.

CONCLUSION

The late Professor Jerome Lejeune, Professor of Genetics at the University of Paris, made an apposite observation on current attitudes to the unborn. In the context of the suggestion that new-born babies who suffered some handicap should be let die, he said:

> Those who delivered humanity from the plague and rabies where not those who burned the plague-stricken alive in their houses, or suffocated rabid patients between two mattresses. Health by death is a desperate mockery of medicine.

In order to redress the unsatisfactory legal position regarding the protection of the right to life of the unborn and to restore harmony between the general provisions of the Constitution and its provisions in relation to the right to life of the unborn, erroneously it seems to us interpreted by the Courts, the Government must and should present a clearly worded Referendum, so that the people of Ireland are given a straight choice to accept or reject the deliberate killing of the unborn child. In our view no other approach is capable of protecting the unborn's rights.

Therefore having considered the Green Paper and the options set out, the Thomas More Medical Association urges resolution of the issue of induced abortion by way of the First Option recommended by the Green Paper, i.e. an absolute constitutional ban on abortion.

No other option is capable of protecting the life of the unborn and the integrity of current medical practice.

FAMILY AND LIFE
25 NOVEMBER 1999
FAMILY AND LIFE

GLOSSARY OF TERMS USED

Abortion: an action or omission chosen with the intention of killing a living unborn human being. It does not apply to what is called 'spontaneous abortion' [miscarriage] or to any legitimate, necessary and proportionate medical treatment that may have as an unintended side effect, the injury and death of the unborn child.

The Constitution: Bunreacht na hÉireann (Constitution of Ireland), enacted by the People 1st of July, 1937.

The 1983 Amendment: the Eighth Amendment to the Constitution, passed in September 1983, and added to *Bunreacht na hÉireann* as Article 40.3.3.

A PREDICTION REALISED

1.1 Abortion became a public issue in Ireland when the Pro-Life Amendment Campaign (PLAC) was formed in 1981. This was an umbrella organisation of some 14 groups, all of whom believed that a constitutional amendment was necessary to maintain a complete legal ban of abortion. The PLAC argued that the *1861 Offences against the Person Act* was no bar to future legalisation of abortion. It believed that this law could be modified by case law and/or new legislation, as happened in the UK in 1967, or declared unconstitutional by the Supreme Court, as happened to the abortion laws of the United States in 1973.

The opponents of the Referendum argued that the Amendment was unnecessary, and, among other things, accused the PLAC of wasting public time and money. Despite the passing of the 1983 Referendum, seventeen years later it is clear that the PLAC's fears were well founded, and, if anything, they seriously underestimated the pressures for legal abortion.

2.1 In fact, the *1861 Offences against the Person Act* offered minimal legal resistance to the legalisation of abortion. Already it had been interpreted in Britain to permit 'lawful abortions' in the 1938 Bourne case. The judge in the case declared that a doctor could perform an abortion lawfully if he believed the mother's life to be at risk, or that she would become a 'physical or mental wreck' if the pregnancy continued. Thereafter, this ruling was the legal basis of thousands of abortions done by British doctors up to 1967, and still applies in Northern Ireland where the 1967 Abortion Law does not hold force.

2.2 The pressure for new legislation on abortion in Britain increased in the Sixties. Abortion law reform groups campaigned for a 'clarification' of the existing law, arguing that the Bourne case was not sufficiently clear and certain to protect doctors from prosecution. In 1967 the (United Kingdom) Abortion Act was passed, permitting 'lawful abortions' on six defined grounds. Although the law's promoters assured the public that the law would be strictly enforced and the number of abortions would remain small, neither of these things happened. The number of abortions performed in Britain is approaching some 200,000 *per annum* (1997), and the activities of private abortion clinics have made abortion on demand a practical reality.

2.3 Britain's history in this area is little different from any other western country that has legalised abortion. Despite the best intentions of the law framers, once abortion is legal, its occurrence rapidly increases, and abortion on demand exists in all but name.

3.1 The wording of the 1983 Amendment was a compromise formula, and was not happily received by the PLAC when the government of Mr C. Haughey first announced it in November 1982. It was pro-life rather than anti-abortion. It approached the problem of prohibiting abortion by affirming the right to life of the unborn child that is 'equal' to that of his/her mother. 'Equal' is the key word; remove that word and the Amendment has little force. The wording of the Amendment clearly implied that the 'unborn' is a human being, of the same nature and with the same legal status of his/her mother, and by implication of the rest of the 'born' population.

3.2 The 1983 Amendment's intention was to make explicit the Constitution's protection of the unborn. By doing so it intended to prohibit **any and every** direct attack on the life of the unborn, even though it avoided saying this, and omitted any prohibition of abortion by name or under any class of actions. Despite these omissions the Amendment was understood by the Supreme Court up to February 1992, and both by those who voted for it and against it, as **a total ban of abortion**.

AN UNRESOLVED CONTRADICTION

4.1 The Irish Constitution has a Christian character that permeates it from start to finish. It begins with an acknowledgement of the Holy Trinity 'from Whom is all authority and to Whom as our final end, all actions both of men and States must be referred, ...' and 'Humbly acknowledging all our obligations to our Divine Lord, Jesus Christ, who sustained our Fathers through centuries of trial ...' This part of the Constitution alone would be sufficient to outlaw abortion as an 'unspeakable crime'.

4.2 A second feature underpinning the Irish Constitution is the concept of Natural Law as the source of fundamental human rights and obligations. This feature distinguishes the Irish Constitution from one that is based on positive law where human rights are given to the individual by the State or by a decision of the majority of the voters in a referendum (majoritism).

4.3 In speaking about the fundamental rights of Ireland's citizens (Articles 40-43), there are references to 'inalienable and imprescriptible rights, antecedent and superior to all positive law' (Art. 41.1), 'the inalienable right and duty of parents ...' (Art. 42.1), 'the natural and imprescriptible rights of the child' (Art. 42.5), and 'the natural right antecedent to positive law ...' (Art. 43.1.1.). These rights belong to human beings irrespective of the form of government. They flow from the nature of human beings and human society. Even though the decision of the people in a referendum is the final arbiter of Irish law, the Constitution does not favour majoritism, as it again reminds us that the people's power is subject to God's law, and its decisions must follow a recognition of human nature and human morality – 'All powers of government, legislative, executive and judicial, derive, **under God**, from the people ...' (Art. 6.1) (Emphasis added).

4.4 The most basic personal right is the right to life and the State has the duty to protect that right against all attack (Art. 40.2). None of the rights mentioned in article 40 may be restricted or taken away without the due process of the law.

4.5 The majority of the citizens of the State still declare themselves members of the Catholic Church, a church that most decidedly treats abortion as 'an unspeakable crime'. Their abhorrence of abortion should be presumed to remain.

THE *X* CASE AND IRISH LAW

5.1 In 1992 the judges in the High and Supreme Courts were faced with a case of a minor – referred to as *X* – pregnant as a result of statutory rape and threatening suicide if she did not get an abortion. The two courts were asked whether or not the girl had a right to have an abortion, and the Supreme Court in a majority decision judged that she had (*The Attorney General v. X and Others*, edited by Sunniva McDonagh, BL, Dublin 1992).

5.2 We believe that the judgment was faulty for a number of reasons, the most serious of which is that it permitted one human being to take the life of another human being, **directly and intentionally**, and that action is totally contrary to the Irish Constitution, and the European tradition of law on which it is based. A second serious reason was the court's misinterpretation of the 1983 Amendment.

5.3 In the *X* case the Counsel for *X* argued that the 1983 Amendment did not exclude all abortions. Surprisingly, the Counsel for the Attorney General made no effort to oppose this interpretation. He accepted the argument that the 1983 Amendment allowed abortion in an unspecified manner, even though he made no effort to define the act of abortion or connect his statement with the practice of Irish doctors in this area (*The Attorney General v. X and Others*, p. 38). Four judges of the Supreme Court also accepted that the 1983 Amendment permitted some abortion, and on 5th March, 1992, stated that Irish law permitted the abortion of *X*'s unborn child.

5.4 This was the context of the formulation of 'the test' to solve the alleged clash of rights of mother and unborn child. In doing this *X*'s counsel made use of the Bourne case. Prior to 1983, Irish legal opinion described the Bourne case as an unsound interpretation of the 1861 law, and rejected the suggestion that it would be made use of in an Irish court (Ó Síocháin, *The Criminal Law of Ireland*, 1981, p. 140). Apart from belonging to another jurisdiction, the Bourne case was precisely the kind of legal approach that the 1983 Amendment was designed to exclude.

5.5 It is accepted by both the High Court and the Supreme Court that the debates in the Oireachtas can help in establishing the meaning of laws and their interpretation. If the Court in the *X* case had looked for guidance from this area, there would have been little doubt that the 1983 Amendment outlawed abortion in all circumstances, and that was the understanding of both its supporters and opponents at the time of its presentation to the people.

5.6 Having decided that there was a conflict of rights between mother and baby, the Supreme Court presumed without further discussion that the solution lay in allowing the mother to kill her baby. It did not examine the legality of allowing one human being to take the life of another human being in solving an apparent conflict of rights. In doing this, we believe the Supreme Court's decision placed a serious contradiction in Irish law that remains today.

5.7 Irish law acknowledges that the right to life of a human being, like other basic human rights, is not conferred by the State but is anterior to any human law. The 1983 Referendum acknowledged that the unborn child has the same right to life as those who are born yet the *X* case permitted the same unborn to be deliberately killed.

5.8 How can any Irish court permit the unborn's right to life to be directly and knowingly taken away by another person?

Irish law, like the law of most other jurisdictions, understands that there are situations where the State's agents or even individuals, may use deadly force, as in self-defence, police arrest, etc., but in strictly limited circumstances where no other way is available. When someone is killed, as for example when the Gardaí kill an armed criminal resisting arrest, the law requires a careful scrutiny of the event to ensure that no excessive force was used and the death of the criminal was not deliberately sought in advance. In the past when the State inflicted capital punishment for certain crimes, the law insisted on a due process that required the jury to arrive at certainty of guilt before the judge pronounced the death penalty on the accused.

It would be a profound irony for the Irish government to legalise abortion. Having abolished the State's power to kill those convicted of certain serious crimes, it should now make lawful the deliberate killing of a whole class of human beings, this time without any due process of a court of law.

Irish basic law is totally opposed to granting any individual, either as a servant of the State or a private individual, the power to take the life of any other innocent human being. A law like the British 1967 Abortion Act allows a whole class of people (i.e., pregnant women) in far from limiting circumstances to kill another whole class of people (i.e., their unborn children) as a matter of right and without the due process of a court of law. This is totally contrary to Irish law. The Christian character of the Constitution and the declared right to life of the unborn cannot be reconciled with a judicial interpretation permitting abortion, still less any law permitting abortion. (This is true of British and American law, both of which justified their abortion laws by assuming that the unborn is not a 'complete' human being.)

Subsequent laws (the right to travel, and the Abortion Information Act) and judgments (the *C* case) were based on the validity of the *X* case, but these only compounded the contradiction. Is it surprising that the Constitutional Review Body advocates a wholesale revision of the Constitution to achieve some measure of internal harmony? It must be pointed out that it saw the solution to this contradiction in the elimination of the Christian and natural law bases of the Constitution; that would open the way for abor-

tion, foetal experimentation, euthanasia and other acts that treat some human beings as less equal than their peers.

The question remains: How can a mother be permitted to kill her unborn child, who is incapable of action or choice, and whose mere existence, not actions or choices, is defined as a threat to the mother's life?

6.1 **The *C* case** in November 1997 highlighted the inherent contradiction that the *X* case has created in Irish law. In that case a judge of a district court was asked by the Eastern Health Board to sanction a minor's abortion, to be arranged, supervised and paid for by the same health board.

The judge of that court sanctioned that course of action, and her decision was supported by a judge of the High Court who reviewed the order of the District Court. *C*'s unborn child was killed on the authority of a district court. The judges of both courts based the decisions on the *X* case.

6.2 The obvious question must arise. How could a court of 'local and limited jurisdiction' (to preside over offences incurring penalties of up to two years in jail or a £1,000 fine) deal with a matter of such gravity? Since the question centred on the life or death of a human being, how could this court believe that it had the authority to deal with the case? The fact that it was a children's court, and was not considering a criminal charge against anyone, does not free the district court from its own constitutional limitations (Art. 34.3.4).

6.3 One answer suggests that the two judges in the *C* case were able to abstract from the existence and the death of the unborn child and concentrate on abortion, to use their own phrase, as a form of 'medical treatment' for the mother. If abortion is no more than a form of 'medical treatment', then the taking of a human life does not arise, and there is no problem when a lower court allows a state agency to override the wishes of the parents regarding the alleged choices of their daughter of one or another form of medical treatment.

6.4 Another perplexing feature of the *C* case was the behaviour of the Attorney General. When the decision of Judge Mary Fahey of the District Court was challenged before Judge Geoghegan in the High Court, the Attorney General appointed two counsels for the sole purpose of defending the interests of the unborn child. What greater interest had the Attorney General than the life of *C*'s child? When Judge Geoghegan decided that the District Court should stand despite the mistakes of its judge, it was widely reported that both senior and junior counsel wanted to appeal to the Supreme Court, and so reported to the Attorney General.

It was all the more puzzling that the Attorney General instructed them to inform the Supreme Court that they did not wish to appeal. This was a most surprising omission in the form of a formal directive of the Attorney General himself.

This decision of the A.G. had more than one consequence. The Society for Protection of the Unborn Child, which had a *locus standi* in other similar cases concerning abortion, decided not to join the case precisely because the unborn child of *C* was already represented by the A.G.'s team. It clearly could not have foreseen the A. G.'s decision, but the net result was that there was no one to plead for the right to life of the unborn child before the Supreme Court on the Monday morning of November 21, 1997.

A MEDICAL-LEGAL DISAGREEMENT

7.1 Another undesirable development of the *X* case is the chasm that has developed between legal thinking on abortion, and current medical ethics and practice in Ireland.

The *X* case allowed a woman to have an abortion because she threatened to commit suicide. In the judgment of the Supreme Court, an important question centred on the reality of *X*'s declared intention to take her own life.

7.2 The evidence that her threat was a real and substantial risk to her life rested on the unsupported testimony of a clinical psychologist, rather than a psychiatrist, yet neither the judges nor the counsel for the A.G. queried his standing.

7.3 The clinical psychologist was not a Registered Medical Practitioner with the Medical Council in Ireland, and therefore not a 'medical person' in the recognised sense. His evidence should not have been admissible 'as relating to the assessment, diagnosis and treatment of mental illness and specifically in relation to the risk of suicide'. In Britain the evidence of a psychologist in a murder trial in November 1980 was declared inadmissible by the judge, subsequently confirmed on appeal, since he was not a qualified medical person (see Brian McCaffrey, MB, BCH, BAO, FRCPsych. DPM, letter in *Irish Medical Times*, 13.3.92) (Appendix 1).

7.4 The clinical psychologist's evidence of *Miss X*'s condition and her intention to kill herself was immediately challenged when the judgment was made public. Professor Patricia Casey, Department of Psychiatry, UCD, described his evidence as 'medically unsound', and denied that his evidence on *Miss X*'s suicidal intention was supported by current research. Far from an abortion alleviating the trauma of rape, it is four times more likely to add to it and lead to suicide, especially among young women [see notes 2 and 4]. The value of the same clinical psychologist was called into question at a later date when he expressed his personal disapproval of Ireland's constitutional ban of abortion in a newspaper interview.

7.5 Lastly, there was no effort by any party to seek for a second corroborating opinion about the mental state of *Miss X*. These points were the cause of considerable dissatisfaction on the part of Irish doctors.

8.1 Indeed, Irish obstetricians and gynaecologists as represented in the Irish Medical Council seemed to have gone out of their way to distance themselves from the views of the Supreme Court when they affirmed that they knew of no medical condition that required abortion as part of its treatment. What might

have been life-threatening conditions in the past, no longer are so today.

This conclusion is supported by a review of the statistics of maternal deaths in the National Maternity Hospital, Holles Street, Dublin over a 10-year period (Murphy J. and O'Driscoll K: 'Therapeutic Abortion: The Medical Argument'. *Irish Medical Journal*, 75(1982) pp. 304-6). Out of 74,317 births there were 21 maternal deaths. The two authors of this review examined the cause of death in each case, and found that the availability of abortion in Ireland would not have helped even one mother. There is no reason to believe that the figures from the other maternity hospitals are any different from those of Holles Street.

8.2 It may be suggested that the Irish maternal-death figures are good because women with certain conditions, allegedly requiring abortion as part of their treatment, go to Britain because they can't obtain it in Ireland. However, the statistics for abortions performed in England and Wales on non-residents (and that includes women giving Irish home addresses) give no support whatever to this suggestion.

Between 1974 and 1990 none of the recorded 115,567 abortions on non-residents were sought to avoid life-threatening conditions, and there is no evidence that women seek abortions in Britain because they cannot get adequate medical treatment in Ireland, due to the non-availability of legalised abortion (Abortion Statistics 1974-1990. Office of Population Census and Surveys, HMSO).

The statistics on abortion in Britain show that the vast majority – over 90% – are not sought because the pregnancy is seen as a risk to the life of the mother. Of the 1,403,527 abortions performed in that period only a tiny number (0.25%) claimed that the pregnancy was a threat to the life of the mother. The main reasons given by women seeking abortions are psychological or social, e.g., that the pregnancy was a risk to the mental health of the mother or her existing children.

8.3 A thorough survey of medical literature on the interaction of pregnancy, disease and its treatment was made by a group of doctors soon after the *X* case in 1992. Its finding supported the statement of Ireland's gynaecologists and obstetricians. The survey failed to find any pathological condition that required abortion as part of its recognised treatment.

In the various forms of cancer and heart disease, a pregnancy does not obstruct the treatment of the disease (*Current Controversies in Abortion: An Information Update*. Dublin 1992, pp. 9-21, see Appendix 3).

There is no evidence that a pregnancy increases the risk or growth of a cancer, nor hampers the treatment of cancer. Surgery or chemotherapy may be given to a pregnant woman as to a non-pregnant one. In both cases the informed decision of the woman is the deciding factor.

SUICIDE AND RAPE

8.4 The persons in the *X* and *C* cases were both teenagers who had become pregnant through rape (at least in the legal sense). The unborn child in neither case was a threat to the life of the mother in any physical sense. The public were told that the threat to life lay in the mental state of both mothers, who (allegedly) regarded the prospect of bearing a child with such abhorrence that they declared their intention to take their own lives.

While accepting that no one can be certain about the outcome of suicide threats, studies of this subject show that pregnancy, far from being a risk factor, reduces the risk of suicide and mental illness in general. This is probably due to the hormonal changes in a woman's body during pregnancy. The results of a study done in England and Wales over a ten-year period show that pregnant women are 20 times less likely to attempt suicide than non-pregnant women (Appleby L: 'Suicide during pregnancy and in the first post-natal year'. *British Medical Journal,* 302 (1991) pp. 137-140).

The desire for suicide/termination surely is often the result of pressures from parents, partners or counsellors who believe abortion is the only choice. We can legitimately suspect that the Eastern Health Board's minders shared a view that an abortion was the only possible course of action, and communicated this view to *C*.

8.5 In the case of rape there have been some studies of rape victims who became pregnant. Most of the women continued with their pregnancy, even though abortion was freely available. None changed their minds after the birth of their babies, and wished they had chosen an abortion. There is no evidence that an abortion is therapeutic or restores the mental equilibrium of rape victims. In some cases, an abortion is experienced as a repeat of the violence of the original rape, and deepens the sense of violation and dehumanisation. No doubt, the abortion choice is often an immense convenience for others, be they family members or partners.

8.6 Leaving aside the physical risks that are well documented in medical literature, abortion carries very definite psychological risks. Even the abortion providers who offer what they call 'post-abortion counselling' acknowledge Post-Abortion Syndrome as a reality. The negative consequences may occur soon after the abortion or many years later. In some cases serious psychiatric problems will emerge, and teenagers are especially at risk. The girl in the *C* case, despite being in the care of the Eastern Health Board, appeared to have suffered the very thing that her abortion was intended to avoid.

8.7 People, especially teenagers, can experience suicidal thoughts for a variety of reasons, such as the failure to pass an exam, obtain a job or gain the affection of a boy/girl friend. Medical treatment for one suicidal does not normally give in to the patient's demands, even if it is possible. To quote Professor Casey, 'A time of crisis [is] never a time to recommend any major life event such as an abortion or a hasty marriage.' Yet, this is exactly what was done in both the *X* and *C* cases.

Suicidal desires are countered by constant supervision and control, counselling, and medication. The treatment seeks to alleviate the patient's extreme feelings of anger, self-hatred or loss. It is extremely

difficult to verify or measure these emotions, to determine if they are authentic or suggested by others, and how they will influence future behaviour. Will it come about that anyone who wants an abortion will claim that they are suicidal following rape? (See note 3 and 4.)

IS A FORMULA IMPOSSIBLE?

9.1 An objection to a referendum, frequently heard, states that it is impossible to find a wording for an amendment prohibiting all abortion, yet permitting certain forms of medical treatment for pregnant women.

We find its incredible that such every day ethical thinking in this matter cannot be adequately expressed in legal terms. There seems to be a resistance to formulating the commonplace ethical concepts regarding the intended and unintended effects of a doctor's action, and the intention of the doctor performing the action. Doctors are constantly faced with situations where they have to choose an action, which produces more than one effect. It may involve a drug in pain relief, or it may be a surgical procedure. They wish to alleviate pain or promote recovery, but they are aware that the action carries known risks and may lead to death.

9.2 No one calls them murderers if the patient dies. Firstly, because their intention was not to kill. Secondly, the action chosen was not of its nature a killing one. When abortion is examined there is a clear difference between the doctor who treats a pregnant woman for uterine cancer, and the abortionist who kills her child. The first wishes to save the life and health of both the mother and the unborn child, if it is at all possible. He does not want to harm the child. The abortionist has only one intention – to kill the unborn child. The action of the first is life-saving of its nature, even if the treatment may lead to the injury or even death of the unborn child. In contrast, the action of the abortionist of its nature is directed to the death of the unborn.

9.3 Doctors of all persuasion know when a surgical procedure is an abortion or not. The first question to be answered is what is *the intention of the doctor and pregnant woman*. If the intention of either or both is to end the baby's life, the nature of the action is clear. It is an abortion. If the intention is to cure the mother from some life- or health-threatening condition, this intention will be accompanied by efforts to ensure the continuing health/survival of the baby.

The second question is what is *the nature of the procedure*. If it poisons the baby, cuts him/her in pieces, or causes the mother's body to reject the baby, then such procedures are abortifacient. The procedures of an abortionist have little to do with the health of the mother, but invariably kill the baby.

The doctor who treats the cancerous womb of a pregnant mother will do all he can to save the baby, even if the proposed medical treatment requires the removal of the womb. I find it hard to believe that legal experts cannot express these distinctions in appropriate terms.

9.4 Therefore, I propose the following option to your committee: that an explanatory clause be added to Article 40.3.3., the Eighth Amendment to the Constitution, passed in September 1983, and added to Bunreacht na hÉireann. The following is a suggested wording.

> Where abortion is understood to signify the intentional killing of the unborn, no law shall be enacted, nor shall any provision of this Constitution be interpreted so as to render abortion lawful.

It should remove any possibility of 43.3.3. being interpreted to permit abortion in any form or circumstance, as happened in the *X* case.

A NEW REFERENDUM OR LEGISLATION?

9.5 The agitation for legislation following the *X* case has become more demanding. Groups such as the Dublin Abortion Rights Group talk about 'women at risk', and demand legislation according to the *X* case.

The concept of 'limited abortion' is spurious. No abortion law in any country has succeeded in its well-publicised aim of keeping abortion rare, and there is no basis for any assurance that this would be different in Ireland, should abortion be legalised. Even then, there is no assurance that another 'hard case' would not be brought to the courts, and found 'lawful', requiring further legislation. The judges in the *X* case did not limit abortion to one case or even one type of case. They accepted that some abortion was permitted.

Politicians, judges and doctors have to accept that abortion will continue to be a contentious and divisive issue. There can be no consensus about an action that involves killing a human being

A new referendum that gives the people a choice of outlawing abortion once and for all is the only fair way to resolve this legal confusion and contradiction. Offering a pick-and-mix bag of proposed legislation allowing 'some abortion' would be rejected, just as Albert Reynolds' (A-Little-Abortion) Referendum in 1992 was rejected.

If the unborn baby is a human being, there can be no exceptions. No amount of political or judicial arguments can justify the taking of an innocent human life. The unborn child is not doing anything other than existing; he is not an aggressor by any normal definition, nor is he threatening his mother or siblings, unless one adopts the topsy turvey logic of subjectivism.

At the time of the 1983 Referendum, its critics and opponents made predictions of maternal deaths, if it were passed. Yet, there was never any real likelihood that Irish doctors would be restricted by the 1983 Amendment from continuing to give full treatment to pregnant women. These predictions were without any basis, and never were realised. In fact, it can be argued that doctors are more effective in their care of the lives of mother and child in Ireland where abortion is not an option than in those countries where abortion is commonly practised (see UNICEF's survey of maternal mortality).

Abortion divided the country in 1983. Then, the people of Ireland voted by two to one to exclude

abortion. Seventeen years later the divide on this question remains but is clearer. Those calling publicly for legal abortion have no qualms today about expressing their views. The groups opposed to the 1983 Amendment, namely, the Women's Right to Choose Campaign (founded 1981) and the Anti-Amendment Campaign (founded 1982), argued that the 1983 Amendment was 'unnecessary', a waste of public money, sectarian, and a threat to women's health.

In 1983 a huge anti-abortion consensus existed in Ireland. So much so that the Anti-Amendment Campaign considered it prudent to conceal the fact that some of its supporters wanted abortion legalised. Today, most of the prominent people opposed to the 1983 Amendment want legal abortion as a right. Abortion is part of a lifestyle, and has little to do with medical care and treatment.

We acknowledge that the legalisation of abortion is supported by some, among whom are prominent politicians, doctors, lawyers and other professional people. Their support for abortion arises from their own personal beliefs and political views, and not from medical or legal needs.

No judicial interpretation, added amendments or legislation permitting abortion in Ireland or its promotion elsewhere could be reconciled with the Christian character of the Irish Constitution.

We affirm our belief that the vast majority of Irish people wish to have an opportunity to rectify the Supreme Court's *X* case interpretation of Article 40.3.3, and re-affirm the right to life of the unborn by way of a referendum.

Notes:

1 Letter of Brian McCaffrey in *Irish Medical Times* [13.3.92].

2 Newspaper report on Prof. Casey in *Irish Medical News* [16.3.92], and *Irish Independent* [20.3.92].

3 Drs. Mona Byrne, Ciarán Craven, Maura Nesta Nic Ghearailt, Berry Kiely, Janina Lyons and David Power, *Current Controversies in Abortion: An Information Update*. Dublin 1992, pp. 9-21.

4 From the *Irish Times*, Jan 13, 1999:

> ABORTION AND SUICIDE
> Sir, – In response to my article of December 14th, Dr Dermot Walsh (January 4th) correctly points out that the prediction of suicide in any individual belongs in the realm of unreliable predictability and, furthermore, is open to exploitation. The late Dr Michael Kelleher, writing in the *Irish Journal of Psychological Medicine* in the aftermath of the 'X' case, made the same point when he stated:
>
> > The research evidence indicates that medicine and psychology does not have the ability to predict suicide, even with a moderate degree of success.
>
> There are no studies on the association between threats of suicide and completion of the act, since threats are so common and completed suicide is so rare. Thus, extrapolating clinically or statistically from threats to completed suicide is impossible.
>
> All of which prompts the question: why did our courts not examine this aspect more thoroughly in the 'X' and 'C' cases? And where were the diligent and independent-minded journalists of the day who should have been asking that question? Dr Walsh, correctly, in my view, states that there is no conclusive evidence that the suicide rate in women is influenced by the availability or non-availability of abortion. However there is strong supporting evidence that pregnancy is associated with a lower than normal suicide risk and procured abortion is associated with an increased suicide risk.
>
> A review in Finland of women who committed suicide between 1987 and 1994 found the suicide rate associated with procured abortion was six times greater than that associated with birth.
>
> A number of studies in the UK and the US have shown that pregnant women have a significantly lower incidence of suicide than non-pregnant women of the same age. Not only is the risk of actual suicide lower in pregnancy but so also is that of attempted suicide, despite the relatively high rate of psychiatric illness in pregnant and postnatal women.
>
> *Yours, etc. B. A. KELLY, MRCPI, DCH,*

VINCENTIAN PARTNERSHIP FOR JUSTICE
25 NOVEMBER 1999
SR BERNADETTE MAC MAHON
SUBMISSION RE GREEN PAPER ON ABORTION

I am writing on behalf of the Vincentian Partnership for Social Justice (which consists of the Society of St Vincent de Paul, the Vincentian Congregation, the Sisters of the Holy Faith and the Daughters of Charity).

Concern for the gift of human life at all times from conception to death requires an absolute constitutional ban on abortion. We submit that this can only be achieved by an honest and clear wording that enables ordinary people to know clearly the core meaning of the amendment. At the same time it is essential that the wording allow for care of the mother as well as the unborn child. Thus the wording suggested by the Pro-Life Campaign in October 1992 adds to Article 40.3.3 as follows:

> 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, as far as practicable, by its laws to defend and vindicate that right.
>
> It shall be unlawful to terminate the life of an unborn unless such termination is the unsought side-effect of medical treatment necessary to save the life of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life.

Such wording captures the reality of the present medical practice in Irish hospitals. We submit this as a transparent and clear wording of one option in a referendum.

KNIGHTS OF ST COLUMBANUS
22 NOVEMBER 1999
NIALL M. KENNEDY, SUPREME KNIGHT
SUBMISSION ON THE GREEN PAPER ON ABORTION

Our position has been made quite clear in earlier submissions and therefore we believe we should do no more than re-state our position in a short concise manner.

Following the Supreme Court findings in the 'X' case,

the amendment to Article 40.3.3 of the Constitution is now deemed to have a meaning which was not intended or understood by those voting on the amendment, whether for or against. It is obvious, therefore, that the Constitution contains a sub-Article which is not in accord with the wishes of the people. The only way in which that position can be corrected, is by yet a further Referendum. Distasteful as this may be to us all, the unfortunate sub-Article in question deals with a subject which is literally of vital importance, and as such, cannot easily be ignored.

The Green Paper itself acknowledges that the vast majority of submissions received argued the right to re-affirm in a referendum their demand for a total ban on abortion.

The medical experts have stated categorically that while there are no medical circumstances in which it is necessary to directly kill a baby in order to save the mother, a baby may sometimes die as a non-intended consequence of medical intervention to save the life of the mother.

Our members believe that only a referendum will resolve this issue and that the wording must not allow for interpretations other than that which is the will of the people. It can be said, in fact, that almost every option outlined in the Green Paper will require a Referendum to be held.

IRISH FAMILY PLANNING ASSOCIATION
NOVEMBER 1999
ALWAYS & NEVER

1 INTRODUCTION

1.1 The Green Paper

1.1.1 The Irish Family Planning Association (IFPA) welcomes publication of the Green Paper on Abortion and endorses the efforts of its authors to provide a calm and rational context in which this issue can be discussed.

1.1.2 The IFPA welcomes the call for further submissions, by the All Party Oireachtas Committee on the Constitution, as part of the process of determining how to proceed to resolution. We recognise that the committee will have a challenging task and wish all its members well as they undertake their potentially onerous duties.

1.2 IFPA credentials

1.2.1 The IFPA is a national voluntary organisation and recognised charity which was founded in 1969. The Association's founders desired to change the appalling health and social circumstances in which many families in Ireland lived and, in particular, the health consequences for mothers and their children of repeated pregnancies.

1.2.2 The primary aim of the IFPA's founder members was to alter the social and legal environment in Ireland so that information and services, regarding all methods of family planning, were accessible to everyone. Over the past 30 years the aims and objectives of the Association have broadened and developed. The IFPA remains fundamentally committed to ensuring that all persons have access to the method of contraception which is most suitable to their individual and particular needs. However, this commitment is now part of a broader policy to promote and protect the individual basic human rights of all persons within the context of their reproductive and sexual health, their relationships and their sexuality. In 1969 the IFPA opened its first clinic. Now it has three large medical centres and six additional counselling centres. Initially the IFPA provided contraceptive services, and now it provides a comprehensive range of sexual and reproductive health services, including pregnancy counselling. Through the provision and development of its services and through its advocacy activities, the Association is acutely aware of the myriad difficulties which can affect any person in their reproductive health and, in particular, women faced with crisis pregnancy.

1.2.3 The IFPA has a number of key relationships with the state sector both as a service provider and as an adviser on sexual and reproductive health matters.

1.2.4 The IFPA has a particular focus on the educational, information and service needs of young people and has a large base of younger people among its clients and members. The IFPA conducts research and provides services specifically related to the needs of young people.

1.2.5 The IFPA makes this submission on the basis of more than 30 years of first hand and unrivalled experience in the field of reproductive health and crisis pregnancy in Ireland.

1.2.6 The IFPA is anxious to assist the committee to find a mechanism by which the hitherto intractable issue of elective termination of pregnancy can now be resolved, and is happy to provide such further documentation, information or advice as may be requested by the Committee.

2 SCOPE OF SUBMISSION

2.1 This submission recognises that the Government's Working Group has already considered, at great length, the various conflicting submissions made to it, which set out the moral, political and legal arguments in support of the various alternative viewpoints on this issue. It is not our intention to re-state the submission which the IFPA made to that Group, since the product of that Group's work (the *Green Paper*) should now be the focus of this discussion.

2.2 We respectfully submit that the Committee should not now allow itself to be drawn into any re-working of the Green Paper. We believe that your key task is not to ponder the moral and other issues associated with Irish abortion or to attempt to determine the ultimate outcome of this process; the IFPA submits that it is your primary task to deliver a framework which will enable either the Oireachtas

or the people or both to make a democratic decision capable of resolving the issue. This will require courage, imagination, clarity of thought and a willingness to critically assess the process which brought us to our current position.

2.3 We particularly hope that the Committee will assist the nation to come to terms with the fact that, whatever abortion is, it is not an issue that can easily be dealt with by simply ticking the *YES* or *NO* box on a ballot form, or by the tortuous and tautological construction of new forms of constitutional wording. We hope you will create the conditions in which we can all consider both the realities and the central political or moral choices. We should not allow ourselves to be trapped into discussing competing forms of words in place of the actual issue, as has happened before.

2.4 We are compelled to express our disappointment that the Green Paper has so little to say on measures that could and should be taken immediately to address the underlying issue of unplanned pregnancy. We do this in the strongest of terms. The IFPA regrets to note that once again the government has allowed the blinding light of the abortion 'debate' to distract it from taking concrete measures to minimise unplanned pregnancy in the state. The Committee would do great service by spurring the government to action in this respect, even before beginning an examination of the legislative and constitutional options. In the absence of concerted action we suggest that there will be at least 100,000 Irish abortions by 2010.

2.5 Official UK figures indicate that in the time since the establishment of the Working Group on Abortion there have been at least 11,500 Irish abortions, while since the *X* case there appear to have been at least 39,000 Irish abortions. Both figures may be substantially understated.

2.6 This submission responds to the options set out in Chapter 7 of the Green Paper. Copies of our submission to the Working Group, *Facing Up To Reality*, are being made available with this submission as reference documents.

2.7 Throughout this submission the terms *abortion*, *elective termination of pregnancy* or *elective termination* or *termination* are used to refer to any medical intervention designed to bring about a (non-spontaneous) induced miscarriage, before the foetus achieves capacity for independent life.

2.8 Throughout this submission the term *unborn* is used in the context of its inclusion in Article 40.3.3 of Bunreacht Na hEireann. It should be noted that this is an undefined term which originated in the United States and was inserted into the Irish Constitution in 1983, without elaboration.

3 THE OPTIONS

This section of this submission discusses each of the options (i-vii) set out for consideration in the Green Paper. This discussion seeks to compare and contrast each of the options in terms of their relationship to other options, their relevance to the daily reality of Irish abortion and their effective capacity to contribute to a political resolution of the issues raised.

3.1 *Absolute* ban on abortion Option (i)

3.1.1 Problems of language and logic This is an option most notably advocated by groups involved in initiating the 1983 referendum on abortion and which then strongly advocated support for the text of the Eighth Amendment to the constitution.

Such groups have since found that the meaning of the form of words which they supported is not what they had assumed it to be. The Green Paper indicates very clearly that there are now significant ambiguities in the use of the term '*absolute*', in the context of this option, as advanced by those same groups.

Those advocating such an '*absolute ban*' do so on the basis of sincerely held personal beliefs, which we respect. However such beliefs, even if shared by all members of society (which they are not), do not easily translate into constitutional provisions.

3.1.2 Medical issues A significant part of the problem with defining this option is a refusal by its proponents to acknowledge that any medical intervention which brings a pregnancy to an unnatural and premature end, without the birth of a baby, is in fact an abortion or elective termination.

This refusal is symptomatic of an obsessive preoccupation with the word 'abortion', a word which does not appear in the Constitution or the 1861 Act.

Any 'absolute' ban on abortion would be capable of interfering with established medical practice in relation to a number of critical situations associated with pregnancy. No amount of word play or 'spin' is capable of changing that fact. Medical practitioners do not deal in *absolutes*. ***Always*** and ***Never*** are words outside the scope of normal medical practice.

The Green Paper provides a critical analysis of some of the concepts recently invented as part of an effort to overcome the logical inconsistencies inherent in this option. We refer to concepts such as '*double effect*', '*direct and indirect*' and '*deliberate or intentional*'. These are examples of double talk and the IFPA agrees with the authors of the Green Paper that these concepts are not viable and lack intellectual rigour.

3.1.3 Equal right to life of women The inherent objective of this proposal is to create a right to life for 'the *unborn*' which may supercede that of the pregnant woman and could endanger her life. In other words to turn the clock back on the *X* case judgment which relied on the equal right to life of the woman. There is an unwillingness on the part of those who support this option to openly argue for deletion of the phrase 'with due regard to the equal right to life of the mother' from article 40.3.3 of the constitution. No ban could be '*absolute*' without the removal of that phrase, at the least.

3.1.4 Political assessment The Green Paper makes a clear and compelling case that this is not a real option. An *Absolute Ban* is not the meaning of this option or even the intent of those proposing it. The so-called *absolute ban* amounts to no more than a political slogan. To allow this option to go forward would amount to playing a confidence trick on the electorate, offering those who are unambiguously opposed to abortion something that cannot be achieved. For this reason alone this option should now be ruled out of further consideration.

Any referendum held for the purpose of amending the constitution in accordance with this option would be unlikely to attract the support of a majority of voters. Such a referendum would, in our view, not provide an opportunity for resolution.

If this option were to be supported in a constitutional referendum it would certainly set the stage for further traumas such as that of the *X* case and would not therefore serve to provide a remedy to the ongoing difficulty with this issue.

3.2 Amendment of the constitutional provisions so as to restrict the application of the *X* case Option (ii)

3.2.1 Context This option seeks a referendum to remove the risk of suicide as grounds for abortion in Ireland. In essence this would require a re-run of one part of the 1992 referendum, that being the so-called 'substantive amendment'.

The measure proposed in this option was heavily defeated in 1992. No legislative action has been taken in this matter since.

This scenario, as envisaged in the Green Paper, is identical to that set out by the Government in 1992, when it was stated clearly, that legislation to regulate the provision of abortion would follow that referendum. It could be viewed as somewhat farcical if this option were now to be the outcome of eight or more years of delay. The country would quite literally have come full circle.

It does not appear from the Green Paper that any submission received by the Working Group sought or supported this option.

3.2.2 Political assessment Given the strength of feeling evoked by the *X* case and the appalling circumstances of the subsequent *C* case it is, at best, doubtful that it would prove possible to persuade sufficient voters to remove the risk of suicide as grounds for abortion. Had the 1992 substantive amendment been passed the grounds on which *Miss C* was permitted to travel for abortion would not have been available to the High Court. In such circumstance a future *Miss C* might be compelled to carry to full term a pregnancy resulting from rape, notwithstanding her own desire to end her life rather than go through with the pregnancy. Forcing a woman to endure a situation which renders her liable to commit suicide is a direct interference with her inherent right to life. Such a scenario would not be acceptable to the great majority of the Irish people.

A referendum along these lines has no real prospect of success, and in consequence offers no prospect of resolving the issue. If such a provision were inserted into the constitution it would create the conditions in which future *X* and *C* cases would unfold, returning us to our present unsatisfactory position.

3.3 Retention of *status quo* Option (iii)

This option has the effect of legitimising and perpetuating seven years of inaction. Such a plan can only be justified if the present situation is considered to be sound or desirable.

The consequences of this option would include, in perpetuity:

- continued uncertainty as to the legal position;
- an unknown number of future cases such as the *X* or *C* cases, with appalling personal consequences for all those involved, probably followed by another process such as this;
- ongoing reliance on undefined terms such as 'the *Unborn*';
- continued governmental inertia on programmes to tackle unplanned pregnancy;
- High Court and Supreme Court time taken up, on a rolling basis;
- political system seen to fail as a result of actions of lobby groups;
- at least 100,000 Irish abortions in the next ten years.

3.3.2 Additional future complications The *X* case brought to light certain inadequacies in the *status quo*. However there is no reason to believe that the total extent of the inadequacies of the Eighth Amendment have yet been exposed.

Medical advances, for example, will further test article 40.3.3. Emerging techniques for the treatment of the foetus *in utero* may give rise to conflicts between the wishes of doctors to treat the foetus and the wishes of a pregnant woman who may object to the impact that such treatment might have on her. Developments in *Assisted Human Reproduction* could give rise to the need to reduce the number of pregnancies, where there are large numbers of implanted embryos, and a process known as *foetal reduction* may be necessary if any of the foetuses are to survive pregnancy. This may give rise to conflicts in the *right to life* of the various *unborn*. These issues are fully discussed in the IFPA submission to the Working Group.

We submit that society does not yet fully comprehend the full extent of the dangers and difficulties represented by the *status quo*.

3.3.3 Political assessment This option may be attractive to Government since it entails no action whatsoever and replicates an approach which has been well practised over more than seven years at the time of submission. However, were the Committee to recommend this option it is likely that the whole Green Paper process would be open to the criticism that it was an act of gross political cynicism and irresponsibility. Confidence in Irish political processes and the system of government would be further undermined.

3.4 Retention of constitutional *status quo* with legislative restatement of the prohibition on abortion Option (iv)

3.4.1 Context This option differs from Option (iii) only to the extent that it creates a veneer of political action for, in effect, doing little or nothing at all. This option offers all the disadvantages of Option (iii) (please refer to paragraphs 3.3.1 and 3.3.2 of this submission), but requires legislative effort to achieve the same outcome.

This option differs from Option (v) only to the extent that, while it still envisages leaving matters to be determined on a case by case basis, it also contemplates doing by legalisation what the people refused to do by referendum in 1992, that is, to eliminate suicide from the available grounds for abortion or termination of pregnancy, within the state.

The IFPA submits that this option manifestly fails the test of good governance. This option envisages expending legislative time, to create the impression of political action, while actually achieving nothing. This option would lead to case after case coming before the courts, in the full glare of media attention. In the event of hard cases, such as those that have gone before, this approach adds insult to injury for the unfortunate woman or girl at the centre of the case.

3.4.2 Medical issues – general This option also puts doctors in an invidious and, we submit, intolerable position. The prospect of doctors having to take critical decisions about the well being of their patients, knowing that however well they serve their patients' interests, they could find themselves having to defend themselves against serious criminal charges, is not appropriate to the provision of quality health services in a civilised country. This should not be the basis on which we propose to govern ourselves.

The Green Paper makes the point that legislation to eliminate suicide from the available grounds for abortion or termination of pregnancy would be open to Constitutional challenge. The IFPA offers the Committee its view that it is beyond all reasonable doubt that such a challenge would be mounted.

3.4.3 Medical issues – assessing risk of suicide At paragraph 7.44 the Green Paper sets out a mechanism for '*proving*' a risk of suicide. This describes a process by which a medical practitioner would be required to '*clearly prove such a risk in advance to an appropriate expert committee and authorisation would have to be obtained from the committee*'.

There are existing standards for assessing risk to mental health including risk of suicide, such as that required for the purposes of committal under the Mental Health Act, 1945. The opinion of any two doctors is sufficient for committal for up to 48 hours, with the counter signature of a consultant Psychiatrist being sufficient for committal for a period of up to six months.

It is not easy to see why the test envisaged in the Green Paper should appear to be so much more stringent in the case of a person seeking a termination of pregnancy.

The IFPA would argue that the test as envisaged in Options (iv) and (v) should certainly be no more burdensome than that set out in the Mental Health Act, 1945.

3.4.4 Political assessment It is worth noting that there is no *discussion* associated with this option in the Green Paper.

By seeking to do by legislation what the people refused to do in referendum, this Option has implications for Irish democracy which go far beyond the issue of abortion. It is difficult to see what is to be gained from such a course of action. In our view this option does not progress matters at all, and risks making things worse.

This Option, in form, content and construction appears out of place in the document having regard to the overall construction of the Green Paper.

3.5 Legislation to regulate abortion in circumstances defined in the *X* case Option (v)

3.5.1 Context This option differs only marginally from option (iv). It may be regarded as dealing with unfinished business from the 1992 referendum. This option is required, as a minimum, to deal with the consequences of the *X* case. In the event of a woman qualifying for abortion under the terms of the *X* case, but being unable to travel, the lack of such legislation would lead to serious difficulty.

Legislation such as that set out in this option was promised, by the Reynolds government, in the event of the proposed *substantive* amendment being defeated. **In the absence of any consensus in the committee, as to how to proceed, this option should be regarded as the default position.**

Suggested mechanisms for assessing suicide risk are discussed in paragraph 3.4.3 of this submission and need not be repeated here.

If this option is selected it will be necessary to ensure that there is provision for all children, minors or wards of court to be treated equally in terms of their access to the rights that would be created under this option. Provided this issue is properly addressed in any proposed legislation this option could help to address the specific concerns arising from both the *X* and *C* cases.

3.5.2 Political assessment It is deeply disquieting that legislation, such as that envisaged under this option, did not follow automatically from the defeat of the proposed *substantive* constitutional amendment in 1992, since this failure reflects poorly on our record of good governance. As all major political parties have been in government since 1992 this is not, in any sense, a partisan criticism.

Such legislation is the minimum that should be expected to emerge from this process.

3.6. Reversion to the pre-1983 position Option (vi)

3.6.1 Context The IFPA submitted to the Working Group on Abortion that the issue of abortion is one that

cannot be satisfactorily dealt with by way of Constitutional provisions. The logic of this position is that the IFPA supports the deletion of Article 40.3.3. We would argue that this should be done irrespective of current public policy on abortion.

The Eighth Amendment has had many consequences that were not envisaged by those persuaded to vote for it, and possibly not even by those who proposed it. These consequences have included the various information injunctions, the closure of counselling services, censorship of magazines, the High Court injunction against *Miss X* and her parents, the appalling circumstances of the *C* case and the decision of the Supreme Court in the *X* case.

Experience since the Eighth Amendment provides compelling evidence that the Constitution is not the appropriate vehicle for regulation or resolution of this issue. If there is a desire to maintain ongoing legal limitations of the right to abortion *in Ireland* this can be achieved by way of legislation. If such legislation is found to be faulty or in need of review, there would be no necessity for ongoing referenda to facilitate this.

If public policy demands ongoing legislative prohibition of abortion this can be done without the need for the Eighth Amendment. If public policy seeks a more realistic and enlightened approach, either now or later, this can be dealt with by the Oireachtas without the unwieldy process of constitutional referenda.

3.6.2 Constitutional '*protection*' for the '*unborn*' Any proposal to delete the Eighth Amendment is likely to be characterised, by some groups, as *removing constitutional protection for the unborn*. We submit that such alleged constitutional protection is illusory. In practical terms the 1983 amendment has not in fact *protected the unborn*. Since 1983 we know that at least 85,000 Irish women, and probably considerably more than this number, have had elective terminations of pregnancy/abortions.

In assessing the *pros* and *cons* of the Eighth Amendment any claim of *constitutional protection of the unborn* arising from its existence should be discounted.

We do know, however, that the Eighth Amendment has contributed to inequality in society. Although its provisions never really affected those with the 'insulation of the cheque book', others of more modest means have been put to financial hardship, and often debt, as a result of the cost of travelling abroad for abortion. Among those who have paid the greatest price for the Eighth Amendment are those whose need to avail of abortion has forced them before the courts and exposed their lives to media scrutiny. They have both been among the most vulnerable members of society, two young girls pregnant as a result of rape.

We also know that Irish women are having their abortions at a later gestational stage than their British counterparts, a factor which increases the potential for medical complications. Details are given in the IFPA's Working Group Submission at page 19.

Abortion has been practised since the earliest of times. No criminal sanction or constitutional provision has ever or will ever stop women seeking abortions. In many countries criminal sanctions result in unsafe abortions which cause the deaths of about 70,000[1] women every year world wide, and a much larger number suffer from infections, injury and trauma. Victims of unsafe illegal abortions fill hospital wards in such countries. In other countries criminal sanctions result in women going abroad, as in Ireland, or 'State-hopping' as happens in the United States of America.

3.6.3 Political assessment If the Committee were to suggest that the 1983 amendment was a mistake and the Constitution was, with the benefit of hindsight, the wrong place to deal with an issue such as abortion, it is likely that the vast majority of people, irrespective of their sincerely held moral perspective on abortion, would agree.

We submit that it is not now enough simply to sweep away the Eighth Amendment. In our view there would be a significant body of opinion that would expect such a move to be twinned with active measures, to include:

- priority programmes to minimise unplanned pregnancy;
- provisions to deal with the needs of women in need of abortion for medical reasons, but unable to travel;
- provisions to ensure that the needs of minors in the same situation as *Miss X* or *Miss C*, can be dealt with outside the courts and away from the glare of media publicity;
- provision to deal with other hard cases.

In our view repeal of the Eighth Amendment should be undertaken in tandem with repeal of the relevant provisions of the Offences Against the Person Act, 1861 and the creation of legal protection for Irish Doctors who deem it appropriate to provide abortions within the state, on the basis of their medical judgement. This approach should certainly form part of any electoral consultation.

3.7 Permitting abortion on grounds beyond those specified in the *X* case Option (vii)

3.7.1 Context The *X* and *C* cases demonstrate that abortion is not a black and white issue.

Public reaction to these cases demonstrated that many people who may have personal anti-abortion instincts and would not themselves contemplate abortion, recognise that there are situations in which exceptions should be made and that at such times only the person directly affected is in a position to judge what should be done. This section of the Green Paper usefully sets out a tiered approach to legalisation of abortion, which reflects the diversity of opinion on the issue.

3.7.2 Political assessment An *absolute* ban on abortion *without exception* is likely to command the support

1 'The Right to Choose: Reproductive Rights and Reproductive Health', UNFPA (United Nations Population Fund), New York, January 1998. ISBN 0-89714-451-1 (See Appendix F, *Facing up to Reality*, p.22).

of a small proportion of the population. Similarly the lifting of all legal restrictions on access to abortion, though the preferred course of the IFPA, may not presently command majority support. It is our view that a consensus position lies somewhere in between these two positions.

It is our view that there is support for exceptions which go beyond the terms of the *X* case, and that given the opportunity to fully express their preferences on the matter in an exhaustive ballot, the consensus position would lie somewhere in the various tiered options set out very clearly in paragraphs 7.65 - 7.91 of the Green Paper.

The Green Paper invites us all to play the role of *King Solomon* by considering where the line should be drawn. That is to individually consider which set of tragic circumstances would qualify a woman to choose for herself whether or not to continue with a pregnancy and which other tragic sets of circumstances are such that society should make that choice for her, in advance. This section of the Green Paper clearly demonstrates the problems that arise from attempting to regulate such things.

Public Opinion polls are of only limited value, but an *Irish Times*/MRBI poll published in *The Irish Times* on December 11th 1997 asked questions similar to those posed in this option. The results showed that 77% felt that abortion should be permitted where the '*Mothers Life is at risk*'; 42% where '*Mother's health is at risk* '; and 28% '*For whoever needs it* '. In this poll only 18% said abortion should be permitted '*Not at all*' and 5% had no opinion. This was a more sophisticated poll than those associated with constitutional referenda in that it allowed respondents to fully express their preferences.

3.7.3 IFPA approach Our conclusion is that it is unreasonable for society, in cases of problematic pregnancy, to take the role of arbiter unto itself. We argue that it is not appropriate for society to draw such arbitrary lines, on behalf of the individual citizen, in relation to this issue. Since an absolute ban is neither desirable or feasible, for all the reasons set out in the Green Paper, we believe that the only practicable approach is to allow women to make such decisions for themselves, in consultation with their chosen medical and other advisers.

It would be our belief and hope that, given the opportunity to consider the realities set out under this option in the Green Paper, as opposed to unrealistic absolutist and notional '*quick fix*' constitutional proposals typified by the Eighth Amendment, the great majority of Irish people would agree with our proposed approach to this issue.

4 RECOMMENDATIONS

The IFPA's Recommendations to the All Party Oireachtas Committee on the Constitution are in three parts.

- **Primary recommendations** set out the actions which the IFPA would like to see emerge from the process as ultimate outcomes. These are the measures which we feel offer the best solution to the needs of Irish women and Irish society in general.
- **Secondary recommendations** relate to a situation in which the actions contained in our Primary Recommendations are not ultimately implemented.
- **Process recommendations** relate to ways in which the Committee may seek to achieve a national consensus on this issue.

4.1 Primary recommendations

Having regard to the matters set out above, the IFPA submits that:

4.1.1 The committee should strike out Option (i) (*Absolute Ban* on Abortion) for the reasons set out in the Green Paper and in this submission.

4.1.2 The Committee should recommend that Article 40.3.3 of the Irish Constitution be repealed in its entirety and the Constitution should be amended to provide that any right to life in the Constitution refers only to persons who are born.

4.1.3 The Committee should recommend that Articles 58 and 59 of the 1861 *Offences Against the Person Act* should be repealed.

4.1.4 Legislation should be introduced to permit minors to have access to the courts so as to ensure that they are equal to other women in regard to their ability to avail of medical treatment, including termination of pregnancy.

4.1.5 Increased resources should be made available to health boards, schools and family planning service providers, including the IFPA, to make available increased education, information and contraceptive services to the general population. These measures should include:

- the introduction of a universal free entitlement to sexual and reproductive health care for all;
- enabling access to this new entitlement via any service provider capable of demonstrating possession of a family planning certificate, high quality premises and high quality standards of service;
- the promotion of increased take-up through choice of service by enabling users to choose where to 'spend' their free entitlement;
- the rigorous enforcement of statutory quality standards for condoms (eg. EN 600) and outlawing the sale of so-called 'novelty condoms' or 'fundoms' which have no prophylactic value;
- the provision of funding to enable the IFPA to provide a national contraceptive education and information programme on a planned and well-resourced basis.[2]

4.1.6 Implementation in full of the IFPA's '*TEN POINT PLAN To Reduce Unplanned Pregnancy*', submitted

2 *Improving Reproductive Healthcare in Ireland*, IFPA 1993, A Submission to the National Health Strategy. Chapter 6 – Promoting Reproductive Health.

to the Department of Health in 1993. [Appendix (i): *Improving Reproductive Healthcare in Ireland*, IFPA 1993] see Appendix A, *Facing up to Reality*, p.20.

4.1.7 That increased resources be made available to health boards and to agencies such as the IFPA to fund the development and operation of specialist free sexual health services for young people, in each urban population centre, along the lines recommended in *A Young Peoples Health Centre for Dublin* IFPA/EHB, April 1997.

4.1.8 That the relevant government departments should establish a quantified target reduction in the relatively high proportion of Irish abortions carried out later than the twelfth week of gestation, as an immediate practical measure, supported by appropriate programmes and resources.

4.1.9 That the Regulation of Information (Termination of Pregnancies Outside the State) Act, 1995 should be extended so as to regulate the activities of agencies that do not give *Act Information*, and those not funded by the state.

4.2 Secondary recommendations

Having regard to other proposals which have been or may be made to the Committee we further submit that:

4.2.1 The committee should recommend to the government that it should not attempt to amend Article 40.3.3 of the Irish Constitution. The IFPA contends that there is no form of words which can satisfactorily amend this Article. The Green Paper draws attention to the considerable difficulties which exist in this regard. We further submit that there is no form of words which could be presumed likely to command the support of a greater number of the electorate in a conventional constitutional referendum.

The IFPA submits that Article 40.3.3 is fundamentally and inherently flawed, not least because history has demonstrated that the issue of abortion is too complex to be adequately dealt with by way of constitutional provisions. Time spent attempting to amend this article would be time wasted and would not contribute to a resolution of the debate.

4.2.2 In the event that the Committee does not agree to propose, or the people of Ireland do not agree, to delete Article 40.3.3 of the Constitution, the government should address the issue of abortion through legislation. In such circumstances we recommend that:

(a) The legislature defines an 'unborn' as a foetus which has reached that stage of pregnancy at which, if born, it would be capable of independent life.

(b) The legislature amends Articles 58 and 59 of the 1861 Offences Against the Person Act so as to provide that it would be unlawful to induce the termination of a pregnancy of more than 22 weeks gestation, other than for the purposes of premature delivery, unless necessitated in order to save the life of the pregnant woman, or where there is a congenital abnormality of the foetus rendering it incompatible with life.

It would be necessary, in the interests of women's health, to provide that it would be unlawful for any person other than a person appropriately qualified and trained, and registered under the Medical Practitioners Act, 1978 to induce a termination of pregnancy.

4.2.3 Legislation should be introduced to permit minors to have access to the courts so as to ensure that they are equal to other women in regard to their ability to avail of medical treatment, including termination of pregnancy.

4.3 Process recommendations

4.3.1 'Preferendum Vs neverendum' In the event of any option being selected which requires a referendum, the IFPA strongly recommends that the electorate be given the opportunity to express their full preferences in respect of the various options set out in the Green paper ranging from Option (iii) to Option (vii) (e), **excluding Option (iv)**.

This expression of views should take the form of a *Preferendum* in which each voter would be able to express their preferences for each of the choices on a similar basis to the conduct of a Presidential election or single seat by-election, with all votes being exhaustively re-distributed, at full value, following the elimination of the least popular choice at each stage of the count.

Variants (a) to (e) under Option (vii) should be grouped in layers, using the example of the opinion poll referred to at 3.7.2., to facilitate full democratic expression. For example a person voting for option (e) would clearly also be in support of option (d), (c), (b) and (a) as well as Option (v).

4.3.2 Political assessment This would be an innovative method for establishing true national consensus on this issue. It would have the advantage of enabling and requiring electors to consider the detail of the issue and look beyond simple *black* and *white* or yes or no, scenarios.

The *Preferendum* concept is consistent with the proportional principle of our electoral system, inherently democratic and it probably offers the only way to move things forward constructively, in the context of referendum politics. In contrast, a further simplistic conventional referendum could be characterised as just another in a series of '*Neverendums*', the fifth in less than twenty years on this issue.

A further advantage of this approach is that it would give clear guidance to legislators.

It would probably be essential, prior to the holding of such a *Preferendum*, that the current post *McKenna Judgement* approach to referenda be revised to facilitate funding and 'airtime' for advocates with genuine interest in the issue, as opposed to the *neutral* Referendum Commission.

The IFPA is available to provide further detail or assistance with the *Preferendum* concept, in this context, on request.

LAWYERS FOR CHOICE
C/O IVANA BACIK, BL, LAW LIBRARY, FOUR COURTS
SUBMISSION TO ALL-PARTY OIREACHTAS COMMITTEE ON THE CONSTITUTION

INTRODUCTION

Lawyers for Choice is a recently-established group of independent lawyers who have united around a shared concern about the need to bring abortion law in Ireland into line with the reality of women's lives. We believe, for a variety of reasons, both legal and social, that abortion should be available on request in Ireland. In the chapters which follow, we outline why we have come to this considered view.

1 THE LAW ON ABORTION

The constitutional position

The *X* case The main judicial interpretation of the permissibility of abortion under Irish law is to be found in the decision of the Supreme Court in the *X* case. However, the net effect of this decision is far from clear, particularly as the five judgments given vary in their interpretation as to when abortion is permissible.

Having regard to the need to look at the pregnant woman's rights in the context of her life situation, Finlay CJ held that Article 40.3.3 could not be interpreted as permitting abortion only in cases of inevitable or immediate risk to the life of the pregnant woman. Rather, the proper interpretation was that:

> if it can be 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.

Finlay CJ held that the risk to the first defendant's life – the risk that she would commit suicide – had to be taken into account by the Court when reconciling her right to life with that of the unborn, 'as would be appropriate in any other form of risk' to her life. Finlay CJ was of the view that this risk could not be monitored in the same way as a risk to her life arising out of physical causes, in that it was not possible to monitor her condition in order to postpone termination of pregnancy. Accordingly, he was of the view that Ms *X* had established the test set out above.

Finlay CJ did not actually state that abortion would be permissible only if the test set out in his judgment was satisfied. However, his statement that his test is the 'proper' interpretation of the Eighth Amendment appears to indicate that he would not contemplate lawful abortion in any other circumstance. Finlay CJ did not state how a possible risk to life could be distinguished from a risk to health, but how this distinction is to be applied is a very important issue in practice.

Egan J's test is perhaps the most similar to that of the Chief Justice. He rejected the concept of a static hierarchy of rights, stating that conflicts between rights must be resolved by having regard to the particular circumstances of the case before the court. Egan J held that the Eighth Amendment envisaged lawful abortion. Furthermore, he held that to require certainty that continuance of pregnancy would result in the death of the pregnant woman would constitute a denial of her right to life. In his view the 'true' interpretation of the Constitution was that:

> a pregnancy may be terminated if its continuance as a matter of probability involves a real and substantial risk to the life of the mother.

Egan J did not use quite the same formulation as Finlay CJ. However, he also seemed to rule out the possibility that health grounds, in the absence of any threat to life, could give rise to a right to an abortion by stating that '[t]he risk must be to her life'. Egan J was of the view that the risk of suicide should be regarded as a risk to life and that the first defendant came within his test. Egan J's use of the term 'true' appears to indicate that in his view abortion is constitutionally permissible only in the circumstances that he outlined. Conversely, however, he appears to be of the view that the decision in Bourne (see below) was a correct interpretation of s. 58 of the Offences Against the Person Act, although, the scope of the criminal prohibition and that of the constitutional prohibition are not necessarily identical.

O'Flaherty J sketched out the history of the Eighth Amendment, which he did not believe had brought about any fundamental change in Irish law. He went on to interpret the amendment having regard to the provisions of the Constitution as a whole. O'Flaherty J held that the Constitution has as its core a commitment to freedom and justice. He held that:

> Until legislation is enacted to provide otherwise, ... 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.

He further held that the danger had to represent a substantial risk to the life of the pregnant woman, although risk of imminent or immediate death was not required. O'Flaherty J also held that Ms *X* was entitled to an abortion under this test. O'Flaherty J's formulation is interesting in that it seems to envisage the possibility of the Oireachtas enacting legislation prohibiting termination of pregnancy in the circumstances he outlined, without interfering unduly with the right to life of the pregnant woman. On the other hand, he did not specifically rule out the possibility of legislation providing for abortion in a broader range of circumstances: '[a]bortion, as such, certainly abortion on demand, is not something that can be legalised in this jurisdiction'. In this, his judgment seems to give more discretion to the Oireachtas in drawing up legislation on abortion than do the judgments of Finlay CJ or Egan J.

McCarthy J gave what was perhaps the most 'liberal' judgment on when abortion is constitutionally permissible. He did not rule out the suggestion that there was a hierarchy of rights and went on to say that the right to life 'would appear to rank at the top of the scale'. He held that the life of Ms *X* was a 'life in being' while that of the unborn was a 'life contingent', i.e. contingent upon survival in the womb until successful delivery. In this he appears to differ from Finlay CJ who said that it would not be correct to refer to the life of a viable foetus as contingent upon that of the pregnant woman.

McCarthy J went on to hold that in classifying the right to life of the woman and of the unborn in this way he

was not setting the right of the former above the right of the latter, but rather was vindicating as far as practicable the right to life of the woman, whilst with due regard to her equal right to life, 'vindicating, as far as practicable, the right to life of the unborn (Article 40, s. 3, sub-section 3)'. This statement is somewhat confusing: McCarthy J could be interpreted as indicating that the sole constitutional protection of the right to life of the unborn is located in Article 40.3.3. However, this interpretation seems to be contrary to his earlier dictum in Norris. McCarthy J went on to indicate that the amendment 'envisage[d]' lawful abortion. He further held that the purpose of the Eighth Amendment was to preclude the legislature from 'an unqualified repeal of s. 58 of the Act of 1861 or otherwise, in general, legalising abortion'. He held, however, that the right to life of the unborn as enshrined in the amendment was qualified. He held that one could not balance the right to life of the unborn against the right to life of the pregnant woman, because if one did the right of the former would always prevail. He went on to state that in practice certain death of the foetus will arise from termination of pregnancy, whereas it is never certain, however highly probable, that continuation of pregnancy will lead to the death of the pregnant woman.

McCarthy J's test sets up a false proposition as the probability of the death of the pregnant woman implies – at least pre-viability – the probability of foetal death. It could be argued that the need to prevent the probable ending of two constitutionally protected lives outweighs the need to prevent the certain ending of one such life. This would provide a more principled justification for the decision than is provided in McCarthy J's judgment. The same false premise can be discerned in the other judgments in the case.

These judgments fail to consider the possibility that refusal to permit termination of Ms X's pregnancy could have led to the death of both herself and the foetus, had she gone on to commit suicide. The fact that McCarthy J refers to the other constitutional rights of the woman (as laid down in Articles 40 and 41) could be read as indicating that, in his view, the Constitution, interpreted as a whole, gives a different, if not higher, status to born life than to the unborn. In this regard, it may be significant that the Eighth Amendment did not equate the status of the unborn generally with that of 'persons' or 'citizens'. This lack of equation arguably allows for an interpretation of other constitutionally guaranteed rights, such as the right to bodily integrity or the rights of the family, which would exclude the unborn from their ambit. If such an argument were to be accepted, the rights of the pregnant woman, looked at as a whole, might be said to outweigh the right to life of the unborn.

McCarthy J held that abortion is constitutionally permissible where there is a real and substantial risk attached to the 'survival' of the pregnant woman 'not merely at the time of application but in contemplation at least throughout the pregnancy'. Arguably, this requirement has implications where the threat to the life of the pregnant woman is suicide. If a woman was to suffer a brief period of suicidal feelings this might not suffice to render termination of her pregnancy lawful under McCarthy J's test, if the risk to her life could be 'contained', whereas ongoing suicidal feelings, identified as such by qualified personnel, could provide a ground for termination. While McCarthy J's formulation did not specifically distinguish life from health in the way the Chief Justice's statement did, the use of the term 'survival' indicates that he had a 'life or death' in mind. However, later in his judgment, McCarthy J indicated that although the Oireachtas is precluded from generally legalising abortion it may have a degree of discretion: he adverts to the position of rape victims, under-age pregnancies and pregnancies arising as a result of incest.

The following statement could be read as envisaging the possibility of legal abortion on the above grounds or even in the absence of specific grounds but subject to a time limit:

> Legislation may be both positive and negative: negative, in prohibiting absolutely or at a given time, or without meeting stringent tests ...

McCarthy J seems to have been of the view that such legislation could be constitutionally permissible as he goes on to list certain positive measures which the Oireachtas might take, such as providing agencies to help pregnant women, which appear to be constitutional. While it would be possible to argue that the Constitution permits abortion on a number of specific grounds: e.g. if necessary to protect the right to health or bodily integrity of the pregnant woman, it is difficult to see how it could be interpreted so as to permit the legalisation of abortion within a particular period of pregnancy, unless it is argued that the term 'unborn' does not cover the foetus from the moment of conception. In any event, McCarthy J held that Ms *X* fell within his formulation and was entitled to have her pregnancy terminated.

Hederman J, dissenting, held that the right to life is 'the essential value' of every legal order and 'central' to the enjoyment of all other rights. This may indicate a belief that there is a hierarchy of rights, with life at its apex. He also held that each provision of the Constitution has to be interpreted in light of the ordinary meaning of its words with due regard to the other provisions thereof. He held that Article 40.3, as originally enacted, and the Eighth Amendment both had as their most significant objective the protection of human life. He held that the Eighth Amendment had established 'beyond any dispute' that the right to life protected by the Constitution did not depend on birth. Hederman J further held that the state is obliged in principle to outlaw abortion. However, he recognised that the death of a foetus could take place as an 'indirect' but foreseeable consequence of an operation undertaken for other purposes without infringing the law. He held that:

> it is difficult to see how any operation, the sole purpose of which is to save the life of the mother, could be regarded as a direct killing of the foetus, if the unavoidable and inevitable consequences of the efforts to save the mother's life leads to the death of the foetus.

Hederman J held that abortion is permissible only:

> where there is evidence of such a weight and cogency as to leave open no other conclusion but that the consequences of the pregnancy will, to an extremely high degree of probability cost the mother her life and that any such opinion must be based on the most competent medical opinion available.

In formulating this test Hederman J formulated a test which was stricter than that argued for by Ms X's counsel.

Arguably however, it was not so strict as that initially put forward by the AG: namely, an imminent and all but inevitable risk that the life of the pregnant woman would be ended if she had to continue her pregnancy. Hederman J held that the evidence put forward in the instant case did not meet this high standard. He held that the certain risk to the life of the unborn if an abortion were carried out had to outweigh the less certain risk to the life of the first defendant, which risk he held could be reduced by care and supervision.

Legal developments since the *X* case Following the decision in the *X* case, its implications have been considered by both the legislature and the judiciary. Shortly after the case was decided, the Oireachtas passed three bills to amend the Constitution. The aim of the first Bill was to reverse the Supreme Court's decision that abortion was constitutionally permissible where a threat to the life of a pregnant woman was a risk of suicide, while enshrining the remainder of Finlay CJ's (arguably non-exhaustive) definition of a lawful abortion as the sole ground on which an abortion could lawfully be performed. The second Bill dealt with the question of freedom to travel abroad and the third dealt with the issue of information on services lawfully available in other states.

The first Bill proposed to amend the Constitution for the twelfth time by appending the following provision to Article 40.3.3:

> It shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life, not being a risk of self-destruction.

The Twelfth Amendment was opposed by a number of pro-choice groups who wished, at a minimum, to maintain the lawfulness of abortion in circumstances such as those in the *X* case. It was also opposed by a number of anti-abortion groups who, while seeking to overturn the decision in *X*, did not think that the proposed wording went far enough, in that it still allowed for abortion in limited circumstances. They also wished to avoid the insertion of a statement in the Constitution which specifically recognised the lawfulness of abortion in any circumstances. The Pro-Life Campaign argued that termination of unborn life should only be permissible where it was 'an unsought side-effect of medical treatment necessary to save the life of the mother'. The amendment was rejected by the People on 25 November 1992.

The *X* case has been most recently considered by the Supreme Court in the Information Bill case. The Bill, as passed by both Houses of the Oireachtas, was referred to the Supreme Court by the President for a decision as to its conformity with the Constitution. The case was argued before the Court by the Attorney General, who argued in favour of the constitutionality of the Bill, and by two sets of counsel, one representing the interests of the pregnant woman and the other representing the interests of the unborn, both of whom argued against it, albeit for different reasons. Judgment for the Court was given by Hamilton CJ. This judgment provides a useful guide as to how the courts may interpret the provisions of Article 40.3.3 should they be called upon to decide on the lawfulness of a particular abortion in the future. In Article 26 cases the Supreme Court is obliged to deliver a single judgment. Obviously, a majority decision is required, but individual judges may disagree with particular aspects of the judgment, or indeed the whole judgment. Therefore, if the ratio of such can be regarded as being limited to the simple finding that a Bill is constitutional, the judges may not necessarily follow the reasoning set out in the judgment in full in future cases, provided that by so doing they do not purport to declare unconstitutional any provision of the Act. This means that the remarks of Hamilton CJ in the Information Bill case may not represent the Supreme Court's last word on the issue of the lawfulness of abortion under the Constitution.

In the Information Bill case, the Court endorsed the method of constitutional interpretation laid down by Finlay CJ in *X*, with its express distinction between 'life' and 'health' and its acceptance that a risk of suicide could be regarded as a risk to life. The Court added a gloss to Finlay CJ's test, by implying that abortion would not be constitutional in any other circumstance:

> It would appear … however that irrespective of the mother's constitutional right to travel, [here the Court is referring to the woman's right to travel prior to the coming into force of the Thirteenth Amendment] the exercise of that right would have to be subordinated to the constitutional right to life of the unborn in circumstances where the pregnancy constituted no threat to the life of the mother.

Presumably, if a pregnant woman is not (but for the enactment of the Thirteenth Amendment) entitled to travel outside the jurisdiction to obtain an abortion, it would not be lawful for her to terminate her pregnancy within the state.

The Court further endorsed the decision in *X* by rejecting arguments put forward by counsel for the unborn that it had been wrongly decided. In the instant case, the Court held that the Constitution was not subordinate to natural law. This meant that the fact that arguments based on natural law had not been put before the Court in *X* did not invalidate its decision in that case. However, it could be argued that the natural law, even if not superior to the Constitution, could influence its interpretation. The Court also held that counsel for the Attorney General was correct to accept that the Eighth Amendment envisaged lawful abortion. It further held that the lack of medical evidence before the Court did not invalidate its decision. Hamilton CJ, relying on the pre-Article 40.3.3 case law discussed above, also held that even prior to the Eighth Amendment the right to life of the unborn was constitutionally protected as an unenumerated personal right under Article 40.3.1.

The High Court has also considered the issue of abortion in the *C* case, basically upholding the judgment of Finlay CJ in the *X* case. The constitutional law on abortion thus remains as set out in *X*, with the addition of the Supreme Court's interpretation in the subsequent Information Bill case and the High Court's interpretation in the *C* case. The judgments do not, set out clear rules which would enable medical personnel to decide whether or not a particular abortion would be constitutionally permissible, or even constitutionally required. As is outlined below, the criminal law in this area is also not wholly clear.

The criminal law

The historical position At common law, abortion was not treated as a species of homicide: the law of homicide only applied where the victim was born and achieved an existence independent of the mother. Abortion was a misdemeanour, but only if carried out after the foetus had 'quickened' in the womb. Quickening was thought to occur when the foetus's movements within the womb became apparent to the pregnant woman, i.e. midway through pregnancy. Following Lord Ellenborough's Act in 1803, abortion of a quickened foetus became a felony. In 1837 the Offences Against the Person Act abolished the distinction between quickened and non-quickened foetuses and thenceforward abortion became a felony irrespective of the stage of pregnancy at which it was carried out. The present criminal prohibition on abortion is contained in s 58 of the Offences Against the Person Act 1861 which states:

> Every woman being with child who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether or not she be with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and on being convicted thereof shall be liable to be kept in penal servitude for life.

Similar developments occurred at roughly the same time in other common law countries. In the context of the United States in particular there has been considerable debate as to whether legislation criminalising abortion was aimed primarily at the community's interest in the protection of pregnant women, or whether it was enacted in order to protect the unborn as well as, or instead of, the pregnant woman.

S 59 of the Act created a substantive offence of 'unlawfully' supplying or procuring 'any poison or other noxious thing, or any instrument or thing whatsoever' knowing that it is intended to be used for the purpose of procuring an abortion, whether or not the woman in question is pregnant or not. These provisions were confirmed by s 10 of the Health (Family Planning) Act 1979.

Exceptions to section 58 of the Offences Against The Person Act When looking at the criminal law on abortion, it must be considered whether the artificial induction or termination of pregnancy where the foetus has not yet reached viability must, in all circumstances, be regarded as an offence under s 58. In essence, there are two schools of thought on this matter, both of which answer this question in the negative. The first school of thought, which appears to dominate the case-law and academic commentary in the jurisdictions discussed below, argues that the defence of necessity applies to s 58. The second school does not concentrate on the necessity defence, but rather on the word 'unlawful' contained in s 58.

There is a third school of thought, exemplified by McCarthy J in *X*, which does not admit of any exceptions to the prohibition contained in s 58. This school of thought has not been accepted in any of the other jurisdictions discussed below, nor has it been raised in the context of an Irish criminal case or accepted by any of the other judges in *X*. If this interpretation of s 58 of the 1861 Act were to prevail, the provision would have to be struck down as unconstitutional, as the section would purport to criminalise conduct even where it was necessary to save the constitutional right to life of the pregnant woman as set out in the *X* case.

The first school of thought considers whether the legality of abortion in certain exceptional circumstances can be regarded as coming within the general defence of necessity. The second considers whether any exceptions may be specifically based upon the word 'unlawfully' contained in s 58. This distinction is not purely academic in the Irish context. The scope of a defence based on medical necessity may depend on the state of medical knowledge existing at a given point in time (especially if an objective test of culpability is used).

On the other hand, the scope of a defence based solely on the use of the word 'unlawfully' may, arguably, be dependent on, inter alia, societal views on abortion, the relative values of foetal and maternal life as expressed in the Constitution, by Parliament or otherwise.

Obviously, medical knowledge and social mores may be inter-related to an extent, but neither is based wholly on the other. It cannot be said that either school of thought would necessarily be more extensive than the other, although it may be argued that social mores are more flexible and over time more variable than the state of medical knowledge.

When considering the scope of s 58, it is first necessary to look at the case-law dealing with s 58 and its equivalent in other jurisdictions. The most notable interpretation of s 58 is perhaps that contained in the English case *R v. Bourne*. In this case, Macnaghten J directed the jury that abortion was in general a criminal offence. However, he held that in the case of abortion, as in the case of homicide, 'there may be justification for the act'. He drew the jury's attention to the word 'unlawfully', which, in his opinion, 'is not, in that section, a meaningless word'. He held that that word must be read as importing into s 58 'the meaning expressed by the proviso in s. 1, sub-s. 1, of the Infant Life (Preservation) Act, 1929'. S 1(1) of the 1929 Act provides that:

> any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother shall be guilty of felony, to wit, child destruction … Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.

Macnaghten J then went on to define further what was meant by preservation of the life of the pregnant woman. He indicated that he did not think that a clear distinction between the life and the health of the pregnant woman could be made: 'since life depends upon health, and it may be that health is so gravely impaired that death results'. He held that a 'reasonable', as opposed to a 'wide and liberal' meaning had to be given to the phrase 'preserving the life of the mother'. He referred to the fact that the prosecution had not contended that a doctor had to wait until the pregnant woman is 'in peril of immediate death'

before performing an abortion. Macnaghten J held doctors had the right, and the duty, to perform an abortion 'where it is reasonably certain that a pregnant woman will not be able to deliver the child which is in her womb and survive'. Macnaghten J emphasised that he was taking a 'reasonable' view of the law. He was of the view that the law did not regard the pregnant woman's desire or request for an abortion as sufficient justification for performing a termination, but neither did it provide that abortion could not be performed in any circumstances.

Macnaghten J set out his classic test on the permissibility of abortion in the following passage:

> if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the pregnancy will be to make the woman a physical or mental wreck, the jury are entitled to take the view that the doctor who, under those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother.

Bourne was acquitted by the jury.

The Bourne direction did not rely on any relevant previous case-law (although such case-law did exist) and is confused in places by references to the 1929 Act. However, Macnaghten J did not hold that s 58 had in some way been amended by the 1929 Act: he was of the opinion that the latter statute simply expressed, in relation to child destruction, what was already implicit in relation to abortion:

> These words express what, in my view has always been the law with regard to the procuring of an abortion, and, although they are not expressed in sect. 58 of the Act of 1861, they are implied by the word 'unlawful' [sic] in that section.

Bourne has been followed in subsequent English cases. However, it has been suggested that s 58 was interpreted in a broader sense in these cases. Two cases in particular, *R v. Bergmann and Ferguson* and *R v. Newton and Stungo*, indicate that the possible implication in Bourne that the health of the woman, when taken separately from a threat to her life, might not be sufficient to warrant an abortion, did not reflect a fixed interpretation of English law. Whatever the true interpretation of Bourne may be, the subsequent case-law seems to indicate that where serious injury to health is feared, the court will not look too narrowly into the question of danger to life. In *Newton and Stungo*, Ashworth J held that abortion was not unlawful where it is done 'in good faith for the purpose of preserving the life or health of the woman'. He went on to say that 'health' includes both physical and mental health. In that case, the woman seeking the abortion was reportedly in a suicidal frame of mind.

The post-Bourne cases seem to indicate that doctors will have a defence if their belief as to the state of the pregnant woman's life and/or health is honest: the requirement of reasonableness which is mentioned in Bourne is absent from both cases. Even prior to Bourne, other jurisdictions, including Canada and Massachusetts, had interpreted legislative provisions similar to s 58 as allowing for exceptions to the prohibition on abortion where the life of the pregnant woman was at risk. In fact, earlier English case law which indicated that s 58 did not prohibit all abortions also existed, although it is not referred to by Macnaghten J. Indeed, it has been contended that Bourne in fact gave a narrower interpretation of the circumstances in which abortion could be regarded as lawful than previous cases, medical practice and legal and medical academic commentary indicated.

He finds further support for this view in Bergmann and Newton. Despite the fact that it is not immune from criticism, the Bourne judgment has been relied upon in courts of first instance and appeal in many other jurisdictions, including Northern Ireland, Australia, Canada, British West Africa, New Zealand, Fiji, British East Africa and the US to interpret similar or identical provisions.

International human rights law

The argument for a general right to abortion based on international human rights law is debatable. However, in extreme circumstances, for example, where a threat to the life of the pregnant woman exists, there is a strong case for saying that a right to abortion exists under conventions such as the International Covenant on Civil and Political Rights or the European Convention on Human Rights, on the basis that the right to life of the pregnant woman must be protected. If very harsh measures are taken against women who seek abortions, it may possibly be argued that their rights, for example, the right to freedom from inhuman or degrading treatment protected by both the ICCPR and the ECHR, have been infringed.

The right to health of women, is also protected by the International Covenant on Civil and Politcal Rights and the Convention on the Elimination of Discrimination Against Women. Where international human rights law and specifically the European Convention on Human Rights is of particular relevance however, is in its requirement that the law be clear (see below).

The European Convention on Human Rights The law relating to abortion in Ireland is vague and uncertain. The Constitution does not lay down any clear criteria as to when pregnant women are entitled to have their pregnancies terminated. This lack of clarity is not made up for in legislation: there is no legislation setting out guidelines as to how the rights of the pregnant woman and of the unborn may be assessed and balanced. The judgments of the Supreme Court in the *X* case are not wholly consistent, although this inconsistency has, to an extent, been lessened by the judgment in the Information Bill case. The ambit of the criminal prohibition of abortion is not wholly clear either.

This lack of clarity in the law means that Ireland is most likely in breach of its international obligations, inter alia under the European Convention on Human Rights. Article 8 of the Convention guarantees a right to respect for private life. It provides:

> 1 Everyone has the right to respect for his private life and family life, his home and his correspondence.
>
> 2 There shall be no interference by a public authority with this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of crime and disorder, for the protection of morals, or for the protection of the rights and freedoms of others.

While not all interferences with a woman's decision-making powers relating to the continuation or termination of her pregnancy necessarily fall within the scope of the right set out in paragraph 1 above and the substantive restrictions placed on that right may be justified having regard to the exceptions set out in paragraph 2, it may be questioned whether any interference with the pregnant woman's right to respect for her private and family life that occur under the Irish legal system is 'in accordance with law' for the purposes of the Convention.

The European Court of Human Rights has interpreted the requirement that any interference with this and other rights similarly protected be in accordance with the law in a number of cases. It is not sufficient that a particular interference with a Convention right is permitted or required under domestic law: the domestic law must be sufficiently clear and foreseeable to allow an individual (with legal advice as appropriate) to ascertain whether his or her conduct or proposed conduct is in accordance therewith.

It has been argued by Professor Simon Lee in the context of Northern Ireland that the criminal law prohibition on abortion set out in s. 58 of the Offences Against the Person Act is so unclear that it lacks the quality of 'law' within the meaning of the Convention. This is despite the fact that the law in Northern Ireland is somewhat clearer than the law in this jurisdiction, in light of recent case-law in that jurisdiction.

Furthermore, Northern Ireland does not have the added complexity of a constitutional protection of the unborn. If it can be argued that the law in Northern Ireland is insufficiently clear to meet the standards set by the Convention, an even stronger case can be made in respect of this jurisdiction. It is also important to note in this context that the failure of the Oireachtas to legislate on abortion, and the resulting lack of clarity in the law, drew criticism from McCarthy J in the *X* case: in the course of a judgment in which he had to apply the provisions of Article 40.3.3 to a specific instance.

The European Court of Human Rights in the Open Door case held that Ireland's law on access to information about abortion services available in other countries was 'law' for the purposes of the Convention. However, it is possible that it would take a different view in relation to abortion. The differing nuances and emphases in the various judgments in the *X* case cannot be said to provide a clear and comprehensive picture as to the constitutional law on abortion. The subsequent Information Bill case has not made the position much clearer, and the remarks of the Supreme Court in that case on the scope of any possible exception to the general prohibition on abortion may be said to be obiter. Furthermore, there appears to have been no case-law in Ireland which has dealt directly with the interpretation of s. 58 of the 1861 Act. As is discussed above, this lack of clarity puts doctors and nurses in a very difficult position. These facts might well lead the European Court of Human Rights to question whether Ireland's law on abortion is in accordance with the Convention.

2 WOMEN'S RIGHT TO CHOOSE

Lawyers for Choice recognises that abortion involves important legal questions of privacy. When women make a decision about the personal and intimate experience of pregnancy, they are engaged in a private process of decision making. There is no evidence that abortion is ever an experience that a woman desires to go through. Rather, when women decide to abort their pregnancies they are making a moral decision about the best thing to do in the particular circumstances of their pregnancies. As with any moral decision, women consider their rights and responsibilities to themselves, to their potential child, and to other important people in their lives, and come to a conclusion about the best response to their pregnancies. Abortion law must also accommodate this private moral process.

If legislators remove abortion from the moral decisions which women are allowed to make, they are effectively saying that they do not trust women to make these decisions. There are two possible rationales for this. In the first instance, the denial of women's moral authority to make abortion decisions assumes that women will always make bad decisions when it comes to abortion and therefore cannot be allowed to do so. Some people overtly believe this because they believe that abortion is always wrong. However, Lawyers for Choice believes that the law should not reflect this view in the interests of pluralism and justice to women.

Those who are not absolutist about the wrongness of abortion but would still deny women reproductive authority operate according to the assumption that women are not to be trusted with such important decisions, that other people such as doctors, psychologists and lawyers are better able to make them. In the alternative, those who believe women's authority over abortion should be restricted are implicitly holding women to a higher moral standard than normally operates when we determine whether people should be permitted to make certain kinds of ethical decisions. In other words, the other possible rationale for denying women reproductive decision making authority is that women will only be let make reproductive decisions if they always make 'good' ones. The fact that women might make wrong decisions is implicitly relied on to justify denying them decision-making authority on a morally complex issue. In the first instance, women are assumed to be morally weak. In the second instance, women are held to an inappropriately high moral standard.

When individual women are confronted with the possibility of abortion their personal histories also affect how they understand and act on the issues involved. A woman who is pregnant due to rape may well have a different kind of connection with her foetus, and will probably have a different understanding of her freedom and equality, than a woman who becomes pregnant as a result of consensual sex. A woman who has been pregnant previously may respond differently to the fact and value of her pregnancy than a woman who has not. An unemployed woman will probably have a different experience of pregnancy than a middle class woman. Thus a woman's circumstances, those related to issues of class, age, ethnicity, as well as those related to personal experiences, will affect what the fact of pregnancy means to a particular woman and her loved ones. They will also affect how that woman and others in her midst value her life, her foetus's life, the lives of other important people to her, her freedom, and her equality. In regulating the conditions of abortion provision, abortion law should make it easier rather than more difficult for individual women to negotiate

their personal circumstances responsibly.

The history of abortion tells us that while the legal regulation of abortion is a controversial issue now, this was not so years ago. The manner in which we interpret the facts and the values of pregnancy have changed and will continue to change. In the past abortion was one of a range of reproductive health services that midwives provided or that women administered to themselves. With the advance of medical technology and the growth of the medical profession abortion became a safer procedure, but women began to have less control over the administration of health services generally. Thus the denial of abortion services to women became an issue as doctors, who were dominantly male, assumed authority over reproductive health.

Abortion has also become a controversial issue because of the historical changes that have taken place in the roles that women play in our society. Given the increased acceptance in the twentieth century of the equal participation of women in the public sphere, as workers and as citizens, the ways society makes women responsible for child bearing and child rearing have changed along with these developments.

In other words, while we no longer directly confine women to the private sphere of caring for husband and children, we make it difficult for women to fully participate in the public sphere by such measures as the denial of subsidised child care, and the restriction of abortion services. We refuse to allow women to opt out of motherhood when they become pregnant, and we deny them any assistance with child care when they become mothers. The demand for abortion legislation which would give women reproductive control is part of the broader demand that public policy fulfil its moral obligation to women by providing the conditions which make women's equality and freedom possible.

In the immediate past, Irish abortion law has reflected and enforced the view that the value of foetal life is significant enough to constrain not only women's access to abortion, but, until 1995, also the ability of women and men to access information about abortion services. This prioritisation of the value of foetal life has had negative consequences on the lives, health, and welfare of Irish women, and on the social values of life, freedom (including free speech) and equality.

It is in recognition of this that Lawyers for Choice believe that current abortion law must be changed radically. The wrong that abortion law has done to women in the past imposes an important consideration on lawmakers, because it creates a demand that they demonstrate that they take women's interests seriously.

Abortion law also has to consider that the personal histories of women affect how they and their families and friends interpret the fact and value of pregnancy. The ways in which a woman's life is affected by social factors, such as class, age, ethnicity, sexuality, will influence how she relates to the actuality of pregnancy. Her prior personal experiences, such as previous pregnancies, or the sexual activity which gave rise to this particular pregnancy, will also affect how she feels and thinks about being pregnant. Indeed, when we contemplate how to change our abortion law, we should do so in the knowledge that both our own public and private experiences contribute to the effects that this law will have on people's lives.

3 GREEN PAPER OPTION FAVOURED BY LAWYERS FOR CHOICE

Lawyers for Choice believes that pregnant women are the most appropriate persons to decide whether an abortion is right or wrong in the particular circumstances of a pregnancy. In order to facilitate those women who decide that abortion is the most appropriate response to their circumstances, abortion should be provided through legislation which recognises that women have final decision making authority in pregnancy – effectively, a law which provides for abortion on request. By recognising pregnant women as the ultimate decision makers over the appropriate way to treat their pregnancies, this law would give women alone the authority to decide whether to continue or terminate the pregnancy.

We believe that this legal policy is the best way to balance the range of interests that arise with regard to abortion, and that it is the simplest and clearest way of doing so. Such a law recognizes that abortion is a morally complex issue and empowers the person who is most centrally affected and best positioned to decide what the appropriate response to a particular pregnancy should be. This law recognizes the value of foetal life by acknowledging that given the particular circumstances of pregnancy, women are the mediators of that value.

Therefore, Option 7 is the option which Lawyers for Choice calls upon the Committee to recommend. In particular, Lawyers for Choice favour Option 7(e), presented at page 126 of the Green Paper. That is, the option entitled 'Abortion on Request'.

Lawyers for Choice believes that Option 7(e) is the only one to be adopted for the following reasons:

1 It is the clearest and most honest way in which to reform the present unsatisfactory and confused state of the law.
2 It is the only one which provides for the full recognition of women as autonomous human beings, with decision-making power over their own bodies. It is the only one which recognises women's right to choose.
3 If any of the other options are recommended by the Committee and implemented by the Government or Legislature, the social reality of abortion in Ireland will not be addressed, since women will continue to travel to England to obtain abortions on grounds wider than those provided for in Ireland. Only Option 7(e), will really address the needs of women in Ireland.

Lawyers for Choice believes that the only way in which full recognition of women's right to choose can be provided for in law is through the introduction of legislation allowing abortion on request.

This could only be done through the repeal of Article 40.3.3 of the Constitution, the repeal of the relevant provisions of the 1861 Act, and the enactment of legislation providing that women have the right to request an abortion.

Clearly, such legislation would need to provide for the regulation of premises where abortions would be carried out; for the provision of state funds within the medical card system where women are unable to afford an abortion themselves; the regulation of private clinics, and so on.

In short, Lawyers for Choice believes that this option is the only one which truly addresses the needs of women in Ireland.

THE CHURCH OF IRELAND, THE GENERAL SYNOD
16 MARCH 2000
GREEN PAPER ON ABORTION

ROLE OF THE CHURCH COMMITTEE – MEDICAL ETHICS WORKING GROUP

RESPONSE TO THE IRISH GOVERNMENT'S GREEN PAPER ON ABORTION

(Withdrawn by the Church of Ireland General Synod in May 2000)

1 The Role of the Church Committee welcomes the publication of the Green Paper on Abortion as a positive effort to take this issue forward. The Interdepartmental Working Group has clearly taken seriously the very diverse opinions on the subject within Irish society and has obviously shown sensitivity to the various perspectives.

2 From the Church of Ireland perspective the issue of abortion doesn't lend itself to the sort of clear definitions that law requires. However we realise that such definitions have to be made and a clear way forward found. The Green Paper has helped to clarify many issues in this process.

3 We examined all seven options and while recognising the merit of some, none of them totally reflected the main body of opinion within the Church of Ireland. Because of the complexity of the issue we believe that it must be addressed by legislation rather than in the Constitution, though this route may have implications for the Constitution. Legislation has greater potential for reflecting the complex opinions on the issue within Irish society, a diversity we find reflected in our own church.

4 We recognise that at this stage in the process what are needed are practical proposals for a way forward, and so we offer the following as a possible direction for such legislation:

That the legislation should:

- define its area of concern with respect to abortion by defining both an upper and a lower limit for its remit. We find merit in the UK's Human Fertilisation and Embryology Authority's use of the 14 day stage as a significant stage in the development of the embryo, and suggest that this should be the earliest stage for this legislation's concern. This would have the advantage of separating post-coital contraception (e.g. IUCD and the morning-after pill), IVF and similar treatment for infertility, and the treatment of victims in sexual assault clinics, from the abortion question. Defining the upper limit is also important but this is complicated by the fact that late abortion merges with early viability of the premature infant.
- within these parameters, put in place a legal structure within which abortion is illegal but exceptions are permitted. We have in mind a reporting system whereby each incidence must be reported to a designated officer who will not proceed with a prosecution if the doctor(s) can show that certain conditions have been fulfilled. These conditions would have to be clearly set out. The designated officer should be a member of the judiciary with knowledge in this area whose sole basis of judgement would be adherence to the criteria in the legislation. To refer it to a wider panel or a non-legally trained person would be to invite re-introduction of the moral controversy into individual decisions.

5 In our opinion the exceptions to be considered should include:

- situations where the continuance of the pregnancy represent a substantial medical risk to the life of the mother;
- lethal or severe congenital abnormality in the foetus;
- pregnancy after incest (evidence would be required);
- pregnancy after rape (evidence would be required);
- cases where 'the probable consequence of the pregnancy would be to render a woman a mental and physical wreck' (the Bourne judgement 7.56);
- genuine cases of threatened suicide. We recognise the risk of suicide is a particularly difficult medical condition to quantify, but we would not wish to exclude genuine cases while not denying the potential for abuse.

All of these criteria would require precise and clear definition to ensure they remain exceptions and do not become a 'back door' to abortion.

6 We recognise that legislation along these lines may require Constitutional change.

7 This approach, based on a ban on abortion but allowing for some exceptions, has some advantages worth noting:

- abortion remains illegal;
- the criteria can be changed by amending legislation if problems of definition arise (e.g. if it became apparent that a criterion had the potential to become a 'back door', or if a new situation arose which had to be addressed);
- even those most opposed to abortion allow that exceptions should exist, often by making a distinction between direct and indirect abortion. The approach outlined would allow for these as exceptions, thus avoiding the difficulties in law referred to in 7.23 and also permit alternative treatments (7.19).

8 We reiterate our opinion (September '98) that this approach does little for the many thousands of women from Ireland who undergo abortions each year, and support a comprehensive programme of education, along with easy access to comprehensive contraceptive services.

THE CHURCH OF IRELAND
5 JULY 2000
THE RT REV. HAROLD MILLER,
BISHOP OF DOWN AND DROMORE

STATEMENT TO OIREACHTAS ALL-PARTY COMMITTEE AT PUBLIC HEARINGS

This group of three people was chosen by the Standing Committee of the General Synod of the Church of Ireland, at its June meeting, to report on its behalf to the All-Party Committee. The first thing I must tell you is that the Submission by the Medical Ethics Working Group of the Role of the Church Committee which was, I believe, sent to you, failed to be accepted by the General Synod in May, and is no longer, therefore, to be considered the official position of the Church of Ireland. The amendment which led to the submission on Abortion being removed was passed in the General Synod by 166 votes to 164, suggesting that the Church of Ireland represents a diversity of opinions on certain aspects of the abortion issue. The three of us have been chosen to convey something of the spectrum of views which co-exist in the Church of Ireland, and which (as we all know on this particular issue), can be very strongly felt (see Appendix III, p. A324).

However, not least in the light of an article in last Sunday's *Sunday Times* by Kevin Rafter, it is important to begin with areas in which all three of us are agreed. These include the following:

1 We are agreed in expressing gratitude for the Green Paper, and for the fair-minded and helpful ways in which it disentangles, presents and focuses the major issues and the potential ways forward.

2 We reaffirm together the Lambeth Declaration on Abortion, which remains as the essential and official stated position of the Church of Ireland. It reads as follows:

> 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 the violation of the personality of the mother) save at the dictate of strict and undeniable medical necessity.

This implies that there can be medical circumstances in which a termination of pregnancy is required.

3 We agree together on Section 2 of the Medical Ethics Working Group Submission:

> From the Church of Ireland perspective the issue of abortion doesn't lend itself to the sort of clear definitions that law requires. However, we realise that such definitions have to be made and a clear way forward found.

The Green Paper has helped to clarify many issues in this process.

4 We accept the spirit of the second part of section 3:

> Because of the complexity of the issue, we believe that it must be addressed by legislation rather than in the Constitution.

It has been the official view of the Church of Ireland throughout the abortion debate that the Constitutional way is not the best method of dealing with this issue.

We would therefore say that the conclusion of the Green Paper on p 172 is very close to the stated position of the Church of Ireland:

> The Review Group, therefore, favours, as the only practical possibility at present, the introduction of legislation covering such matters as definitions, protection and appropriate medical intervention, certification of 'real and substantial risk to the life of the mother' and a time-limit on lawful termination of pregnancy.

The suggestion of the Medical Ethics Group, that we:

> put in place a legal structure within which abortion is illegal but exceptions are permitted

is close to our own view.

5 We are agreed that the right to life itself is the most basic of human rights, and that this applies to the life of the foetus in the womb. We are also agreed that one of the tasks of the Christian church is to protect the weakest and most vulnerable, and that the unborn falls within these categories.

6 We are totally agreed in our opposition to abortion on demand.

7 We are agreed that abortion should be permitted in situations where the continuance of the pregnancy represents a substantial medical risk to the life of the mother, even if in a few exceptional cases this requires direct rather than indirect abortion.

8 We agree with the importance, noted by the Medical Ethics Group, of 'a comprehensive programme of education' but would wish to emphasise that this *must* include education in moral values.

9 We are agreed that in-depth pastoral care and ministry are necessary to help many women through the trauma of unwanted pregnancy and abortion; and, although we believe most abortions to be wrong, we would emphasise the crucial importance of not-judgmental care in the process of healing and restoration.

The essential areas of disagreement among members of the Church of Ireland are in the following areas:

(a) Whether it is appropriate to define a lower limit below which legislation is not concerned. The sentence (in the Medical Ethics Submission): 'We find merit in the UK's Human Fertilisation and Embryology Authority's use of the 14 day stage as a significant stage in the development of the embryo, and suggest that this should be the earliest stage for this legislation's concern', is unacceptable to many. Those who oppose the 14 day limit are often not prepared to label the IUCD and/or the morning after pill as 'contraceptive' devices. They are also concerned that the 14 day limit has an arbitrary character; and they may have strong views on life beginning at conception. Some may also wish to make the moral point that, where we are uncertain about whether a 'life' or 'nascent life' exists, our approach should be an essentially conservative one.

(b) We are not in agreement about what constitutes an 'exception' other than medical risk to the life of the

mother. At the moment, that is the only agreed exception, though some would want to extend this to the risk of suicide, where others would strongly oppose this exception.

The three areas of greatest disagreement are:

(i) lethal or severe congenital abnormality in the foetus
(ii) pregnancy after incest
(iii) pregnancy after rape.

Another area was also added in the Medical Ethics Submission. It is as follows:

> Cases where 'the probable consequence of the pregnancy would be to render a woman a mental and physical wreck".' (The Bourne Judgement 7.56).

This raises very difficult questions of interpretation for many, and there would be genuine difficulty for many members of the Church of Ireland with any loophole that would allow the door to be open, which has been opened widely (e.g.) in England, where the vast majority of abortions are performed for social and psychological reasons.

Having said that these are areas of debate and discussion among members of the Church of Ireland, this does not mean that every individual view is to be considered as of equal moral 'weight'. The official position of our church still remains an essentially conservative, but not totally 'black and white' one.

COUNCIL ON SOCIAL RESPONSIBILITY OF THE METHODIST CHURCH OF IRELAND
8 NOVEMBER 1999
SUBMISSION ON THE 'GREEN PAPER ON ABORTION' PREPARED AND ISSUED BY THE CABINET SUB-COMMITTEE 1999

The Southern Executive Committee of the Council on Social Responsibility speaks on behalf of the Methodist Church on matters relating to social, economic and political issues affecting the Republic of Ireland.

1 The Methodist Church has made periodic public statements on the question of abortion, particularly around the time of the constitutional referenda on the issue. This submission draws on these earlier statements and other reports produced by the Church from time to time. The position outlined below represents therefore the long-standing position of the Church on this matter. In outlining this position, we have attempted to draw out the inferences which are relevant to the recently issued Green Paper, in order to ensure that the statement is relevant to the current situation.

2 The Methodist Church believes that complex social issues should not be dealt with by Constitutional amendments, but rather by appropriate legislation. The Constitutional route is, we believe, inappropriate both because it is too blunt an instrument for such issues – giving rise to the danger of neglecting real issues through over-simplification, but also because the Constitution is inherently the wrong place for such specific matters, rather being the place for laying down general principles for guiding legislation, and establishing the outer boundaries of behaviour necessary to maintain the integrity of society. We therefore opposed the previous referenda on principle, irrespective of the content.

3 We are also extremely concerned about the over-simplification of the issues in prior debates on the matter and the lack of concern for the social and personal circumstances which cause women to seek the perceived solution of an abortion. There has also been a lack of discussion about means of prevention or reduction of the very high rate of abortions carried out annually on Irish women. There is an urgent need for comprehensive counselling, follow-up support, and contraceptive facilities, among other matters, to ensure that our society is really pro-life in its attitude. Given the absence of such services, we are concerned that none of the legislative or constitutional options outlined in the Green paper are likely to have any significant effect on the thousands of women seeking abortions in the UK. In a caring and responsible society, this must surely be the primary focus of attention.

4 The Methodist position on abortion, re-iterated at several Annual Conferences of our Church, can be summarised as follows:

(a) We believe that abortion on demand is wrong. We believe that a fetus cannot be regarded as just an appendage of the mother's body, but that as it evolves towards personhood, so it should progressively be accorded rights culminating with full respect as an individual on birth.
(b) However, we also believe that abortion is a permissible choice in a small number of very specific cases, in particular:-
  – where the mother's life is at risk; *(we are advised by experienced obstetricians that this does arise as a real issue in modern obstetric practice, contrary to the views expressed in some quarters)*
  – where there is risk of grave injury to the physical or mental health of the mother;
  – in cases of rape or incest;
  – in cases of gross abnormality of the fetus (e.g. anencephaly).
(c) We still maintain that Constitutional clauses are not the way to deal with the abortion question. The best solution would still, we believe, have been the introduction of carefully drafted, sensitive but restrictive legislation. Complex social issues require the comprehensive detailed approach which is possible with legislation, but impossible through the blunt instrument of a few words in a Constitutional amendment.
(d) When, however, the decision was made to proceed with the three referenda in 1992, we believed that:
  – the referenda on travel and information should be supported
  – the referendum on abortion should be opposed

Our reasons for so arguing were that firstly there was a need for clarity following the Supreme Court judgement in the *X* case on the travel and information issue, even if the wording was far from ideal, but secondly that the third proposed amendment

did not adequately deal with supporting the rights of the mother when complex decisions must be made.

In the event, the people's decision was in accordance with this recommendation.

5 In addition, the Methodist Church favours a pluralist democratic society where all shades of opinion are treated with respect. The role of law should not attempt to legislate for a specific form of morality, but rather to set minimum standards for the social good. In keeping with the general nature of such a society, the approach should be to give maximum individual freedom, and should only restrict such freedom where there is a clear and unmistakable social necessity. There are many aspects of social behaviour of which we might disapprove, but that is not in itself a ground for considering legislation.

6 Given the analysis above, we now turn to consider the options outlined in the recent Green paper. From our stated position it is clear that **we do not support:**

- **OPTION 1: An absolute constitutional ban on abortion**
  (since we believe that abortion is permissible under certain restricted circumstances)
- **OPTION 2: Restrict the application of the *X* case**
  (since the permitted grounds in the *X* case are in conformity with the grounds we believe should be permissible)
- **OPTION 3: Retention of the *status quo***
  (since it is clear that there is a legal vacuum, and if abortion is legal in certain circumstances as a result of the *X* case, that should be regulated properly by appropriate legislation)
- **OPTION 4: Retain the *status quo* with legislative restatement of prohibition**
  (the intent here seems to be to restrict the legal position as far as possible within the terms of the *X* judgement – we would oppose this for the grounds already stated)
- **OPTION 5: Legislation the terms of the *X* case**
  (although as already stated, this seems to be the minimum necessary to regulate the present situation, we do not support it as the best solution, since the *X* judgement is more restrictive than the position we have adopted)
- **OPTION 6: Revert to the pre-1983 situation**
  (since (a) a British Act of 1861 is clearly not appropriate for the complexities of 21st century Ireland; and (b) that act does not deal with the special circumstances outlined above where we believe abortion to be permissible)

7 We therefore opt for **OPTION 7: legislation going beyond the *X* case.**

As already stated, we do not favour easy or liberal abortion, but rather sensitive legislation to allow abortion, subject to appropriate medical and ethical guidelines, for a restricted set of circumstances. These circumstances include, but go further than the grounds outlined in the *X* case. Of the possible grounds listed in the Green Paper, **we can therefore support**

- Risk to physical/mental health of the mother – with the caveat that we are talking about serious certified conditions
- Pregnancy as a result of rape or incest
- Congenital Malformations

but NOT for either

- Economic or social reasons, nor
- On request

8 We believe this is the best approach towards the sort of open caring society that is most in keeping with our understanding of the implication of the Christian Gospel based on love and respect for the dignity and worth of each individual.

ABORTION REFORM
NOVEMBER 1999
SUBMISSION TO THE ALL-PARTY OIREACHTAS COMMITTEE ON THE CONSTITUTION

EXECUTIVE SUMMARY

Favoured Approach of Abortion Reform

Abortion Reform supports the legalisation of abortion in Ireland.

Abortion Reform believes that this outcome is more important than the process by which it is to be achieved. In that context,

If the Constitution is to be amended:

(a) Abortion Reform supports the holding of a Preferendum-type vote.
A number of options for reform would be put to the people, including an option or options extending the grounds for legal abortion beyond the *X* case ground.

(b) In such a Preferendum, Abortion Reform would call for the repeal of Article 40.3.3 and its replacement by legislation legalising abortion.

If the Constitution is not to be amended:

(a) Abortion Reform supports the introduction of legislation to implement the *X* case test, permitting doctors to carry out abortions where the continuation of a pregnancy poses a real and substantial risk to the life of a pregnant woman.

(b) This would be the very minimum option acceptable to Abortion Reform.

INTRODUCTION

Abortion Reform is a newly-established coalition of individuals and organisations which aims to:

promote a better understanding of the realities of Irish abortion;

promote an environment in which the issue of abortion can be discussed calmly and responsibly;

promote the reform of Irish law so as to ensure the provision of legal abortion within the state;

ensure equal access to abortion as an integral part of the health services.

Many people, while not describing themselves as 'pro-choice', do not believe that an absolutist ban on abortion is either feasible or desirable. Abortion Reform was set up to promote an environment in which those people can identify with the need to introduce legal abortion in some instances at least.

It is in this context that Abortion Reform is making this submission to the All Party Oireachtas Committee on the Constitution. We very much welcome the Green Paper produced by the Interdepartmental Working Group and published in September 1999, and we also welcome the opportunity to make submissions to the All Party Oireachtas Committee on the conclusions reached in the Green Paper.

As Abortion Reform is newly established as a group, we believe it is appropriate for us to consider in some detail the conclusions reached in the Green Paper, and so we have set out our responses to the Green Paper in the format adopted in the Paper itself. Thus, our submission takes the form of a commentary on each of the chapters of the Green Paper.

We also attach with this submission our own Policy Document, which sets out the position and policy of Abortion Reform.

We hope that our submission will be of some assistance to the Committee, in representing, as it does for the first time, the views of a broad coalition of individuals and organisations, all of whom have in common a belief that some form of legal abortion should be provided in Ireland.

CHAPTER 1
MATERNAL HEALTH

1.1 Abortion to save the life of the woman

It is clear from the Green Paper that there are numerous medical conditions where elective termination of pregnancy is justified to protect the life of the pregnant woman and it is also clear that elective terminations are carried out for this purpose.

The Master of the Rotunda, Dr Peter McKenna has reported (Irish Times 4th July, 1998) that abortions do occur in Irish hospitals and as is stated at paragraph 1.20 of the Green Paper, most ectopic pregnancies are managed 'by therapeutic intervention involving termination of the pregnancy.'

Whilst medical opinion may vary on the need for elective terminations in certain circumstances, it is without doubt that there are certain circumstances where termination is necessary. Hence, an absolute constitutional ban on abortion is not appropriate as pregnant women, like all other human beings, have a right to life. (Universal Declaration of Human Rights).

It seems that some submissions to the Green Paper made reference to the 'double effect' theory and the difference between direct and indirect abortion. Such distinctions may lead to interesting case law, but to continue to deal with a therapeutic medical treatment of women in this manner is to ignore the medical necessity of elective termination of pregnancy. Given the complexities of medical situations, any law regulating a medical treatment should be as clear and simple as possible and introducing further complexities to an already difficult and, frequently, stressful situation is not advisable.

Abortion Reform endorses the view expressed at paragraph 7.19 of the Green Paper where it states 'it is difficult to see how the destruction of the embryo can be described as an unintended side-effect".

Abortion, therefore, must be one of the medical treatments available to women who have a crisis pregnancy. Whether the woman decides to avail of this medical treatment is for her to decide, just as any other adult decides on their appropriate medical treatment.

1.2 Centrality of maternal health

Chapter 1 of the Green Paper 'Pregnancy and Maternal Health' sets out the life threatening situations in which a pregnant woman may find herself. Maternal health, however, is a much wider topic than this as it includes the quality of a woman's health, whether physical and/or mental.

Maternal health issues are raised indirectly at pages 121 to 126 of the Green Paper. These pages clearly illustrate the real problems and difficulties of regulating access to abortion, for example, how can it be established that rape or incest took place or how severe must an abnormality be? The issues raised on these pages clearly show that any discussion of legislation moves abortion into the court room and out of the doctor's clinic or the pregnancy counsellor's consultation room which is where the decisions should be made.

The difficulties raised in pages 121 to 126 are central to maternal health. However, they are discussed in terms of constitutional and criminal law which, generally, will not solve a maternal health crises. A woman who is pregnant with a handicapped child may make her decision as to whether or not she has a termination in the context of the emotional needs of her family and of herself and is unlikely to do it with a copy of the latest criminal code in her hand.

Maternal health must be placed centrally in any discussion of what provision to have for abortion in Ireland.

In summary, therefore, in order to protect a pregnant woman's right to life, elective termination must be available as a possible medical treatment for her. A complete constitutional ban on abortion would require the deletion of Article 40.3.3 and a new amendment inserted. Such a ban would place the State in conflict with its international obligations under the Universal Declaration of Human Rights.

CHAPTER 2
LEGAL CONTEXT FOR ABORTION

2.1 Analysis of the present law

Article 40.3.3 was inserted into the Constitution at the behest of anti-abortion campaigners, who argued that it would have the effect of 'copperfastening' the prohibition on abortion already provided for through the 1861 Offences Against the Person Act. This Article has subsequently given rise to two separate lines of authority; one, relating to information on abortion, and the second relating to the issue of abortion itself.

(i) Information on abortion The first such line of authority was initiated by the Society for the Protection of the Unborn Child, in a series of cases which they took

during the 1980's against providers of information on abortion. These cases, beginning with the decision of Hamilton J in *AG (SPUC) v. Open Door Counselling Ltd [1987] ILRM 477*, established that the provision of information on abortion was unlawful under the Constitution. However, the European Court of Human Rights in *Open Door No. 2 (1993) 15 EHRR 244* found that the actions of the Irish state in effectively prohibiting the dissemination of information on abortion were in breach of Article 10 of the Constitution, which guarantees the right to freedom of expression.

Further, in another reference to a supra-national court, this time the reference to the European Court of Justice in *SPUC v. Grogan [1992] ILRM* 461, that Court raised the possibility that a future right to provide information on abortion might be established through EC law, given that abortion was defined in the Court's judgment as a 'service' within the meaning of the Treaty. Where an information provider had a commercial or economic link with a service provider in another jurisdiction, then EC law would apply, although, because no such link existed, the Court did not make a ruling in respect of the students' unions in the Grogan case.

The result of the interpretations offered by various courts as to the implications of Article 40.3.3 for information on abortion might be described as unexpected. However, the second line of authority, relating to the issue of abortion itself, has produced an equally unexpected result.

(ii) Interpretation of Article 40.3.3 on abortion The wording of the 1983 Amendment provides that the right to life of the 'unborn' can only be respected, defended and vindicated 'with due regard to the equal right to life of the mother'. Thus, it should have been predictable that where the two rights come into conflict, the courts would inevitably have to decide which of them took priority. In both the *X* and the C case, the two rights were decided by the Courts to be in conflict, due to the suicidal intentions expressed by both *X* and C arising from their crisis pregnancies.

It was accepted by the Supreme Court in the *X* case, in the words of Finlay CJ, that if '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.' Any other interpretation of the 1983 Amendment would, it is submitted, endanger the lives of pregnant women.

Similarly, then, any future referendum purporting to replace the 1983 Amendment with a form of wording prohibiting abortion to save the life of the pregnant woman would also endanger the lives of women. The *X* case test represents the most limited form of abortion possible; that necessary to save the life of the woman. This is the most minimal formula possible in order to safeguard the lives of pregnant women. Any formula purporting to limit the *X* case test would therefore put the lives of pregnant women at risk.

(iii) The direct/indirect distinction in law Any formula which has been put forward by anti-abortion campaigners tends to rely upon a distinction between 'direct' and 'indirect' abortion. Thus, according to their reasoning, any abortion directly performed to save the life of the pregnant woman would be outlawed, but treatment would still be permitted where the loss of the foetus is the indirect consequence of treatment necessary to save the life of the woman (see definition offered at para. 1.09 of the Green Paper).

Those putting forward this formula deny that direct abortion is ever necessary to save a woman's life. However, the distinction between direct and indirect treatment in this context is far from clear (see in this context the reasoning of the Supreme Court in *Re a Ward of Court [1995] 2 ILRM 401*).

To adopt this approach would be to create further confusion for medical practitioners and patients, involving as it would a philosophical or metaphysical enquiry into the state of knowledge and intention of the doctor or treatment provider at the time of providing the treatment. This type of enquiry should not be necessary in a medical crisis where a threat to the life of a patient exists; the doctor should be able to perform whatever life-saving treatment is necessary, without having to think about whether the consequence of the treatment is a direct or indirect abortion.

Moreover, the contention that direct abortion is never necessary as a life-saving treatment is itself challenged by international medical studies (see Chapter 1 of the Green paper generally, and especially para. 1.28, 'the scientific literature does note situations where elective termination was performed to protect the life of the mother'). See also the medical practice in Northern Ireland, referred to in Appendix 3 of the Green Paper, which instances 4 particular cases in which NI courts ruled termination to be lawful in order to save the life of the woman or girl in each case (p. 151-2).

The Constitution Review Group also took a critical view of the purported direct/indirect distinction in their Report of May 1996, in which they concluded that it would be unsafe to rely upon the distinction. The conclusions reached in the Green Paper itself are similarly critical of the validity of the distinction. For example, para. 7.24 of the Paper states that 'An absolute ban [on abortion] would .. seem to accept the contention that a 'direct' abortion is never necessary to save the life of a mother, although the evidence on this point is not conclusive and that contention remains controversial.' (p. 110).

The best medical and legal opinion would suggest that it would be dangerous to attempt to restrict the wording of the Eighth Amendment any further. Thus, abortion would remain lawful under the *X* case test. In order to clarify the legal position of doctors faced with life-threatening pregnancies, it is desirable that, if Article 40.3.3 is retained, legislation should be passed to provide for the circumstances in which abortions might be performed.

The Constitution Review Group recommended the introduction of legislation as the preferred option, and suggested that such legislation should include, for example, a definition of 'unborn' and a provision as to what certification would be necessary to prove the real and substantial risk existed.

Finally, Abortion Reform supports the view that abortion should be available through a legislative framework, rather than under the Constitution. The possible forms which such a framework could take are examined in Chapter 7 of this Submission.

CHAPTER 3
INTERNATIONAL AND EU LAW CONTEXT

3.1 The State's obligations under international law

Chapter 3 of the Green Paper discusses the nature and extent of national obligations under international and European Union Law. The conclusion is reached, at 3.12, that none of the enumerated international agreements appears to place any limits on the freedom of States who are Parties to such agreements to adopt whatever abortion regime they wish. This statement is not accurate as it can be argued that a right to reproductive self-determination, which includes abortion, has emerged under international law.

3.2 International human rights law and abortion

The most obvious right violated by the denial of access to abortion can be the right to life. The International Covenant on Civil and Political Rights states, at Article 6, that 'Every human being has the inherent right to life. This right shall be protected by law…' This implies that health care should include termination of life-threatening pregnancies. An absolute ban on abortion (as in Option 1) in Irish law would violate the woman's right to life.

Human rights to good health and to health care have also been recognised under international law and are pertinent to the lawfulness of abortion. The International Covenant on Economic, Social and Cultural Rights, at Article 12, includes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Health is a concept which encompasses the obvious physical health, but also includes mental health and social well-being. These health rights entitle women to claim abortion rights where their health, physical or psychological, is threatened by pregnancy. The right to good health is an aspect of the right of bodily integrity and the allied rights to liberty and security of the person. These rights would seem to serve the state's negative interests in non-interference in an individual's pursuit of means to limit, or to promote, fertility. Hence, it recognises a woman's reproductive choice as an element of her personal integrity and autonomy, and not in any way solely dependent on health justifications.

All persons, including women, are entitled to be free from torture, cruel, inhuman and degrading treatment or punishment according to the dictates of international law. This right provides a basis upon which it can be argued that compelling a woman to carry to term a pregnancy which has been forced upon her (for example, by rape) amounts to torture.

3.3 The Convention on the Elimination of All Forms of Discrimination Against Women

The most relevant international instrument is the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which is the only international treaty to mention family planning. In the preamble to CEDAW, it is stated that the role of women in procreation should not be a basis for discrimination, while Article 12 (1) provides that 'States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality with men and women, access to health care services, including those related to family planning'. Governments are obliged to develop family planning codes. The legal obligations imposed by CEDAW must be reviewed in the context of the inherent aim of ensuring reproductive autonomy and equality for both women and men. In order to ensure such autonomy, there must be a recognition that women are entitled to control their bodies and their fertility. In promoting equality, it must be acknowledged that reproductive freedom has a different significance for women than it does for men.

It is clear that liability to pregnancy distinguishes women from men on biological grounds and it is well established, under equality law, that negative pregnancy related distinctions are discriminatory against women. It has been pointed out that there are certain fundamental rights that women may have to pursue at much greater cost than men, due to laws that reduce women's power to advance and protect their health where pregnancy is concerned. The right to life, the right to health care, and the right to found a family may be pursued by men without additional hazards due to conception, but when women are pregnant, restrictive laws may impair their rights. Restrictive laws on family planning, including abortion, therefore have a disadvantageous impact on women as opposed to men. If Ireland were to give effect to the principle of non-discrimination under CEDAW, domestic legislation would be enacted which would liberalise access to abortion, thus affording women rights to life, health and family planning equal to those of men.

On two occasions the record of Irish compliance with CEDAW has been reviewed by the UN Committee on the Elimination of All Forms of Discrimination Against Women. The question of access to abortion was raised at both of the hearings, the most recent of which in June of 1999 included several observations on the lacunae in Irish law, particularly as it doubly disadvantages female asylum seekers.

3.4 'International discussions'

In introducing the catalogue of the State's obligations under international law, the Green Paper states, at 3.01, that the chapter specifically excludes consideration of the Irish position in relation to abortion in the 'context of other international discussions which do not entail the assumption of a legal obligation by the State'. In making this decision, the drafters are omitting much so-called 'soft law' and developing customary international law which has a legal impact on the Irish State. The Beijing Declaration and the Platform for Action which emerged from the Fourth World Conference on Women contain much elaboration of reproductive rights, as do the declarations which emanated from the International Conference on Population and Development in Cairo in 1994.

The Final Programme of Action agreed upon in Cairo included recognition that women's reproductive health and rights must be addressed. This was built upon in the Platform for Action where it was acknowledged that the limited power that many women have over their sexual and reproductive lives has an adverse impact upon their health. The document states that good health is essential to leading a productive and fulfilling life, and that the right of all women to control aspects of their health, in particular their own fertility, is basic to their empowerment. Undertakings, such as those to implement this Platform

for Action, must be honoured by the Irish government. During 2000, the Irish government is obliged to publish the mid-term review of its obligations to implement the Platform for Action, and this point must be addressed in that review.

3.5 Conclusion

The rights of women, including life, health and autonomy, and the fundamental norm of equality are all well-established principles of international human rights law. The vindication of the rights of women and the achievement of substantive equality mandate respect for reproductive self-determination, including the autonomy to decide to terminate an unwanted pregnancy.

CHAPTER 4
OTHER GROUNDS FOR ABORTION, SET IN AN INTERNATIONAL CONTEXT

4.1 Range of arguments in Green Paper

Abortion Reform welcomes the fact that this section of the Green Paper deals with a broad range of arguments relating to the possible availability of termination and that it addresses the issues within an international perspective. This approach makes for clarity in a debate where too often the real issues affecting the health, both mental and physical, of pregnant women are dismissed in favour of absolutist positions which attempt to deny the reality of the complex issues involved, and to reject the right of a woman to have access to termination facilities to preserve these aspects of her well being.

4.2 Physical or mental health of the woman

The Green Paper discusses the issue of the physical and mental health of a woman and refers, in sections 4.04 and 4.05, to the many countries which permit abortion on either or both grounds. These sections also state that in most countries where such provisions apply they tend to be implemented 'broadly'. Chapter 1 of the Green Paper describes a large number of medical conditions in pregnancy which endanger the life or the health of a woman. Abortion Reform welcomes the broad scope of the conditions addressed and feel that Chapter 1 must be incorporated into the discussion in Chapter 6 on matters affecting maternal physical and mental health.

Abortion Reform takes issue with the statement in Chapter 1, 1.09, that there is no evidence of doctors refusing to treat women with cancer on the grounds of possible damage to the foetus. This appears to be the situation that arose in the case of Sheila Hodgers in Drogheda in 1983. Both mother and newborn died in this case. [See *Irish Times*, early Sept. 1983, and Emily O Reilly, *Masterminds of the Right*, page 7].

It is argued that in the light of the large number of medical and psychiatric conditions that may arise in relation to pregnancy – and other illnesses already present or likely to develop in the individual woman – it is correct that such grounds should be broadly defined so as to allow for the widest possible scope of remedial treatment to be available to the woman's medical consultant.

4.3 Medical positions on abortion

In this regard it is of relevance that a poll carried out by the Sunday Tribune in 1997 showed that 76% of a representative sample of consultant obstetricians/gynaecologists working in Irish public hospitals stated that they would carry out an abortion if the life of the mother was in danger and if they were legally permitted to do so. The survey was conducted among 43 of the 75 consultant obstetricians/gynaecologists in the country. [*Sunday Tribune* 7.11.97]

These findings run counter to the oft-repeated claims by the anti-abortion lobby that the entire Irish medical profession and its representative groups are in agreement that there is 'no circumstance in which abortion is necessary to save the life of a woman'. It is clear that the hegemony created by anti-choice conservatives within medical pressure groups exerts an intimidatory pressure preventing doctors from speaking out in a public manner on issues related to abortion.

> Very many doctors in Ireland are in favour of a woman's right to choose, but will never come out of the closet, because of the opinion of the Medical Council [Dr Juliet Bresson, *Medicine Weekly*, 16.12.98]

In 1998 Dr Peter McKenna, the Master of the Rotunda Hospital, in an article in the Irish Times, addressed the reality of situations such as molar pregnancy, heart disease and cancer. He questioned the 'double effect' argument, stating 'Can this principle of "double effect" be translated into law?' He is concerned about translating the complexities of medical practise and the rights of patients into simple constitutional statements. 'As practising obstetricians our priority is to ensure that the mother does not die as a result of being pregnant.'.['Hard Case Pregnancies split doctors', *Irish Times* 4.7.98].

In another interview in the same paper Dr McKenna gave examples of two abortions which took place in Ireland to save the lives of the mothers ['Abortions are being carried out in State, says Doctor', *Irish Times* 4.7.98].

In an international context it is important to note that such prestigious professional bodies as the American Medical Association, which represents 294,000 doctors, and the American College of Obstetricians and Gynecologists, membership 33,000, both adopt positions in support of the availability of early terminations and regard abortion as a confidential medical matter between the patient and her physician. [American Medical Association 'Right to Privacy in Termination of Pregnancy', Policy Compendium 1996 and American College of Obstetricians and Gynecologists' ACOG Statement of Policy: ACOG Policy on Abortion', January 1993.]

In relation to public opinion on the issue of pregnancy terminations in cases of threat to the physical and mental health of women, a recent opinion poll has addressed these issues.

Irish Times/MRBI Poll – December 1997

Q. Should abortion be permitted in Ireland if:

Woman's life at risk	35%
Woman's health at risk	14%
To whoever needs it	28%
Not at all	18%
Don't know	5%

This poll indicates that 77% of those questioned accepted

the need for some abortion in Ireland and 49% accepted it in the combined categories of threat to life or health.

4.4 Mental or physical incapacity of the woman

Another aspect which must be considered is the medical need for pregnancy termination in cases where the woman has a long term mental or physical handicap, which predates the pregnancy and which is congenital or incurable. Such instances are not unusual and, as Appendix 3, page 151, of the Green Paper notes, the Northern Irish Courts have held that an abortion in such circumstances was not unlawful. It is quite likely that such a situation will emerge in this jurisdiction at some future time.

Legal provision should be made immediately to ensure that appropriate and sensitive medical care, including termination, be made available in Ireland for women in such situations, without the need for the court cases, massive publicity and long public debates which would be likely to arise in the absence of clear legal regulation of abortion.

4.5 Mental incapacity and consent

In cases of severe mental incapacity the question of whether such a pregnancy resulted from a rape [due to inability to give, or lack of understanding of, consent] would also arise. However, even if judged to be such, no right to abortion would exist on the basis of the rape. This lack of abortion provision would also apply in the case of a mentally incapacitated girl or woman pregnant as a result of incest.

As Northern Ireland is the nearest jurisdiction to the Republic, a consideration of the law applying there is relevant. In Northern Ireland up to 500 therapeutic abortions are carried out each year, on the grounds of the woman having a serious medical problem which could jeopardise her life or health; if she is mentally subnormal; if there is a substantial risk of a disabled child; or if she has been raped. The legal basis for these laws is provided by the 1945 Northern Ireland Criminal Justice Act, which provides for abortion after 28 weeks to save the life of a woman. This is a grey area, as the law does not make provision for an abortion in such circumstances under the 28 week limit. [*Irish Times* 14.11.94].

4.6 Rape/incest

The two cases, 'X' and 'C', which re-ignited the abortion debate in Ireland in the 1990s, both stemmed from situations involving raped minors. Both cases led to an outpouring of public support and sympathy for the girls involved and changed many individual attitudes towards abortion in the real circumstances of rape.

Abortion Reform would reject the view mentioned in section 4.18 of the Green Paper, namely that abortion adds a second traumatic experience to the woman who is pregnant as a result of rape. In such cases abortion can often be an essential aspect of the woman's recovery from the rape and lack of availability of abortion can have a seriously detrimental impact on a woman's mental health.

In cases of rape and incest the distress surrounding the crisis pregnancy is even higher than in cases of unplanned pregnancy arising from consensual intercourse. No woman should be forced to carry to term a pregnancy which has been conceived as a result of coercion – to impose such a restriction is a fundamental assault on the right of a woman to her dignity and bodily integrity. In relation to incest, a number of additional complications may arise for the woman, mostly relating to the dysfunctionality of the family and the individual circumstances arising therefrom. There is also the possibility of malformation of the foetus due to genetic factors.

In a European context it is relevant to note that those states which place quite severe restrictions on the availability of abortion – i.e. do not have abortion on request or only allow it within strict lower time limits – all permit terminations in cases of rape.

The European countries which have a specific provision for abortion in cases of rape include: Cyprus, Czech Republic, Denmark, Finland, Germany, Greece, Hungary, Iceland, Italy, Luxembourg, Norway, Poland, Portugal, Slovak Republic and Spain. [International Planned Parenthood Federation, 'Abortion Legislation in Europe' February 1997. It can be seen that these comprise most members of the European Union, as well as those states commonly perceived as 'traditionally Catholic'. In the EU member states not named above, abortion is available to rape victims under more broadly-expressed legal provisions.

In cases of pregnancy arising from rape or incest, great attention should be paid to assessment of the mental state of the woman involved, and all provision should be made for immediate crisis counselling, both in relation to the pregnancy and to deal with the psychological impact of the illegal act which has been perpetrated on the woman involved.

All women and minors who have been victims of a sexual assault should have access to a termination, without being forced to go through numerous court proceedings.

4.7 Congenital malformations

The Green Paper discusses a number of circumstances of foetal malformation as possible grounds for abortion.

The decision on what course of action to adopt in cases of foetal abnormality in pregnancy are dictated by a large number of individual factors:

- the nature of the disability diagnosed;
- the degree of seriousness of the abnormality;
- the possibility of cure or treatment;
- the age of the woman and her circumstances, including the number of other children in the family;
- the presence of another child or children with a serious disability;
- the quality of life of the baby once born;
- financial and family implications of the lifetime care needed;
- the inadequacy of current state medical, educational and respite care facilities for disabled children and adults.

The discovery that a woman is carrying an abnormal foetus should not mean that the pregnancy is automatically aborted. It is argued that no strict definitions should be inserted into legislation to govern which disabilities might be grounds for termination. The decision to continue with such a pregnancy is one to be made by the woman, along with her partner, if she wishes, and her chosen medical advisers.

In a European context almost every state permits

abortion in cases of foetal abnormality, including: Austria, Cyprus, Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Italy, Luxembourg, Norway, Poland, Portugal, Romania, Slovak Republic, Spain, Turkey, United Kingdom, Northern Ireland. [International Planned Parenthood Federation, 'Abortion Legislation in Europe' February 1997]

Testing for foetal abnormality A large number of foetal abnormalities are now detectable through pre-natal testing. It is worth noting that, in the aftermath of the 1983 referendum, the anti-abortion movement made statements calling for the prevention of testing for foetal abnormality, on the basis that the ban on abortion meant the carrying out of such tests was pointless as abortion was not an option in such circumstances. While not specifically illegal, a grey area surrounded medical procedures such as amniocentesis, chorionic villus sampling and blood tests. Hospitals refused, and some continue to refuse, to provide such procedures to pregnant women, who are therefore forced to travel to Northern Ireland to avail of such services.

This extraordinarily cruel interpretation of Article 40.3.3 completely ignores the distressing impact of the discovery of foetal or newborn disability on the parent/s. With pre-natal testing early in pregnancy, time is available to make necessary medical and environmental arrangements prior to the birth. With counselling and time, the emotional impact of making the discovery of the disability at birth is also eased.

A concern would arise that in the event of a referendum being passed re-defining Article 40.3.3 in a conservative manner, this may strengthen the effort by anti-abortion interests to impose restrictions on the rights of women in Ireland to have access to such medical testing during pregnancy.

CHAPTER 5
WOMEN'S RIGHT TO ABORTION

5.1 Control of fertility

Control of fertility is essential to women's control over their lives, to their existence as autonomous members of society in a position to fully participate in the economic, political, social and cultural life of their country. The extent to which women exercise control over their fertility affects their choices in every aspect of their lives; their participation in employment, education and training, in the household, in their local community and in the wider political and public spheres.

Women and men have a right to bodily integrity, to physical and mental health and well-being, to sexual expression and reproductive control. As equal members of society, women have the right to have their needs equally recognised and equally met. Abortion is one of a range of reproductive health services needed by women in all countries.

Historically and currently, all attempts to block women's access to abortion have failed, not just in Ireland but world-wide. Ireland, like every other country in the world, has abortion – we simply export it. Making abortion illegal in any one country results in a situation, at best, in which women are forced to avail of abortion services in another jurisdiction and at worst, in which women take enormous risks with their health and lives by accessing illegal or underground abortion services or by attempting to induce abortions themselves. Tens of thousands of women die globally every year in such circumstances.

In Ireland, our close proximity to Britain and the relative freedom of travel between the two countries enables many Irish women to avail of their private abortion services. Despite a series of referenda and court cases involving individual women, large numbers of Irish women travel to Britain for abortions every year. 96% of the world's countries provide for abortion where a woman's life is threatened – protection of women's health is a legal basis for abortion in 89% of industrialised countries.

Relying on another jurisdiction to provide abortion is a wholly inadequate response to the clear need and demand for abortion services within this State. For many individual women and for certain particularly vulnerable groups of women, the journey to Britain poses significant financial or health problems. For some, it may even be impossible.

5.2 Problems arising due to lack of Irish abortion services

Our reliance in Ireland on services available in another jurisdiction is morally irresponsible, but it also creates access problems for many women:

> It imposes severe financial burdens on women who must bear the cost of travel and accommodation in another country as well as the cost of accessing the service in the private marketplace.
>
> It creates an information gap resulting in a situation in which many women travel for abortion without counselling and with little or no information of how and where to access services.
>
> It means that many women are having abortions at a later stage than would be the case if services were available locally.
>
> It poses additional health risks and potentially serious delays on women who are experiencing health problems during pregnancy.
>
> It means that women's medical histories and files are frequently unavailable to those providing abortion services to Irish women.

Abortion in another jurisdiction is not a realistic option for women in specific circumstances:

- a situation which is potentially life-threatening;
- displaced women, for example women asylum-seekers, who are not in a position to travel;
- women or minors in the care of the State, where their pregnancy is not characterised as life-threatening;
- women whose health or financial resources do not permit them to undertake the journey.

It means that women operate under conditions of secrecy and are frequently unlikely to avail of after-care services.

Reducing the numbers of unwanted and crisis pregnancies is in the interests of all women and requires the development and implementation of a national comprehensive programme of sex education and reproductive health services. Successive governments have failed to date to allocate the resources necessary for such services. Criminalising abortion and forcing women into another jurisdiction neither reduces the level of crisis pregnancy nor lowers the Irish abortion rate. Ireland's abortion rate

is similar to that of other countries in Europe. Denying its existences and creating conditions which silence women who have had abortions cannot change that reality.

CHAPTER 6
THE SOCIAL CONTEXT

6.1 Chapter 6 of the Green Paper

This chapter in the Green Paper sets the discussion on abortion against the background of recent changes in Irish fertility trends and the changing context in which women are becoming mothers – the falling birth rate, increase in the age at marriage, increase in the age of women at first birth and increase in women's labour force participation. The rising incidence of non-marital births was noted and it was pointed out statistics on non-marital births do not take account of the variety of other types of relationships women may be in when they become mothers. This acknowledges changes in patterns of family formation in our society.

There has been a tendency to see non-marital motherhood as inherently problematic due to our narrow view of the family, and in this regard such an acknowledgement is welcome. The persistence of a social stigma attaching to non-marital motherhood is also noted however and is related to family, social, educational or career considerations of the woman.

Studies on abortion among Irish women that have been carried out are drawn on to construct a profile of their social and economic characteristics. However, there is no acknowledgement of the fact that our understanding of Irish women's abortion experiences is limited because they have to travel to another health administration in order to have an abortion. Therefore, we are relying on the National Statistics Office of England and Wales to provide us with information on Irish women having an abortion within their health administration, and the data they produce is limited.

6.2 'Factors which contribute to the incidence of unwanted pregnancy'

In the discussion on 'unwanted pregnancy' in the Green Paper, education and contraception are the two main factors considered. The inadequacy of education on relationships and sexuality, and the consequent lack of knowledge and assertiveness, are highlighted. Among the matters mentioned are the need to empower women to assert their contraceptive needs in heterosexual relationships, and the need to address the lack of responsibility on the part of men. Abortion Reform believes that this is a welcome approach. If it is to be effective, any policy that is to be formulated with the aims of empowering women, and of promoting male responsibility in the area of reproductive and sexual health, needs to take account of the broader context of sexual relations in our society. Measures need to be taken which challenge the organisation of heterosexual relationships in our society, whereby women are not encouraged to be assertive with regard to their sexuality, while men are not expected to be sexually responsible.

The need for clear and effective sexuality education programmes which include instruction on contraceptive methods and how to use them was discussed. When discussing strategies on the part of policy to 'reduce recourse to abortion', the RSE programme was presented as the principal way of delivering such education. However to date it has been unclear to what extent this programme has been introduced in schools throughout the State, how accessible it is to students and how effective it is in achieving these objectives. In particular, the fact that education on the use of contraception is not currently included in the RSE programme contradicts the clear recommendation of the Trinity College Women and Crisis Pregnancy Study for the introduction of education on how to access and effectively use each available form of contraception.

Abortion Reform favours the implementation of comprehensive relationship and sex education programmes within all levels of the educational system as well as in health and social services. Abortion Reform welcomes the incorporation of the objective to 'educate and inform women fully about their bodies and reproductive systems, including the physiological knowledge of how pregnancy occurs and methods of contraception' into the SPHE, which is to be introduced as part of the core curriculum before 2000. We would hope that the commitment to this objective will be realised and that it will be aimed at young men as well as young women within the education system. In general it is imperative that the SPHE programme be implemented in full, that it be subject to an on-going review and that it be extended where necessary.

The discussion on contraception in the Green Paper makes it clear that contrary to popular belief, contraception is not widely accessible and available to all women in our society. Addressing the factors which impede women using contraception effectively requires a shift in how we think about women's and men's sexuality in heterosexual relationships. This needs to be combined with a policy approach which ensures the wide availability of contraception to women throughout the country, in such a way that cost does not impede accessibility. Finally, the reference to the role of alcohol in the occurrence of many unplanned pregnancies is a short-sighted approach in that it isolates the sexual act in which conception occurs from broader social norms and constraints governing sexuality and female sexuality in particular.

6.3 Issues surrounding a woman's decision whether or not to have an abortion

6.3.1 Counselling and Information In considering counselling and advice services for women with a crisis pregnancy, the need for the regulation of pregnancy counselling services must be recognised, particularly in light of the recent controversy regarding the practices of the Adams clinic. Secondly, the position whereby providers of the State funded primary health care system, namely GPs, can refuse to provide women with advice on abortion services legally available elsewhere, has serious consequences for women. This position needs to be reviewed and, if necessary, changed, in order to ensure that women have proper access to information and advice services. In the interim, it is crucial that those who refuse to give women such information should be required to refer them on to someone else who will provide such information. This requirement is necessary to safeguard women's right of access to abortion services legally available outside the State.

The Green Paper notes that women presently use varied routes to access abortion services. This would seem to reflect the lack of clarity among women about how to access such services, regional variations in availability of abortion information services and difficulties accessing such services, as well as women's own preferences. Clarity and regulation in the provision of counselling and information services is therefore essential. There is also a need to take account of the fact that different women need different levels of help and advice before travelling, and information services should be flexible enough to take account of that.

The current legal situation, whereby women can only access information on abortion in the context of full counselling, confuses the two issues of counselling and information and defeats the philosophy of counselling, in that the counselling is often perceived as a hurdle which must be crossed in order to access information. The present situation also precludes women who do not feel they need or want to attend formal counselling from consulting health professionals about aspects of the abortion procedure or reputable abortion service providers.

The discussion on post-abortion counselling suggests that all women who have an abortion will want and need post-abortion counselling and medical check-up. It is important to remember that while a check-up is very advisable, abortion is a safe operation for women and thus a check-up may not be necessary. In regard to post-abortion counselling, some women may want counselling to resolve the issues raised by their pregnancy and abortion, but many do not, and their choice should be respected. Meanwhile, it is important that post-abortion counselling services be made accessible to any woman who seeks such services.

6.3.2 The decision to have an abortion The mention in the Green Paper of greater openness and willingness to talk about crisis pregnancy and abortion is welcomed by Abortion Reform as an indication of the greater acceptance of abortion as an option for many women with crisis pregnancies.

Chapter 6 of the Paper considers how women who are faced with a crisis pregnancy consider the implications for them of becoming mothers. The discussion on women's decisions to have an abortion outlines how a pregnancy outside the context of marriage can be seen as a crisis in itself. This indicates how we as a society shape ideas and norms about when it is appropriate for women to mother. The centrality and essentialism of the nuclear family based on marriage in Irish society is a principal factor in this. It has resulted in the image of motherhood outside of this context as being seen as a very costly one for women.

It is striking to see the extent to which motherhood is a role which is unsupported, with the result that mothers are precluded from combining this with other social and economic roles. Single women with a crisis pregnancy were described as dependant on informal and private sources of support if they wanted to become mothers. In our society, lone motherhood puts women and their children at risk of poverty. Thus, we as a society need to address how much we value women as mothers and how much support we will give them in this role. To this end, measures such as State-sponsored childcare and extended maternity benefit and protection are necessary.

Adoption is also discussed as an alternative in this Chapter, and the Green Paper points out that those opposing any legalisation of abortion urge that women should instead be encouraged to consider adoption. While it is important to facilitate women who choose this option, equally with the other options, it should be remembered that the process of going through a pregnancy and giving birth, as well as becoming a mother, has many implications for women. Many women will not want to go through this process if they feel unable to take on motherhood themselves once the child is born. In this sense then, Abortion Reform believes that adoption cannot be considered as a real alternative to abortion.

CHAPTER 7
POSSIBLE CONSTITUTIONAL AND LEGAL APPROACHES

7.1 Options presented in the Green Paper

Abortion Reform supports the legalisation of abortion in Ireland. This outcome is more important than the process by which it is to be achieved. Thus, Abortion Reform would support either a Constitutional referendum, or legislation, or a combination of both, once the effect of the process would be to legalise abortion in Ireland. The very minimum form of legalisation which Abortion Reform could support would be to allow abortions to be performed where the pregnant woman's life was in danger (ie the test outlined in the *X* case).

7.1.1 Option 1

Absolute Constitutional Ban on Abortion This approach is strongly opposed by Abortion Reform. It has been proposed by a number of anti-abortion groups, and would necessarily entail the amendment of the constitution by the removal of Article 40.3.3 and its replacement with another wording, which would rule out abortion in all circumstances including where necessary to save the life of the pregnant woman (the only circumstance in which abortion is presently lawful under the *X* case test).

Proponents of this view argue that medical treatment, where the loss of the foetus is the indirect consequence of treatment necessary to save the pregnant woman's life, would still be permitted. However, this distinction between so-called 'direct' and 'indirect' abortion is medically controversial (see above) and impossible to frame legally, without generating much litigation and tremendous confusion for medical practitioners. It is submitted that it would be unsafe to rely upon a definition whose meaning is not widely understood even within the medical profession.

Indeed, the contention that 'direct' abortion is never necessary to save a pregnant woman's life is not widely accepted among the medical profession (see chapter 1 of the Green Paper on Pregnancy and Maternal Health, and the conclusion reached at para. 7.24 of the Green Paper. See also Chapter 1 of this document for the Abortion Reform discussion of the Green Paper on this issue).
The proposal for an absolute constitutional ban is therefore opposed by Abortion Reform for the following reasons:

(i) A ban on any form of abortion necessary to save the lives of pregnant women would of necessity endanger the lives of pregnant women.

(ii) It would be unsafe to rely upon a spurious distinction between 'direct' and 'indirect' abortion in order to save women's lives.
(iii) No form of wording has been put forward which would further limit the *X* case test, without endangering women's lives.
(iv) Any wording which purported to bring about a complete ban on 'direct' abortion would generate complex litigation on a case-by-case basis, and would present impossible dilemmas for doctors in practice.
(v) The twelfth amendment was rejected by the people in November 1992. If passed, it would have had the effect of limiting the *X* case test to situations where the threat to the pregnant woman's life was a physical one, not including suicide. Thus, an attempt to restrict the *X* case test has already failed and should not be repeated.

7.1.2 Option 2

Restriction of the application of the X case test This option is opposed by Abortion Reform, for the reasons given above. This option was explicitly rejected by the people in November 1992.

7.1.3 Option 3

Retention of the status quo This option is again opposed. It is simply not an acceptable option for Abortion Reform. Two cases have already come before the courts in which young girls' lives have been held in the balance. They have been permitted to have abortions only because they were both suicidal as a result of their pregnancies. If in the future a case were to come before the courts, where the pregnant woman or girl was not suicidal, the court would under the present law have to rule that abortion was not lawful in her situation.

Where a woman with a crisis pregnancy who wished to have an abortion could not exercise her right to travel, because for example she was a ward of court or an asylum-seeker with no lawful means of leaving the country, she could then be forced to continue her pregnancy against her will, under court order. This would place the Irish courts in an untenable position of enforcing physical and mental hardship upon a pregnant woman. It would lead the Irish state into potential conflict with international human rights instruments (see Chapter 3 of this Submission for further discussion).

Thousands of Irish women continue to travel to England for abortions every year, most of whom seek to obtain abortion under grounds wider than those permitted in the *X* case test. Irish law at present simply does not cater for these women. It is time that their position was clarified in law.

Finally, doctors and healthworkers are operating in an unacceptable legal vacuum at present. The law is not clear as to when a doctor may perform an abortion; how he or she is to determine the existence of a 'real and substantial risk', and up to what stage in the pregnancy this risk can operate to justify the performance of an abortion. These matters must also be clarified.

7.1.4 Option 4

Retention of constitutional status quo, and legislative restatement of the prohibition on abortion Abortion Reform also opposes this option. It would involve the further criminalisation of those women seeking abortion, together with their doctors. It would make the present criminal provisions contained in sections 58 and 59 of the Offences Against the Person Act 1861 even more severe than at present, since it would restrict the defence presently open to doctors under the interpretation of those sections in the *Bourne* judgment (see above).

The *X* case test is more restrictive than the test applied by the Court in *Bourne*, so doctors would have even more reason to be concerned about criminal liability than they are at present in cases where terminations are medically necessary to save women's lives. Thus, this option would again potentially put women's lives at risk. It is submitted, further, that the criminal law is not the appropriate legal route to deal with abortion at all. Abortion Reform would favour the deletion of sections 58 and 59 and their replacement with a statutory regime for abortion without criminal sanctions.

The option suggested at para. 7.45 of the Green Paper, that the defence based on psychological or psychiatric grounds be excluded from the legislation, is simply not feasible under the present constitutional regime. It is opposed by Abortion Reform on the same basis as the present option 2 of the Green Paper.

7.1.5 Option 5

Legislation to regulate abortion in circumstances defined in the X case Abortion Reform supports this option as a minimum necessary to protect the lives of pregnant women. However, Abortion Reform believes that ultimately abortion should not be regulated through the Constitution at all, but rather, solely through legislation. This would involve the repeal of Article 40.3.3. In the interim, prior to its repeal, the implementation of the *X* case test through facilitative legislation is supported.

Option 5 would involve no change to the Constitution, but rather would involve implementation of the *X* case test through legislation, thereby enabling abortions to be performed lawfully in Ireland where a 'real and substantial risk' to the life of the pregnant woman had been established.

Abortion Reform supports this as a minimum position, since Abortion Reform believes that this option would go some way towards fostering a climate wherein abortion would be dealt with as a private matter between a woman and her doctor.

7.1.6 Option 6

Reversion to the pre-1983 position Abortion Reform believes that abortion should be regulated through legislation and not through the Constitution. To that extent, a reversion to the pre-1983 position is supported, because that would necessitate the deletion or repeal of Article 40.3.3. However, this approach would only be supported if the deletion of Article 40.3.3 were to be accompanied by the replacement of the relevant provisions of the 1861 Act with the passing of legislation to allow for abortion.

Abortion Reform notes and supports the point referred

to at para. 7.63 of the Green Paper (made in the Constitution Review Group Report), that a reversion to the pre-1983 position would also require that doctors would be afforded legislative protection for appropriate medical intervention, beyond the potential protection offered by the *Bourne* judgment. Otherwise, the law would continue to lack clarity. In the absence of any constitutional prohibition on abortion or any protective legislation, the 1861 Act as interpreted in *Bourne* would be the only law in the area.

Irish doctors might well query the extent of protection offered by that judgment to any intervention they might feel necessary to save the lives of pregnant women. Moreover, without protective legislation, this option would entail litigation on a case-by-case basis to determine the respective pre-1983 implied constitutional rights of the pregnant woman as against her foetus.

7.1.7 Option 7

Repeal of the Eighth Amendment and Permitting of Abortion on Wider Grounds than in the X Case Abortion Reform believes that Article 40.3.3 of the Constitution should be repealed, given the complications which have arisen as to its interpretation, and in order to afford women access to abortion in more than life-threatening situations. Abortion Reform favours the regulation of abortion through a legislative framework, on a broader basis than on *X* case grounds.

In the event that the matter is to be dealt with through Constitutional amendment, then Abortion Reform believes that the only meaningful way in which to enable the exercise of true democracy on this issue is to put the question by way of a 'preferendum'.

Another referendum based simply on a yes/no approach could not provide any satisfactory solution to the problem of how to regulate abortion. A preferendum would enable a number of options to be put to the people, perhaps based on the options set out in the Green Paper and commented upon here. Only such a preferendum would be capable of providing a final resolution to the issue of abortion.

Past votes and past experience have shown the broad spectrum of views which people have on abortion. A preferendum-type vote would be the only way in which this broad spectrum could be truly reflected in a meaningful way. If such a preferendum were to be held, Abortion Reform would support the option of deleting Article 40.3.3 and replacing it with legislation, which could be published in advance as with the Divorce Referendum. Such legislation could specify the grounds on which abortion was to be made available (rape, incest, foetal abnormality etc.) and the conditions under which it might lawfully be carried out.

As to the different grounds on which abortion might be carried out, again these could be put to the people in a preferendum-style vote, so that the option of lawful abortion where a risk to the health of the pregnant woman existed, the option of abortion in cases of rape or incest etc. would all be put to the people. People could then decide for themselves in which of these situations, if any, they believe abortion should be legal.

Abortion Reform View on Grounds for Lawful Abortion Abortion Reform accepts that abortion should be lawful in cases of risk to the health of the pregnant woman, in cases of rape or incest and in cases of congenital malformations. In all such situations, Abortion Reform believes that the issue of whether or not to have an abortion should be a matter to be decided between the woman and her medical adviser.

As to the other options of making abortion legal for economic or social reasons, or upon request, Abortion Reform recognises that if there is a genuine desire among Irish people to address the issue of abortion honestly and rationally, then we can no longer ignore the numbers of Irish women having abortions in England on grounds wider than those of threat to life, foetal abnormality, rape and incest. Consideration must be given to legalising abortion on grounds wide enough to encompass those women.

7.2 Conclusion

Abortion Reform supports the legalisation of abortion in Ireland. This outcome is more important than the process by which it is to be achieved.

If the Constitution is to be amended, Abortion Reform supports the holding of a Preferendum-type vote, in which a number of options for reform of the law would be put to the people, including an option or options extending the grounds under which abortion might lawfully be performed, beyond the *X* case ground. In that context, Abortion Reform would support the repeal of Article 40.3.3, and its replacement by legislation regulating the conditions under which abortion could lawfully be provided.

If the Constitution is not to be amended, Abortion Reform calls for the introduction of legislation to implement the *X* case test, permitting abortion where a pregnancy poses a real and substantial risk to the life of a woman. This would be the very minimum option acceptable to Abortion Reform at this time.

IRISH CONGRESS OF TRADE UNIONS
29 OCTOBER 1999
RESPONSE TO GREEN PAPER ON ABORTION

1 INTRODUCTION

1.1 Congress welcomes the Green Paper on Abortion. The Green Paper identifies in an objective and well researched manner the legal and social complexities of this issue. It confirms that in 1994, the latest year for which full figures are available, over 4,500 women, normally resident in the Republic of Ireland, had legal abortions in England and Wales. The ratio of such abortions to live births in the State is almost 1 to 10.

1.2 When the Eighth Amendment to the Constitution was proposed in 1983, the Congress opposed it. We stated then that the amendment was unnecessary and that it would be unwise and undesirable to proceed with it. All of the issues raised in this Green Paper confirm the validity of that position.

1.3 In accordance with the decision of the Supreme Court in the 'X' case, in circumstances where there is a real

and substantial risk to the right to life of the mother, there should be available within this jurisdiction facilities to legally terminate pregnancies. In the absence of legislation defining how the equal right to life of the mother is to be protected in such circumstances, the health, welfare and civil rights of women in this country will continue to be threatened.

2 RECOMMENDATIONS

2.1 Congress is opposed to any further amendment to Article 40.3.3. of the Constitution as any new wording introduced by way of a further amendment would inevitably be vague and imprecise and give rise to further uncertainty.

2.2 Congress supports the enactment of legislation to give effect to the decision of the Supreme Court in the 'X' case so as to ensure that where there is a real and substantial risk to the right to life of the mother, facilities to legally terminate pregnancies are available in this jurisdiction. Sections 58 and 59 of the Offences against the Person Act,1861 should accordingly be repealed.

2.3 Increased resources should be made available to Health Boards, schools and family planning service providers, so as to enable more education, information and comprehensive family planning services to be available to all who require and need them.

THE WOMEN'S COMMITTEE OF THE IRISH COUNCIL FOR CIVIL LIBERTIES
29 NOVEMBER 1999
SUBMISSION TO THE JOINT OIREACHTAS COMMITTEE ON THE CONSTITUTION

For a discussion of the present Irish law on abortion, in an international context, see Kingston, J., Whelan, A. and Bacik, I., Abortion and the Law, *Dublin: Round Hall/Sweet & Maxwell, 1997.*

This document is an updated and revised version of the document submitted by the ICCL Women's Committee to the Government Working Group on Abortion.

1 THE IRISH COUNCIL FOR CIVIL LIBERTIES (ICCL)

The ICCL was founded in 1976, and is an independent voluntary membership organisation that works to defend and extend human rights and civil liberties. Civil liberties are a precious democratic inheritance. They include the traditional freedoms such as freedom of expression and association, freedom from arbitrary arrest, the right to silence and to a fair trial. They also encompass the right to be free from discrimination on grounds of gender, race, ethnic origin, religion, sexual orientation, disability etc. And in today's diverse world, civil liberties include rights of cultural self-esteem and resourcing, e.g. for ethnic minorities.

Increasingly, the ICCL operates in partnership with civil liberties groups in other European member states, exercising vigilance to ensure that, in a single-state Europe, essential rights and liberties are not whittled away for the sake of political and administrative convenience. There are also opportunities in the international human rights arena. For example, in 1993 the ICCL contributed to holding Ireland's record to account for the first time before the United Nations Human Rights Committee.

Part of the ICCL's work includes monitoring proposed legislation, influencing legislators and mounting public campaigns. The ICCL was particularly active in the campaigns leading to the decriminalisation of gay sexual behaviour (1993), the ending of the State of Emergency (1995), and the lifting of the Constitutional ban on divorce (1995).

The ICCL is affiliated to the International Federation for Human Rights (FIDH), and works closely with the Committee on the Administration of Justice (Northern Ireland), the Scottish Human Rights Centre and Liberty (England).

The Women's Committee is established under the Constitution of the ICCL and has the responsibility for researching and monitoring issues concerning all aspects of human rights affecting women.

2 THE NEED FOR A RIGHT TO ABORTION IN IRELAND

2.1 The extent of abortion among Irish women: facts and figures

Since 1970, over 72,000 Irish women have had abortions in England (Irish Medical Times, Vol. 30 No. 6, Feb. 4,1996). In 1995, some 4,532 Irish women are recorded as having had abortions in Britain. Using these figures, the Irish abortion rate is 5.6 abortions per 1,000 women aged between 15 and 44 (the standard method of calculation, cited in Mahon, Conlon & Dillon, Women and Crisis Pregnancy, 1998, Dublin: Official Publications Office). Mahon et al also use an alternative measure, and calculate that in the same year, 8.5% of all conceptions (excluding miscarriages) ended in abortions.

This official figure may mask the number of Irish women having abortions in Britain, who give false addresses in Britain in order to conceal their identity or origin (See, e.g. p.2, Abortion Information Handbook, Irish Women's Abortion Support Group, May 1995).

These figures indicate that there is a need for abortion among Irish women. At present, for many Irish women this need is addressed through the relative ease of travel to Britain, and the provision of abortion by reputable clinics in Britain. However, for the most vulnerable women in our society; the young, the poor, the unwell, or those with disabilities, it is simply not enough that abortion is available in Britain. For those who are unable to travel, but who need to obtain abortions, Irish society at present offers no remedy.

2.2 The law on abortion in Ireland: the extent of legal uncertainty

Abortion is constitutionally permissible under the Supreme Court judgement in the *X* case (*AG v. X [1992]* 1 IR I), as confirmed more recently by the High Court in the C case (High Court, unreported, November 28, 1997), where there is a 'real and substantial risk' to the life of the pregnant

woman, which can only be avoided by a termination of her pregnancy. Further, although abortion is a criminal offence under sections 58 and 59 of the OAPA 1861, *R. v. Bourne* [1939] 1 KB 687 again provides that a doctor who performs an abortion where she or he believes that the continuance of the pregnancy would make the woman a 'physical or mental wreck' has a full defence to these sections.

However, no doctors will perform abortions in Ireland at present, due to their lack of certainty over the law. This has been further complicated by the Guidelines issued by the Medical Council on 26 November 1998. (Referred to in Paragraph 2.28 in the Green Paper on Abortion.) These guidelines place a doctor at huge risk of being struck off the register for carrying out a constitutionally permitted abortion. Legislation is needed to clarify the present constitutional situation in order that a woman is afforded her constitutional right to have an abortion in circumstances where there is a real and substantial risk to her life. While the ICCL Women's Committee is recommending in this submission that Option (vii) should be accepted the ICCL Women's Committee recommends that in the interim before such constitutional referendum immediate legislation is necessary to implement the *X* case. This legislation shall provide for legal abortion where the woman's life is at risk by reason of her pregnancy (see Section 3 of this submission). We are clear, however, that the figures on abortion show that Irish women need, and indeed are obtaining, abortion, in a much wider range of circumstances than would be allowed for under the *X* case test.

2.3 Changing public opinion on abortion

Further, public opinion has recently tended to indicate a greater acceptance of the need for abortion in Ireland; in November 1992, the proposed Constitutional Amendment which would have restricted the *X* case test by ruling out suicide as a ground for lawful abortion was defeated; and in a recent *Irish Times*/MRBI opinion poll, 77% of those surveyed in December 1997 said they believed that abortion should be permitted in the State (See *Irish Times* report, December 11, 1997). Furthermore, an *Irish Times*/ MRBI Opinion Poll (*Irish Times*, November 8, 1999) shows that 32% wish the law to remain the same and 16% wish to have legislation enacted. There is an ambiguous 50% who wish a Constitutional referendum.

2.4 Conclusion: the need for a right to abortion in Ireland

Given the reality of abortion in Ireland; given the clear expression of public opinion in favour of information and travel, and against restricting the ground for constitutional abortion, in 1992; given the recent expression of support for abortion rights; and given that Ireland is now marked out among EU countries, and indeed internationally, through our restrictive laws on abortion; there is clear need for change in the law to allow for free, and freely available, abortion in Ireland. In other words, Irish women should have the legal right to abortion.

In order to achieve this, the ICCL Women's Committee believes that the Eighth Amendment must be removed, to allow for such a legal right to be established through enabling legislation. This is the only solution which will fully resolve the present legal uncertainty, and which will satisfy the long-term needs of Irish women.

3 ICCL RECOMMENDATIONS

3.1 The Green Paper on Abortion

The ICCL Women's Committee recommends that Option (vii) of the Green Paper be accepted. It is the only manner in which the women will be guaranteed access to freely available abortion within this jurisdiction. In that regard it is clear that repeal of the Eighth Amendment (Article 40.3.3 of the Constitution) is necessary. Furthermore Section 58 and 59 of the Offences Against the Person Act, 1861 should be repealed. Other legislation would then have to be passed so as to ensure that there are no barriers to women's access to abortion (such as may be necessary to give doctors a specific guarantee against the Medical Council).

3.1.1 Option (vii) (e) This is the option that the ICCL Women's Committee recommends. For women, access to abortion is a question of human rights:

> A restrictive abortion law does have a significant impact in perpetuating women's oppression. It exacerbates the inequality resulting from the biological fact that women carry the exclusive health burden of contraceptive failure … moreover, a restrictive abortion law requires a women with an unwanted pregnancy to carry that pregnancy to term with all the consequent moral, social, and legal responsibilities of gestation and parenthood 'International Human Rights and Women's Reproductive Health', Cook, Rebecca in *Women's Rights Human Rights: International Feminist Perspectives,* Peters, J. and Wolpor, A. Eds. London: Routledge, 1995)

While abortion on request could be subject to legislative limitations, it is clear that any such legislation should not be so restrictive as to nullify the right.

Countries such as The Netherlands have liberal abortion laws and also have publicly provided sex education and accessible contraceptive information and services which result in a lower abortion rate. It is clear from the statistics available that Irish women do avail of abortion services in considerable numbers. A liberal abortion regime in combination with a more mature public reaction to sex education and contraceptive is in fact likely to reduce such abortion rates.

The ICCL Women's Committee does not consider it appropriate to discuss in detail the further options set out under Option (vii) as these are clearly more restrictive than Option (vii) (e). There would be concerns however if any legislation that purported to give more liberal access to abortion resulted in further institutionalised oppression of a category of individuals. In this regard while it is clear that a woman should have access to abortion on request (for her own reasons) we would be concerned if Option (vii) (c) were to be enshrined in law in isolation. This would be to select a group of individuals, namely people with disabilities and say that society deems their existence less valuable than others. This would be a retrograde step.

The ICCL Women's Committee would favour a repeal of the Eighth Amendment and its replacement with legislation allowing abortion. In the interim the ICCL Women's Committee would recommend the introduction of legislation to implement the X case test, as the minimum legal reform which can be carried out without amending

the Constitution. The ICCL Women's Committee supports the conclusion of the Constitution Review Group (see their Report to Government, May 1996) that such legislation should be introduced; and the ICCL Women's Committee believes that this should be done as soon as possible. The ICCL Women's Committee also believes that the law should be changed in the following ways:

3.2 Criminal law: The Offences Against the Person Act 1861

The lack of certainty over the effect of the OAPA on abortion again demonstrates the need for new legislation. Recent reports indicate that a retired doctor may be prosecuted for carrying out abortions in Dublin in recent years; if such a prosecution takes place, the doctor may be able to rely upon the decision in *R. v. Bourne* [1939] 1 KB 687 (in which abortion was held permissible under the Act where the pregnancy threatened to make the woman a 'physical or mental wreck'). Given that, apart from this potential case, the criminal law on abortion has fallen into disuse, and that all sides in the abortion debate are of the view that women who terminate their pregnancies should not be treated as criminals, the continuing criminalisation of abortion under this Act is an anomaly. Indeed, the German Constitutional Court has described the criminalisation of abortion as being counterproductive, both for the pregnant woman and for the foetus.

The ICCL Women's Committee therefore recommends the repeal of sections 58 and 59 of the OAPA, and the decriminalisation of abortion.

3.3 EU Law

3.3.1 Information on abortion The ruling of the ECJ in 1991 (the Grogan case) gave rise to the inference that information providers here might establish contacts with clinics in England, and thereby claim a right under EC law to disseminate information on the services offered by those clinics. It is still open to testing. It may be that section 6 of the Regulation of Information (Services Outside State for Termination of Pregnancies) Act 1995, which prohibits persons supplying information on abortion from having any 'interest, direct or indirect' in any clinic offering abortion services outside the State, is thus in breach of EC law. The recent Aadams Family Clinic case exposes how some pregnant women may be exploited when they seek counselling in respect of pregnancy. No pregnant woman can be guaranteed that the entire range of options available to her will be fully explained.

The ICCL Women's Committee therefore recommends that section 6 of the 1995 Act should be repealed or modified to prevent any potential conflict with EC law.

3.3.2 Protocol No. 17 to the Maastricht Treaty (February 1992) There is still uncertainty over whether the Protocol is effective, in the light of the Solemn Declaration and the November 1992 Amendments to Article 40.3.3. It would seem that even after the enactment of the Travel and Information Amendments, conflict is still possible between Irish constitutional or statute law on abortion, and substantive EC law, which conflict the Protocol and Declaration would be expected to resolve. Curtin (*Irish Times*, March 2,1992) has argued that the ECJ would not permit the Protocol to be used by the Irish courts to restrict either travel or information; although she admits that the intention of the parties as clearly to reserve exclusive jurisdiction on the issue of information to the Irish courts.

This being so, the Declaration contradicts this expressed intention, but a number of arguments may be offered against reliance on the Declaration, in particular the argument that it conflicts with the Protocol and is therefore implausible. It is almost impossible to predict how the ECJ would interpret the Protocol and Declaration, although their preference would presumably be to rely upon the Declaration, as this would allow them to maintain intact the body of EC law on abortion and related areas.

Given this doubt over the effect of the Protocol, the ICCL Women's Committee recommends that at the next re-negotiation of the Treaties, the Declaration should be expressly made binding.

3.4 Travel

It is necessary, following the C case (*A and B v. Eastern Health Board, Mary Fahy, C and the Attorney General*, High Court, November 28, 1997), for the provision in legislation of a guarantee that all women should be able to exercise their right to travel to obtain abortions abroad, with the assistance of State agencies where appropriate. In particular, young women, wards of court, asylum seekers, and those whose ability to travel is restricted for other reasons should be given this guarantee.

The ICCL Women's Committee recommends that the right to travel should be guaranteed for all, and that State assistance to travel should be provided where appropriate.

3.5 The need for legislation on abortion: the defeated Twelfth Amendment of November 1992

In the Government Pamphlet published just before the passing of the Travel and Information Amendments, and the defeat of the proposed Twelfth Amendment to limit the test in the *X* case, it was expressly promised that if this Amendment was defeated, legislation would be introduced to implement the test in the *X* case. No such legislation has yet been forthcoming. This failure to legislate has been criticised strongly by the judiciary, most recently by Keane J. in, *SPUC v. Grogan* (No. 4), Supreme Court, unreported, March 6,1997, at p. 33 of his judgement, when he said:

> Almost five years have elapsed since that judgement [the X case] was delivered and successive governments have failed to introduce any form of statutory regime. It is not the function of this court to supplement this governmental and legislative inertia.

In the light of these comments, and the current uncertainty regarding the status of any abortions allegedly performed within this jurisdiction, the ICCL Women's Committee recommends that legislation to implement the *X* case test should be introduced forthwith. Recommendations as to the definitions such legislation should include are set out in the following subsection:

3.6 Content of legislation on abortion

3.6.1 Definition of the 'unborn' It is the view of the ICCL Women's Committee that it would be inappropriate to include any specific definition of the 'unborn' in the

Constitution, but again that the lack of certainty over the meaning of this term at present does show the need for legislation.

However, if such legislation were to define 'unborn' life as commencing from conception, such a definition could potentially outlaw those forms of contraception which might be described as abortifacient; such as the morning-after-pill, and the IUD. This would have dangerous implications for women's health.

Instead, the ICCL Women's Committee recommends that the legislation on abortion should contain a definition stating that the term 'unborn' should only apply to those foetuses that have attained viability, in the medical sense. The test for viability in an individual case would be left to the pregnant woman's medical adviser. Even where a foetus was deemed to be medically viable, clearly under the Constitution the woman's right to life would take priority where it was threatened by the continuance of her pregnancy.

3.6.2 Threat to the life of the pregnant woman The ICCL Women's Committee view is that there is no logic in the distinction adopted by the Supreme Court in the *X* case, between the 'life' as distinct from the 'health' of the pregnant woman. For the purposes of legislating under the *X* case, the ICCL Women's Committee recommends that such legislation should provide a test as to how to determine the existence of a threat to the life of the pregnant woman.

The 'Pro-Life Campaign' has repeatedly said that no situation arises where abortion is necessary to save the life of the pregnant woman. The ICCL Women's Committee agrees with the Constitution Review Group that it would be unsafe to rely on this understanding (see p. 277 of their Report). The *X* case was found by the Supreme Court to be just such a situation; the *C* case was also so found by the High Court in 1997; the death of Sheila Hodgers in 1983 may also have constituted such a case.

Moreover, in no other country in the world does such an understanding form the basis either of medical training or of the law in this area. It is, in fact, widely recognised that women do die of maternal causes, even in Western countries. Indeed, the latest issue of The Progress of Nations, the UNICEF report on achievements in child health, family planning and women's health, states that almost 600,000 women die in pregnancy and childbirth each year; in Western Europe the figure is one woman in 3,200; and in the US, one in 3,300 (Source: Valery Abramov, *Health Communications and Public Relations*, WHO, Geneva).

The ICCL Women's Committee recommends the following test be inserted into the legislation: that a pregnant woman should be entitled to an abortion where the continuance of her pregnancy would, in the opinion of her medical doctor or psychologist, constitute a real and substantial risk to her life, i.e. either her physical or mental integrity. Where such a risk exists to the woman's life, she is constitutionally entitled to have an abortion, and therefore any time limitation on this right contained in legislation would be unconstitutional. The ICCL Women's Committee therefore recommends that the legislation should not contain any time limit.

3.6.3 Protection for doctors who carry out abortions The ICCL Women's Committee recommends that the legislation should provide expressly for protection for those doctors who carry out abortions. It should also provide that health boards have a duty to ensure that women are able to obtain abortions where they are necessary under the Constitutional test. Further, the legislation should provide for sanctions, if necessary in criminal law, for those who may target, harass or intimidate doctors, support staff and patients at any stage in the process of seeking an abortion.

3.6.4 Abortion to be made available through the health system Central to the ICCL Women's Committee policy is the notion that the provision of abortion should be seen primarily as a medical issue; an issue of women's health; not a moral, ethical, religious or legal issue. Further, the ICCL Women's Committee believes that all women should have access to abortion on an equal basis. We do not want to see a two-tier system, such as exists at present, where those who cannot afford to travel are denied the access to abortion which the better-off have. Thus, the ICCL Women's Committee recommends that abortion should be made available through the health system, as accessible to medical card holders as it would be to private patients. As the Supreme Court of Canada has said in the landmark *Morgentaler* decision ((1988) 44 D.L.R. (4th) 385), not providing public health coverage limits and delays access to abortion. Such delay contributes to the ill health of women, and publicly funded abortion services thus benefit the public health.

4 CONCLUSION

In May 1996, the Constitution Review Group suggested five options that are possible in order to clarify the law on abortion. The Government's Working Group has since produced the Green Paper on Abortion that discusses seven options. Without a Constitutional Amendment, the ICCL Women's Committee believes that option (v) of the Green Paper is the most preferable. Thus, the application of Article 40.3.3, as interpreted by the Supreme Court in the *X* case, should be regulated by legislation. The ICCL Women's Committee would therefore recommend that as an immediate measure, legislation should be introduced to implement the *X* case test, covering such matters as definition of 'unborn', protection for appropriate medical intervention, and the certification of 'real and substantial risk to the life of the mother' (see the definitions provided above).

The ICCL Women's Committee's central recommendation however, is a Constitutional Amendment to remove Article 40.3.3. Legislation should then be enacted to ensure abortion on request is available. The ICCL Women's Committee therefore urges acceptance of option (vii) (e), in order to guarantee the right of women to obtain free and freely available abortion in Ireland.

THE WELL WOMAN CENTRE
NOVEMBER 1999
A RESPONSE TO THE 1999 GOVERNMENT GREEN PAPER ON ABORTION

INTRODUCTION, AND WELL WOMAN'S CREDENTIALS

The Dublin Well Woman Centre welcomes the publication of the Green Paper on Abortion, and its consideration by the All-Party Committee on the Constitution. In making this submission, we hope the Government will act to address the complex realities of Irish abortion.

For too long, Irish society has denied the realities of Irish women, who have felt themselves compelled, in *huge* numbers, to travel to other jurisdictions to terminate their pregnancy. Over the last twenty years, we estimate that at least 100,000 Irish abortions have taken place. The fact that one in every ten Irish pregnancies now ends in abortion is a sobering one.

In the past, the debate on abortion has been increasingly polarised, to the point where the homes of Irish politicians have been picketed, and the legitimate operation of pregnancy counselling services have been invaded by so-called 'pro-life' demonstrators. This has had the effect of even further isolating within Irish society those women who, faced with a crisis pregnancy, have made the difficult decision to terminate that pregnancy.

The Dublin Well Woman Centre believes that public opinion in this country now recognises the complexity of issues that lie behind abortion. We hold that the Irish people increasingly recognise that the issue is not one of simple black and white imperatives. We contend that abortion is an issue of personal moral choices, and the Constitution is not the appropriate vehicle to delineate control over a woman's reproductive options.

Furthermore, we recommend the extension of education services, and the provision of better nationwide access to contraception and family planning services, with the aim of reducing the number of crisis pregnancies. Finally, this submission makes the case for the continuance of the rights to travel and information, and for the regulation of all pregnancy counselling services to ensure that there is no repetition of the traumatic 'Baby A' case that came to light in August 1999.

Well Woman's credentials

The Dublin Well Woman Centre was founded in 1978, with the goal of giving women control over their own reproductive well-being and family planning options, at a time when contraception was illegal in Ireland. This crusading zeal has often placed the organisation in the vanguard of divisive and draining campaigns.

This was most notable in 1986, when the Society for the Protection of the Unborn Child obtained an injunction restraining Open Door Counselling and the Dublin Well Woman Centre from furnishing women with information 'which encouraged or facilitated an abortion'. On appeal in 1988, the Supreme Court held that it was unlawful to disseminate information, including the addresses and telephone numbers of foreign abortion services.

In 1992, Open Door Counselling and the Dublin Well Woman Centre took a successful case under the European Convention on Human Rights, challenging the injunction which had prevented them from disseminating information. Since then, the Well Woman has continued to offer non-directive pregnancy counselling within the parameters of the Regulation of Information (Services outside the State for Termination of Pregnancies) Act, 1995.

The Dublin Well Woman Centre has developed significantly from its original brief, and now offers a comprehensive family planning and women's health service to over 55,000 clients annually, including a substantial GMS cohort.

Services available include full advice and provision of various forms of contraception (including vasectomy), cervical smear testing, breast examination, blood and STD screening, menopause clinics, and pregnancy and general counselling. A travel vaccination service will be offered from December 1999, and it is intended to introduce osteoporosis screening and advice in Spring 2000.

By its landmark victory in Europe in 1992, Well Woman justifiably claims to have changed the climate and consensus in Ireland, as far as a woman's right to reproductive self-control is concerned. We are proud of the high degree of professionalism, compassion and integrity with which our pregnancy counselling and information service is offered. (In 1998, over 1,400 women attended at one of Well Woman's three centres for pregnancy counselling).

With the background of twenty-one years of experience, Well Woman now makes this submission to the All-Party Oireachtas Committee on the Constitution.

ABORTION IN CONTEXT: PRIVATE MORALITY OR PUBLIC CONTROL?

Facing up to reality

In various forms, abortion has been practised since the earliest of times. The experience of the last twenty years makes it clear that no constitutional ban or legal sanction can effectively restrain Irish women who have decided to terminate a crisis pregnancy.

Furthermore, Well Woman is opposed to the insertion of clauses into the Constitution, which tend to criminalise those women faced with the need to seek abortion. We would like to see the removal of the 'stigma of criminality' from abortion, and would ask that the Oireachtas All-Party Committee on the Constitution give consideration to deleting sections 58 and 59 of the *Offences Against the Person Act, 1861*. It is the experience of our counsellors that many women feel that, difficult as the decision already is for them, it becomes more difficult as they are aware of doing something that may be classed as criminally wrong.

The Dublin Well Woman Centre is committed to the belief that abortion is a personal moral, ethical and social issue, which has no place in any Constitution. Therefore, we are opposed to the holding of yet another referendum. Both abortion referenda held to date have succeeded only in creating a climate of ambiguity and confusion, and a referendum serves no purpose in defining private morality.

The Third Report of the Second Joint Committee on Women's Rights (1988) also views the Constitution as 'too blunt an instrument' to deal with such a complex moral issue as abortion. The report makes the point that presenting the electorate with a 'yes' or 'no' choice does

not adequately tap the subtlety of their views. The exact quote is:

> In an increasingly complicated world where the rights of minorities must be respected, the Joint Committee feel that legislation should be sufficiently flexible to meet the complexities of modern life. The Constitution, with all its merits, is too blunt an instrument to use to govern such situations because, of its nature, it is too rigid and too difficult to amend to enable it to respond to the needs of a changing society. A person who is called on to answer 'yes' or 'no' to a single question put in a constitutional referendum cannot have regard to a range of nuances arising from the principle proposition even if they have been exhaustively discussed beforehand. This calls into question the desirability of regulating in the Constitution issues which closely affect women as well as other issues in such a way as to preclude flexibility of approach which is essential if the rights of women are to be preserved.

Well Woman's position is that of an organisation which is pro-choices for women, and our priority will continue to be on women having access to *all* the options and to non-judgemental information to enable them to make this most difficult decision. In this, we note that recent opinion polls have increasingly moved in the direction of support for abortion under limited circumstances.

Addressing the problem

Research carried out since the Supreme Court's decision in the 'X' case in 1992 has confirmed that clarification of the ambiguities inherent in the present legal situation is urgently required. Having stated our opposition to further constitutional amendment, Well Woman therefore calls on the All-Party Committee on the Constitution to recommend that legislation is passed to address the anomaly that exists between Article 40.3.3 of the Constitution, and the Supreme Court's decision in the 'X' case judgement that abortion should be permitted in certain, limited circumstances.

One approach would be to legislate to bring the 'X' case judgement into expression on the statute books (option 5 of the *Green Paper*). In stating this, we are mindful of the immense difficulties involved in defining the parameters for such legislation. We acknowledge the view expressed in the *Green Paper* that the number of suicides by pregnant women is extremely small, but it remains nonetheless a risk to the life of the mother, which must be considered.

We acknowledge the *Green Paper*'s premise that, given the high standard of healthcare presently available in Ireland, there can be few *medical* circumstances in which the life of the mother might be endangered, and that would justify directly the availability of abortion in this country. It is essential that any legislation passed specifies clearly and unambiguously those medical circumstances in which an abortion should be permitted, as well as clarifying the decision-making process that would be involved.

Well Woman cautions that it is almost impossible to define medical or other criteria that would not, in time, lead *de facto* to a liberal abortion regime. Some other jurisdictions have found that the only practical way of legislating for abortion is that of limiting the stage of pregnancy at which an abortion should be permitted, and this offers one model which should also be examined.

We also point out that many Irish women having terminations in clinics in the UK do so at later stages of the pregnancy than do their English or Welsh counterparts. The best current medical thinking advocates that abortion in the first trimester is significantly preferable to a later abortion, from the point of view of its impact on the woman's health. We can only conclude that the availability of services within this state would make it significantly easier for Irish women to avail of termination at an earlier stage, as well as having better access to a range of follow-up services.

Finally, Well Woman endorses the retention of the present status quo in relation to current medical freedom to treat a pregnant woman, as outlined in paragraph 2.28 of the *Green Paper on Abortion*.

A decision with life-long consequences

There are those in Irish society who may view abortion as an instant solution to a complex range of social problems. Well Woman refutes this. It is our contention, based on the experiences of those women coming to us for counselling, that the problem is longer term, and most women facing a crisis pregnancy and opting for a termination know that their decision is going to change their lives. We therefore welcome the increase in demand from women for post-termination counselling, and note that we are dealing with an increasing number of requests from *men* for post-termination counselling. This is to be welcomed.

Reducing the number of crisis pregnancies

Evidence suggests that the majority of abortions currently sought by Irish women who travel outside the state are sought for social and/or economic reasons. Elsewhere in this submission we will make the case for addressing some of the social factors that lead to crisis pregnancy and the need to consider abortion.

THE RIGHTS TO TRAVEL AND INFORMATION, AND REGULATION OF PREGNANCY COUNSELLING SERVICES

Some of the options outlined in the *Green Paper on Abortion*, if enacted, would have the effect of rowing back on the present right of Irish citizens to information regarding abortion, and to travel to seek an abortion. In particular, option 6 suggested by the *Green Paper* would, de facto, revert to the pre-1983 position and, with the deletion of Article 40.3.3, the travel and information provisions of the Article could not be maintained in their present form.

Anecdotal evidence from Well Woman centres indicates that many Irish people would wish to retain both the travel and information provisions as currently outlined. Indeed, we strongly state that attempting to restrict access to non-directive pregnancy counselling would plunge Ireland back into the dark ages, and would damage women's health, physically, mentally and emotionally.

In the consultation process involved in preparing this submission, Well Woman counsellors have recalled the years before the right to information was guaranteed, when many Irish women would travel to the United Kingdom for a termination with little or no understanding of the process which would be carried out, or its impact upon

them. Even more tragically, we can assume that they had not been made aware of any of the other options available to them, such as adoption or fostering, and probably had not had the opportunity to discuss these options in a supportive and non-judgemental environment.

While the advent of the Internet makes information available to those with the facility to access the web, many women continue to depend on agencies such as Well Woman for a clear presentation of *all* the options available to them when confronted with a crisis pregnancy.

We urge the All-Party Committee on the Constitution not to make any recommendations to Government that would have the effect of rowing back on the crucial, and basic, right to informed choice. Well Woman offers women (and their partners) a pregnancy counselling service that is truly non-directive in that all options are discussed, and clients are invited to come back for a second, or indeed third, session with a counsellor if they feel that they require additional time before making their decision.

Well Woman also offers clients the opportunity to come for post-termination counselling. Although the numbers using this service are slowly increasing, it is an unfortunate fact that relatively few women choose to avail of this. We must assume that they return to Ireland with little or no opportunity for open, supportive discussion of their situation and the decision they have taken.

On a separate but related issue, Well Woman wishes to use this submission to the All-Party Committee on the Constitution to underline the need for the appropriate regulation of pregnancy counselling services in Ireland. Many Irish people will have been shocked to learn of the actions of one specific agency, and its role in arranging illegal 'private' adoptions, which came to light in August 1999.

Well Woman has been aware since January 1997 of the activities of this agency, and has, over the last two years, sought to alert the relevant authorities to its activities. Furthermore, we have offered pregnancy counselling to up to two hundred women who had previously been to the agency in question (although we understand that many more may have been to this agency in the mistaken belief that it offered non-judgemental information on all options).

At time of writing this submission, the Dublin Well Woman Centre is assisting the Eastern Health Board with its enquiries into the operation of the centre. It would be wrong to pre-empt the conclusions of the Eastern Health Board's enquiry, and any subsequent legal action that may follow. Nonetheless, Well Woman calls upon the All-Party Committee on the Constitution to recommend to Government an appropriate regulatory and accreditation framework to oversee the operation of pregnancy counselling services within the state, as stipulated in paragraph 6.30 of the *Green Paper on Abortion*. We would be delighted to participate in the preparation of the appropriate guidelines for such regulation.

EDUCATION TO REDUCE CRISIS PREGNANCIES, AND OTHER OPTIONS

It is a disturbing reality that, despite Ireland's growing affluence, the numbers of 'crisis' pregnancies ending in abortion, and the number of teenage pregnancies, have risen steadily in recent years.

Recent research in the Midland Health Board area found that 44% of sexually active women between the ages of 18 and 45 were using no method of contraception at all. This begs several questions: Were all of these women hoping to become pregnant? Did they assume that pregnancy would not 'happen' to them? Did they have the opportunity to access family planning information and services?

Well Woman's own experience amongst its predominantly Dublin-based clientele also indicates some disturbing trends. In our three centres, we have noted a 65% increase in demand for emergency post-coital 'morning after' contraception in 1999 as against 1998. While we welcome the fact that our clients are aware of emergency contraception as *an* option, current medical thinking would advocate other forms of 'long-term' contraception as both more reliable, and also preferable from the perspective of a woman's health.

In the United Kingdom, one in every five pregnancies ends in abortion. In Ireland, one pregnancy in every ten ends in abortion – this in a country where abortion does not exist. Clearly, our education system is failing to equip young women *and* young men with information and a sense of personal responsibility regarding family planning. As far as Well Woman is concerned, the current high (and growing) numbers of Irish pregnancies ending in termination represents an embarrassing failure to educate our young people.

To address this, we advocate that the content of the Relationships and Sexuality Education (RSE) Programme be substantially altered to include detailed information on sexual and personal responsibility, and on *all* methods of contraception. The RSE programme needs to be rolled out nationally in a strategic and systematic manner, and not in the ad hoc way it is being done at present.

Information needs to be given in a way that is unambiguous, clear and consistent, and our young people need to be given the necessary assertiveness skills to make informed choices and say 'no' to a sexual relationship if they feel unready for it. To reinforce the sterling efforts of many teachers in delivery of the RSE programme at local level, Well Woman wishes to see the introduction of teams of trained and dedicated counsellors, who would be based in each of the health boards and who would visit schools within its 'catchment' area.

Furthermore, we advocate greater funding for information campaigns on contraception, including outreach programmes by agencies such as Well Woman to schools, etc. We do currently offer a limited education service by seeking, wherever possible, to respond to invitations from schools and community groups to give talks. When this happens, it means that a Well Woman doctor or nurse, all of them qualified and highly experienced in family planning, will visit a school or other group to discuss health issues and answer questions. However, this service is also operated in an ad hoc manner, as Well Woman lacks the financial resources to implement it on a more comprehensive and systematic basis.

We refute utterly the accusation that greater access to contraception for young people leads to greater reliance on contraception, and thence to more unwanted pregnancies and an increase in the number of abortions. We would point to the success of certain initiatives in the Netherlands, where a determined programme of sex education in schools and a readily available family planning service has resulted in the lowest teenage pregnancy rate *and* the lowest abortion rate in the western world.

Ireland has the youngest population in Europe, with almost half our people aged 25 or under. They deserve better service provision as far as family planning is concerned.

Finally, Well Woman recommends a root and branch review of the provision, and operation of adoption services in Ireland. The excellent research carried out in Trinity College, Dublin for the *Women and Crisis Pregnancy* report indicated that few women having a termination had considered carrying their baby to term and offering it for adoption. Well Woman is convinced that the introduction of more 'open' forms of adoption, combined with growing social acceptance of single parenthood, would make it a more attractive alternative, and might lead to more women considering adoption rather than termination.

EXECUTIVE SUMMARY

1 Well Woman believes that the Constitution is not the appropriate means of addressing the complex social, moral, ethical, religious and health issues that lie behind Irish abortions. Further referenda will not succeed in bringing clarity to the problem.

2 The 'stigma of criminality' needs to be removed from abortion by changing the relevant sections in the *Offences Against the Person Act, 1861*.

3 Legislation needs to be passed that tackles the anomaly between Article 40.3.3 of the Constitution and the Supreme Court's judgement in the 'X' case in 1992. One way of doing this would be to legislate for the 'X' case judgement, although this would require vigorous definition of those medical circumstances in which a woman's life is in danger. An alternative may be to legislate for the time limits at which an abortion may be performed.

4 Medical freedom to treat a pregnant woman, as currently expressed, must be retained.

5 Abortion offers no instant solutions, and it is essential that there is access to a comprehensive range of back-up services, including post-termination health checks, and post-termination counselling services – for women *and* men.

6 Well Woman strenuously opposes any legislative and/or constitutional changes which would have the effects of pulling back on the right to travel, and the right to non-judgemental information. To withdraw these rights would be the most retrograde of initiatives.

7 Regulation, as well as an appropriate accreditation mechanism, for non-directive pregnancy counselling services within the state is urgently required.

8 Education on sexuality and sexual responsibility, and access to comprehensive and affordable family planning, needs to be greatly improved in order to reduce the numbers of crisis pregnancies.

9 The system of adoption in Ireland is in need of examination, and may present a possible alternative to women faced with a crisis pregnancy.

WOMEN'S EDUCATION RESEARCH AND RESOURCE CENTRE
26 NOVEMBER 1999

ABORTION IN IRELAND – THE CURRENT SITUATION

There is a longstanding moral obligation on the political establishment in Ireland to deal with the issue of abortion. For over fifteen years, the issue has been fought over in the Oireachtas, in the media, on the streets and most frequently of all, in the courts. Repeated promises since the *X* Case by all political parties to legislate on abortion have come to nothing, despite extremely critical comments from the judiciary on this unacceptable political inaction.

> In the context of the eight years which have passed since the (Eighth Amendment) was adopted and the two years since Grogan's case the failure by the legislature to enact the appropriate legislation is no longer just unfortunate; it is inexcusable. What are pregnant women to do? What are the parents of a pregnant girl under age to do? What are the medical profession to do? (McCarthy J in *Attorney General v. X* Supreme Court 5 March 1992)

> Almost five years have elapsed since (the *X* case) judgement was delivered and successive governments have failed to introduce any form of statutory regime. It is not the function of this court to supplement this governmental and legislative inertia by the making of orders so uncertain and fraught with difficulty. (Keane J in *SPUC v. Grogan*, Supreme Court 6 March 1997)

Despite the fact that the Supreme Court ruling in the *X* case deemed abortion to be permitted under the Irish Constitution where there is a 'real and substantive risk' to the life of a pregnant woman, abortion is not currently being provided in any part of the health system in Ireland. In order to bring our health system into line with the *X* case judgement legislation is required to put it into effect. The *X* case decision has recently been confirmed in the High Court in the *C* case, but rather than provide the necessary service in Ireland, the Eastern Health Board was directly involved in the process of procuring an abortion for the girl in question in England.

Successive governments, since 1992, have promised to deal with the issue but, lacking the political courage and leadership, have failed to do so. This failure to deal with the issue has had serious consequences in leaving service providers operating in a position of legal uncertainty and potential vulnerability and in creating the conditions for the emergence of a new case of an individual girl who has been forced into a situation in which her right of access to abortion has had to be decided before the courts – the *C* case. There is no doubt that continued inaction, and specifically the failure to implement the *X* case judgement will result in future cases before the courts.

An important aspect of the current situation is the shift that has taken place in attitudes towards abortion among Irish people, reflected in many different opinion polls. In particular, attitudes of people around the time of the *X* case and the *C* case reveal a strongly expressed empathy among Irish people with the circumstances of individual women faced with crisis pregnancies. In the aftermath of the *X* case, in June 1992 an Irish Times opinion poll found

that only a minority (17%) opposed abortion in all circumstances. 64% of respondents favoured extending the grounds for legal abortion to 'special circumstances' including rape and incest and a further 18% favoured the availability of abortion where a woman's life is in danger. In the referenda carried out in November of 1992 a clear majority voted for information and travel rights and against the proposal to restrict the effect of the *X* case by ruling out suicide as a ground for abortion. A very significant finding in the most recent opinion poll carried in the *Irish Times* in December 1997, was that 28% of respondents took the position that abortion should be available in Ireland to whoever needs it. A further 49% of those surveyed believed that abortion should be available in specific circumstances. As well as showing that over three-quarters of respondents favoured the availability of abortion in Ireland, that poll also showed a large majority (72%) in favour of legislation.

While individual women, service providers and campaigning groups have been trapped in a legal quagmire, the scale of known abortions being carried out on Irish women has been rising. The latest official data from the UK Office for National Statistics indicated that over 5000 abortions were performed on Irish women in 1997. Over the period since 1990, around 30,000 Irish women have had abortions – about 70% of whom are between 20 and 34 years of age and around 15% are teenagers.

The underlying reason for this – a high level of unplanned and crisis pregnancies – has only begun to receive attention. The latest research indicates that about 50% of pregnancies are unplanned and that nearly 20% of these – one in five – end in abortion. Discriminatory and prejudicial attitudes towards single mothers together with a severe lack of sex education and appropriate services are clearly and directly contributing to the level of Irish abortion. (See Mahon, Conlon & Dillon. *Women and Crisis Pregnancy* Govt. Publications Office 1998).

In this context, it is evident that if Irish women did not have access to abortion facilities in Britain, we would be faced with a huge problem of backstreet, illegal abortions, as is the case in many countries across the world with extremely serious health and life consequences for thousands of women. This does not mean, however, that the current situation is in any way satisfactory. On the contrary, there are a number of serious issues which the lack of nationally-based services give rise to and which may yet become the subject of litigation in the future.

PROBLEMS ARISING DUE TO LACK OF IRISH ABORTION SERVICES

Our reliance on services available in another jurisdiction is morally, socially and medically irresponsible and creates insurmountable access problems for many women:

- It imposes severe financial burdens on women who must bear the cost of travel and accommodation in another country as well as the cost of accessing the service on the private marketplace
- It creates an information gap resulting in a situation in which many women travel for abortion without counselling and with little or no information of how and where to access services
- It means that many more women are having abortions at a later stage than would be the case if services were available locally
- It poses additional health risks and potentially serious delays on women who are experiencing health problems during pregnancy
- It means that women's medical histories and files are frequently unavailable to those providing abortion services to Irish women
- Abortion in another jurisdiction is not a realistic option for women in specific circumstances, as recent history has shown, and which is a matter of grave concern as these situations are potentially life threatening
  - Displaced women, for example women asylum seekers, who have no papers and are not in a position to travel
  - Women in the care of the State where their pregnancy is not defined as life-threatening
  - Women whose health does not permit them to undertake the journey
- It means that women operate under conditions of secrecy and are frequently unlikely to avail of after-care services
- Women and girls who have been abused – sexually and physically – resulting in enforced pregnancy may not be physically or psychologically capable of dealing with the additional trauma of travel and secrecy imposed by the absence of services in Ireland. Women and girls subject to violence within the home may not have the basic freedom of movement necessary to avail of services in another jurisdiction.

INTERNATIONAL CONTEXT

It is estimated that around 200,000 women die each year from illegal abortions. Most of these deaths occur in Third World countries, where abortion services are highly restricted or unavailable. Ireland is the only country in Europe in which abortion is totally unavailable. Within the European Union, the legal situation varies: in the Netherlands, France, Italy, Belgium and the UK abortion is available for social and economic reasons; in Spain, Portugal, Germany it is legal to preserve the health and life of a pregnant woman or where the development of the foetus is impaired; in Sweden and Finland it is available on request. Ireland is alone within Europe and the EU in refusing to recognise that the provision of abortion within the State can be necessary to preserve a woman's health. Despite this, the Irish Government has committed itself to the implementation of the Beijing Platform for Action following the Fourth World Conference on Women held in Beijing, China in 1995. The Beijing Declaration and Platform for Action include a clear commitment to women's reproductive health and choice:

> Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as to other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-

care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

The human rights of women include their right to have control over and decide freely and responsibly on matters relating to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

For the signing up to the Beijing Declaration and Platform for Action to have a practical effect in the Irish context, then the provision of abortion services within this country must form part of its implementation.

SPECIFIC CHANGES REQUIRED IN IRELAND

A number of linked legislative changes are necessary in order to ensure that the legal framework of this country protects, promotes and defends the physical and psychological well-being of women in this country.

1 Repeal of the Offences Against the Person Act 1861 which deems the carrying out of an abortion and the procurement of an abortion as criminal acts
2 Amendment of Regulation of Information (Services Outside State for Termination of Pregnancies) Act 1995 to delete Section 6, which prohibits persons supplying information on abortion from having a direct or indirect interest in a clinic providing abortion services outside the State
3 Deletion of Protocol No 17 of the Maastricht Treaty and/or to make the Declaration to the Treaty binding in order to ensure that Irish courts do not have the exclusive jurisdiction on the issue of abortion information.
4 Introduction of legislation to provide for abortion services within the State based on the protection of the physical, psychological and social well-being of all pregnant women and also to provide for the protection of those providing abortion services
5 Repeal of Article 40.3.3 of the Irish Constitution in order that a comprehensive reproductive health service may be provided for in this country, based on the needs and choices of individual women.

Together with these basic legislative changes, there is an urgent need for a significant restructuring of the health and educational systems so as to ensure that the promotion and protection of the health and well-being of women and girls is safeguarded and the scale of unwanted pregnancies in this country is reduced. To these ends, the following are necessary as a minimum:

1 Public funding for a comprehensive, free, safe and accessible contraception service in all areas of the country, including widespread availability of the morning-after pill
2 Access by all women to the full range of fertility, contraception, sterilisation and other reproductive-related information and services
3 Development of comprehensive relationships and sex education programmes within all levels of the educational system as well as in health and social services
4 Provision of comprehensive non-directive pregnancy counselling services in all areas of the country
5 Provision of safe, legal abortion services in Ireland where necessary to ensure women's physical, psychological and social well-being
6 Provision of comprehensive post-abortion care services.

CONCLUSION

Legislation is urgently required to liberate doctors, family planning clinics and counsellors from the appallingly confused and contradictory legal situation in which they currently find themselves. In light of the above remarks, it will be clear that we are in favour of the introduction of legislation and appropriate education and health services, and see no rationale for a further referendum.

We are of the view that any future referendum (other than one to repeal the Eighth Amendment to the Constitution, Article 40.3.3) can have no purpose other than to erode the equal right to life of a pregnant woman as currently acknowledged and would be as incapable as any previous referendum of grappling with the issues raised by perspectives on abortion in this country. At a minimum, this legislation should implement the terms of the *X* Case judgement – something which has been sought by many politicians, the judiciary, women's groups and others.

The provision of safe and legal abortion in Ireland should form part of a range of information and services relating to reproductive health: contraception, sterilisation, fertility treatments and sex education. The denial of such information and services to Irish women (and men) is a serious and fundamental curtailment of their human right to bodily integrity, health and dignity.

CATHOLICS FOR A FREE CHOICE
NOVEMBER 1999
ABORTION IN GOOD FAITH: REFORMING IRISH LAW

INTRODUCTION

In March of 1998, Catholics for a Free Choice made a submission to the Interdepartmental Working Group on Abortion to offer input to the 'Green Paper on Abortion' from a pro-choice Catholic perspective. CFFC's submission, 'Catholic Options in the Abortion Debate: Reforming Irish Law,' concluded from traditional Catholic principles that even in a country that is predominantly Catholic, laws governing abortion need not adhere to the Catholic hierarchy's narrowly defined position. The reasons cited were threefold. First, Catholic teaching and tradition, which stress the importance of conscience, leave room for a more nuanced position on abortion than that currently taken by the hierarchy. The Catholic Church has acknowledged that it does not know when a foetus becomes a person and has not declared its teaching on abortion infallible. Second, many Catholics themselves do not support the church's position on abortion and their opinion, not the hierarchy's should shape public policy. And finally, the Irish system has instituted a separation between church and state that makes it inappropriate for church doctrine to substitute as public policy.

While we recognise the right of religious institutions

to participate in the life of nations, it is equally important that the diversity of religious opinion and traditions be respected and promoted. The Irish system has instituted a separation between church and state and that must be honoured. The Green Paper is almost silent on this important issue or on concrete steps that need to be taken to honour the views of all religions on this matter.

Catholic teaching calls for respect for the freedom and beliefs of other faith groups and the church accepts the principle of church-state separation. This is especially important on an issue such as abortion, where the church hierarchy's position, as on the issue of contraception, is more conservative than the world's other religions. Many other faith groups accept the possibility of abortion's morality in some or many circumstances. In a pluralistic society in which many faith groups recognise the possibility of abortion's morality, Catholics need not work to legally restrict abortion. Current Catholic theology makes a clear distinction between the moral teachings of the Catholic Church and the right of legislators to use prudential judgement in developing public policy.

ETHICAL AND MORAL CONTEXT

In the 'Ethical and Moral context' section, the Green Paper notes that the Catholic Church hierarchy 'teaches that the direct and intentional killing of innocent human life at any state from conception to natural death is gravely and morally wrong' (sec. 5.42). However, as CFFC noted in its submission, Catholic teaching regarding abortion does not end with this stark ban. There is much room in Catholic theology for the acceptance of policies that favour access to reproductive health options such as contraception and abortion.

Catholic teaching gives primacy to the well-formed individual conscience as the final arbiter in moral decision making. According to the *Catechism of the Catholic Church*, 'a human being must always obey the certain judgement of his conscience.' Secondly, despite the seemingly firm-sounding pronouncement from the church hierarchy that life begins at conception, the reality is that the church does not know when the foetus becomes a person. The Catholic Church has always considered abortion sinful, but its opposition to abortion was strongly linked to its position on sexuality. For example, for much of church history, it was believed that only people who engage in forbidden sexual activity would attempt abortion. Today, the church does not officially teach that abortion is murder because the church has no formal position on when the foetus obtains a soul and/or attains personhood. Even in its definitive statement on abortion, the 1974 'Declaration on Procured Abortion,' the Vatican acknowledged that it does not know when the foetus becomes a person.

It is also important to note that the teaching on abortion is not infallible, although this is a popular misconception, which is tacitly fostered by the church hierarchy. The church has no theological position or factual way to determine the moment a foetus obtains personhood. And infallible teaching requires a consistent church position throughout history. The church has favoured different positions on when a foetus obtains personhood – usually not at conception but later stages in pregnancy – throughout its history. When the encyclical *Evangelium Vitae* was to be published in 1995, there was speculation that the encyclical would declare the abortion teaching infallible. However, use of the word 'infallibly' was ultimately rejected. The fact that this pope – who has made abortion a central theme of his papacy – did not specifically use the word 'infallible' can be read as a sign that such a claim cannot be made.

Equally important, in the Catholic tradition dissent from church teaching is permissible and the church has a long history of disagreement among its members on official teachings. The concept of probabilism allows thoughtful Catholics to dissent from church teachings that are wrong or in development as long as sound reasons for a differing position can be discerned. The process of discernment can involve prayerful discovery of non frivolous reasons for dissent in one's conscience or citing the dissenting views of a number of reputably theologians.*

The Green Paper further notes that the church hierarchy states that the lives of the foetus and the pregnant women 'are of equal value' (sec. 5.43). This equalisation of a fully formed human life with a potential life is a disservice to women who are here now struggling with the very real issues of lack of financial or emotional support or physical or mental health. The lack of availability of legal abortion in Ireland forces women to travel abroad to obtain a basic health care service, disregarding their health and disrespecting their dignity and moral decision making capacity as fully formed adults. It also places an undue burden on poor women, who under the Catholic social justice tradition should receive preferential consideration.

The Green Paper then goes on to mention CFFC's position, noting, 'A submission representing a broader Catholic tradition (outside Ireland) introduces a number of new dimensions to the ethical arguments concerning abortion and points to aspects of Catholic theology which, it argues, would allow for the acceptance of policies that favour access to a wide range of options, including contraception and abortion' (sec. 5.46). CFFC would like to expand on this comment, as we believe that it is evident that our submission is fully consistent with both the Irish Catholic experience and mainstream Catholic theology.

As far as the CFFC submission representing a Catholic tradition outside of Ireland, there is only one Roman Catholic Church. This church does not consist of separate nations and separate peoples. The people of god are the Catholic Church and the word Catholic means 'universal'. Within Catholic theology the term ' applies to the body of the faithful', and does not differentiate nations or peoples. Moreover, Catholics share in the development of church teaching through the principle of reception. The teaching authority of the church is trinitarian. It is not based solely on the statements of the hierarchy, but also on the work of theologians and the lived experience of the Catholic people. Father James Coriden, former president of the

* Richard McBrien's 'Catholicism' defines probabilism as '[t]he moral system which holds that one can safely follow a theological opinion if it is proposed by someone having sufficient theological authority and standing.' Moral theologian Daniel Maguire writes that probabilism gives 'Catholics the right to dissent from hierarchical church teaching on a moral matter, if they could achieve 'solid probability.' Maguire says this solid probability can be achieved through prayerful discovery in one's conscience of '"cogent", nonfrivolous reasons for dissenting from the hierarchicically supported view' or by citing the liberal dissenting view of 'five or six' reputable theologians.

Canon Law Society of America, noted that the principle of reception 'asserts that for a [church] law or rule to be an effective guide for the believing community, it must be accepted by that community.' This is the same for Catholics who live in the United States, the Philippines, Poland and Ireland.

The Irish members of the Catholic church – like Catholics elsewhere – clearly do not accept the teaching that abortion is always wrong in every circumstance. Public opinion proves it and the droves of women who travel to England and Wales each year to have abortions prove it. Seventy-eight percent of Catholics in Ireland say they follow their own consciences in making serious moral decisions. And only about half of Catholics in Ireland believe that abortion is always wrong when there is a risk of foetal abnormality. But it is the nearly 6,000 women who travelled to England and Wales last year for abortions who testify most eloquently to the rejection of the church's ban and its lack of legitimacy in influencing the public policy debate. According to a study on 'Women and Crisis Pregnancy' by Trinity College Dublin, an estimated 8.5% of conceptions in Ireland in 1995 resulted in abortion. Clearly these facts demonstrate that Irish Catholics, like the world's Catholics, have not received the church's teaching on abortion which contributes to the difficulty church leaders have in speaking infallibly on the issue.

Furthermore, the Green paper notes the widespread rejection in Ireland of the church's ban on contraception as the nation's fertility rate declined dramatically between 1980 and 1995. It is therefore incorrect to assert that CFFC's position represents a tradition outside of Ireland. Catholics in Ireland – like Catholics around the world – have forged their own ethics regarding reproductive health issues. Unfortunately, the Catholic Church still plays a considerable role in the way many in Ireland view sexuality and unintentionally contributes to the problem of unplanned pregnancy. The Green Paper notes the need for broader social reforms that would make contraception widely available and provide sexual education for young people. The Trinity college 'Women and Crisis Pregnancy' study found 'considerable ignorance of fertility cycles and a lack of knowledge about how to ensure effective contraception' (sec. 6.14). The study also found that women lacked the assertiveness to effectively negotiate contraceptive use and that men felt little responsibility for contraception. The study identified deeply rooted cultural biases against contraception, as sexually active women feared stigmatisation from their doctors or families from the use of oral contraceptives or from men for having condoms handy. These attitudes can be attributed in no small measure to the Catholic Church, whose patriarchy reinforces passive attitudes in women about fertility control and whose ban on contraception fosters the paradox of sexually active women who do not desire to become pregnant but take no action to prevent pregnancy.

Secondly, as illustrated above, the positions outlined by CFFC in our position paper are not 'new'. In fact, most of them predate the pronouncements of the current church hierarchy. It is this hierarchy that has chosen to reject the church's traditional reliance on individual conscience in moral decision-making, the ambiguity of the church's abortion position throughout the ages and the lack of definite knowledge of when life begins in favour of a 'modern', absolute abortion ban.

OPTIONS THAT SPEAK TO THE REALITY OF IRISH WOMEN'S LIVES

Clearly a solution must be reached that would allow abortion in Ireland under some circumstances. While the Green Paper noted that 'many Irish people regard abortion with abhorrence,' it also concluded that a total ban on abortion is not realistic because of even the remote possibility that women may require abortion in life-threatening instances. It also noted that the 'very significant' number of Irish women obtaining abortions in England and Wales means the 'issue must be addressed' (sec. 7.97).

Of the seven options laid out by the Green Paper, only one – number seven – is truly compassionate and reflects the social justice tradition of the Catholic Church and respect for the moral agency of women. The other six do not represent a range of solutions, but a narrow continuum of extremely restrictive policy options that range from explicit or de facto bans on abortion to very limited availability on a case-by-case basis. Option seven would permit abortion on grounds beyond those specified in the *X* case, ranging from risk to the physical or mental health of the woman to cases of rape or incest, congenital malformation, economic or social reasons and abortion on request. This is the only position that begins to reflect CFFC's assertion that women must be trusted to make the abortion decision in conjunction with husbands, partners, other family, doctors, clergy and other trusted advisors, and is most respectful of individual conscience.

Political forces may consider it more expedient to opt for options one through six, but political expediency aside, the reality is that any solution that does not truly reflect the reality of women's experiences will be short-lived. As with the ban on contraception in Ireland, the issue will wind up in the courts again and again until a solution that is compassionate and realistic is codified into law. The Catholic Church has come to accept democracy and the democratic process and this process gives certain responsibilities to legislators. While there are many options in the hands of the Irish people, legislators have an obligation to address the abortion issue in a way that is reflective of a commitment to justice and the well being of the Irish citizenry.

CFFC welcomes the opportunity to be a part of this continued dialogue on abortion in Ireland. While we respect the right of the Catholic Church to participate in the policymaking process, we respectfully submit that our position offers a lens for viewing this situation that can reduce the need for abortion while simultaneously respecting the rights of women.

THE ADELAIDE HOSPITAL SOCIETY
ADELAIDE & MEATH HOSPITAL, TALLAGHT
25 NOVEMBER 1999

The Adelaide Hospital Society welcomes the publication of the Green Paper on Abortion. The Society is happy to submit views on the Green Paper's options to The All-Party Oireachtas Committee on the Constitution.

In March 1998 the Society made a detailed Submission

to the Interdepartmental Working Party on Abortion (copy attached). The Society's views following the Green Paper's publication are still accurately reflected in the Submission of March 1998 which was based on expert medical advice to our Board.

The Society believes that the primary issues concern (1) the development of positive strategies to reduce crisis pregnancies and thereby the very high level of Irish abortions and (2) the provision of comprehensive healthcare to the great number of women who have had, or will have, terminations of pregnancies. These primary issues must be addressed by Government, by Irish society and by our healthcare system no matter which of the seven options, set out in the Green Paper, are selected. Our submission outlines how these primary issues might be addressed.

The Society is concerned that the narrower focus on the legislative or constitutional options which concern the All-Party Oireachtas Committee on the Constitution will deflect attention from the urgent need to address these primary issues. We are concerned that attention will be deflected from the preventive measures in relation to crisis pregnancies, which we recommended in our Submission, and from provision of proper healthcare for women. Both the specific health care provisions and the preventive measures are required regardless of which option the All-Party Committee eventually pursues.

The Society supports option 5 of the Green Paper as indicated in our Submission, i.e. legislation to regulate abortion in circumstances defined by the *X* case. This option we feel, offers the best protection for the lives of women whose medical condition indicates that a termination of pregnancy is necessary to save the life of the mother. It should be pursued in the context of the major development of a comprehensive health care service for women, which offers the best prospect of both reducing the unacceptably high rate of Irish abortions and of providing the optimum healthcare for Irish women.

THE ADELAIDE HOSPITAL SOCIETY
SUBMISSION TO THE INTERDEPARTMENTAL WORKING PARTY ON ABORTION

1 SUMMARY OF THIS SUBMISSION INCLUDING RECOMMENDATIONS

1 Specific care deficiencies of Irish women having termination of pregnancy at this time:

i) Many women do not receive any professional counselling before resorting to a termination of pregnancy in the UK
ii) Many women do not receive any post abortion professional counselling or contraceptive advice after having had a termination of pregnancy in the UK
iii) Few if any women receive a gynaecological assessment prior to travelling to the UK for a termination of pregnancy
iv) Few if any women receive an infection screen prior to having a termination of pregnancy in the UK.
v) Few if any women have a post abortion scan to determine whether or not retained products of conception (RPOC) are present. (Having RPOC dramatically increases the risk of post abortion sepsis and fertility compromise)

2 The current situation in respect of termination of pregnancy

i) The current constitutional and legal situation is highly unsatisfactory
ii) Irish women with crisis pregnancies deserve better care than that which they receive currently
iii) Too many women are having a termination of pregnancy
iv) It is possible to reduce the number of women having a termination of pregnancy when faced with a crisis pregnancy.
v) Many Irish women have termination of pregnancy at a later gestational age than their British counterparts
vi) Termination of pregnancy is more unacceptable (to everyone) during the second trimester than during the first
vii) Prevention of an unwanted pregnancy is infinitely superior to termination of an unwanted pregnancy
viii) Contraceptive accessibility is poor in many parts of the country

3 The ambitions of this submission

i) We wish to see far fewer terminations of pregnancy occurring
ii) Those women who have had a termination of pregnancy deserve much better healthcare than currently provided
iii) Termination of pregnancy where medically indicated is preferable and safer from a health perspective in very early pregnancy (< 8 weeks) than is termination of pregnancy after 12 weeks

4 Recommendations

1) The Relationships and Sexuality Education Programme (RSE) introduced in schools should embrace a comprehensive programme on sexuality and reproduction which should incorporate a full and frank information module on the various methods of contraception, including postcoital contraception. The recording and duty to notify to health authorities of teenage pregnancies in schools should be seriously considered so that follow up health care can be provided.
2) The government should introduce a national network of contraceptive provision including a number of choices for adolescents (family practitioners, family planning and wellwomen clinics, hospitals, community nurse specialists etc.). The emphasis should be not just on availability but also on accessibility, especially for the poor, the young and the socially deprived sections of our community. Provision of contraception and education should be made as far as possible according to people's choice.
3) There should be a national network of non directional crisis pregnancy counselling services provided in a variety of settings as described above for contraception.
4) There should be a Department of Health sponsored contraception health education programme both

immediately and on a continuing basis such that everyone in the country is aware that contraception, sexuality and reproduction education facilities are widely and freely available. A particular effort should be made to address the immature and irresponsible attitudes of men which underlie so many crisis pregnancies.

5) Contraceptive methods should be accessible to everyone.
6) There should be a number of (regional) gynaecology departments equipped to provide post termination of pregnancy medical service to women. These would include a routine ultrasound scan, a vaginal examination (when necessary), a cervical smear (where indicated) and an infection screen. These devoted clinics would be able to provide the full spectrum of contraceptive services currently available.
7) Health services provision should ensure a comprehensive family planning programme is available for all women.
8) Pregnancy tests should be free and freely available.
9) The Department of Health should fund research into:
   i) improving the uptake of contraception in women at risk of having an unwanted pregnancy
   ii) determining why women present late for counselling with a crisis pregnancy
   iii) the development of predictive pregnancy tests.
   iv) determining the optimum means of improving the availability and accessibility of contraception and postcoital contraception
   v) determining what it is that constitutes an acceptable and popular contraceptive service to those women at risk of having unwanted pregnancy
10) The Department of Health should establish clinics within a comprehensive women's health service provision to support women with crisis pregnancies. These clinics would provide a comprehensive crisis pregnancy service. They would provide a professional counselling and medical assessment service as well as performing medically indicated termination of pregnancy procedures whether pharmacological or surgical, under local or general anaesthesia. Furthermore the clinics would provide a comprehensive post abortion counselling and medical service.

The previous recommendations apply whether or not the Working Group decide to adopt this recommendation.

If the Interdepartmental Working Group decides not to advise the government to establish a termination of pregnancy facility in the jurisdiction it should give serious consideration to establishing a clinical liaison service to women having terminations of pregnancy in the UK. This would improve the post abortion care of Irish women having terminations of pregnancy in the UK.

2 INTRODUCTION

1 The Adelaide Hospital Society, a Christian and charitable organisation, has as its principal object the advancement of medicine, medical care, medical and nursing education and it serves as a means for the charitable participation in the health services of members of the Protestant Churches and those who support our healthcare services for the benefit of all people especially the poor of every denomination.

2 The Adelaide Hospital Society, has a long and continuing involvement in the healthcare of Irish women. The Adelaide Hospital was the first hospital in Dublin to provide a comprehensive service to women wishing to have a sterilisation performed. Today the society supports the Adelaide and Meath Hospital, Dublin, incorporating The National Children's Hospital. The Charter of the Hospital includes the important object:

> To promote and secure the availability as a matter between the patient and his or her doctor, of such medical and surgical procedures as may lawfully be provided within the State…

Respecting this patient doctor relationship is, we believe, fundamental to the ethos of the Hospital. The Society supports the development of a comprehensive women's health programme which will include effective healthcare for women before, during and after crisis pregnancies.

3 We feel an obligation to care for women in Ireland during all their health problems including the particular presentation of crisis pregnancy. This is now so prevalent in Irish society that it behoves us (and other hospitals caring for women) to take a serious interest in how best to accommodate crisis pregnancy needs and to develop our services accordingly.

4 1988 will see the Adelaide Hospital move to a new site in Tallaght and to face new challenges in that area. The most profound change for the hospital will be to provide a comprehensive gynaecology service to the female population of the communities we serve. Part of this comprehensive service should be to care for women with crisis pregnancies. A major component of this service will be to develop strategies to reduce both the numbers of those seeking termination of pregnancy and the period of gestation at which such a choice may be made by the women concerned. An exceptionally high proportion of women in Tallaght are of reproductive age and many of these are single. These women are at especial risk of having a crisis pregnancy and we wish to be prepared to deal with this as comprehensively as possible, within the law.

3 BACKGROUND

1 It is self evident that a major problem exists in Ireland concerning crisis pregnancy and we welcome the Government's initiative in this regard. Approximately 125 Irish women per week have a termination of pregnancy. These terminations take place in the UK rather than here but they are still 'our' abortions. Each one represents a failure and a tragedy. Not only is it a tragedy that Irish women are having terminations of pregnancy in such high numbers but also it is a tragedy that Irish women are having terminations of pregnancy at relatively late gestational ages. Finally it is an unnecessary and an added tragedy that these women often proceed to having a termination of pregnancy without any pre-abortion counselling, education or medical care. This is a circumstance which can and should be changed irrespective of whether the Working Party decides to advocate the introduction of termination of pregnancy services within the jurisdiction of Ireland.

During the last twenty years it has become evident that large numbers of women with unwanted pregnancies are deciding to have pregnancy terminations despite serious opposition to their choice and the lack of facilities for such terminations in the Republic.

It is also evident that many of these women receive seriously substandard pre and post abortion care. We have not had access to the recently completed report commissioned by the Department of Health concerning women who have termination of pregnancy in the UK but anticipate that this report will detail a number of areas where care can and should be improved.

2 Specific care deficiencies of Irish women having terminations of pregnancy at this time:

i) Many women do not receive any professional counselling before resorting to a termination of pregnancy in the UK
ii) Many women do not receive any post abortion professional counselling or contraceptive advice after having had a termination of pregnancy in the UK
iii) Few if any women receive a gynaecological assessment prior to travelling to the UK for a termination of pregnancy
iv) Few if any women receive an infection screen prior to having a termination of pregnancy in the UK
v) Few if any women have a post abortion scan to determine whether or not retained products of conception (RPOC) are present
vi) Having RPOC dramatically increases the risk of post abortion sepsis and fertility compromise.

4 AMBITIONS OF THE SUBMISSION

In making this submission, the Adelaide Hospital Society is conscious of the difficulties facing the Interdepartmental Working Group. Whichever proposals are detailed in the Green Paper, the Working Group is likely to receive sustained and public criticism most especially from groups who do not represent or have to provide for the actual healthcare needs of women. The Adelaide Hospital Society understands the following to be the case:

i) The current constitutional and legal situation is highly unsatisfactory
ii) Irish women with crisis pregnancies deserve better care than that which they receive currently
iii) Too many women are having a termination of pregnancy
iv) It is possible to reduce the number of women having a termination of pregnancy when faced with a crisis pregnancy
v) Many Irish women have termination of pregnancy at a later gestational age than their British counterparts
vi) Termination of pregnancy is more unacceptable (to everyone) during the second trimester than during the first
vii) Prevention of an unwanted pregnancy is infinitely superior to termination of an unwanted pregnancy
viii) Contraceptive accessibility is poor in many parts of the country

The ambitions/aspirations of this submission may be summarised as follows:

i) We wish to see far fewer terminations of pregnancy occurring
ii) Those women who do decide to have a termination of pregnancy deserve much better healthcare than currently provided
iii) Termination of pregnancy in very early pregnancy (< 8 weeks) is preferable and safer, from a health perspective than is termination of pregnancy after 12 weeks

A realistic attempt to achieve these three ambitions is entirely feasible *whether or not the Government decides to provide a termination of pregnancy service in Ireland.*

5 SUBMISSION

1 The legal/constitutional position

We claim no particular expertise concerning the legal or constitutional framework which has led us to where we are today. In our submission we wish to concentrate on the healthcare of women who have or have had crisis pregnancies.

It is essential, however, to medical practitioners and all concerned with health services for women with crisis pregnancies that a clear legal framework is put in place by the Oireachtas following the Supreme and High Court judgements in the *X* and *C* cases. Such legislation should address the circumstances in which a termination of pregnancy is legal.

2 For whom should the law be changed: the common or rare circumstance

A particular difficulty with the evolution of the legal situation is that it has been reactive rather than proactive. In other words the law and Oireachtas have responded to those exceptionally rare cases which have by their very nature demanded a response. The law and Oireachtas appear to have consistently chosen to ignore the common situation of crisis pregnancy. There are obvious reasons for this.

The UK has consistently accommodated the women from Ireland who present with the problem of crisis pregnancy and the Government in Ireland has not been faced with the usual alternative to legalised abortion i.e. illegal and very unsafe abortion.

For example 13 year old girls who are raped do not represent the usual circumstance of women with crisis pregnancy. Suicide is not usually the issue at stake for women with crisis pregnancies.

We now have a situation whereby very large numbers of Irish women, some very young, are travelling to the UK on a daily basis for a termination of pregnancy because they wish to do so. Because the UK provides an 'easy' avenue for these women, suicide is not an issue. To concentrate our efforts on how to deal with the rare and difficult cases does nothing for the 'routine' problems of ordinary women who are pregnant and do not wish to be. Many of these women are desperate to end their crisis. We ignore to our collective shame the needs of the 125 women per week travelling to the UK for a termination of pregnancy.

Likewise, arguments concerning the risks of a continued pregnancy in particular medical circumstances distract from the reality that the very great majority of women opting for a termination of pregnancy do so without significant risk to their life or health. This does not mean that con-

tinued pregnancy will not pose a real or substantial threat to the life of a woman in some cases (for example severe corrected congenital heart disease, some cancers, severe atypical hypertensive disorders etc.). However, we need to legislate for and accommodate these circumstances recognising we will still be left with the problem of how to provide supportive health services for the great majority of women with crisis pregnancy who will continue to travel to the UK.

3 Nomenclature

The word 'unborn' is an adjective not a noun. At term, just before birth, the baby which has not yet been born is correctly termed a foetus. In very early intrauterine life the foetus cannot be and is not (in the medical literature) referred to as an unborn baby. In our healthcare services, the term "unborn" is unhelpful and should be avoided.

4 Gestational Age and the ethics of crisis pregnancy management

An extensive literature exists which comprehensively outlines the arguments for and against performing termination of pregnancy in any and in particular circumstances. These arguments will not be rehearsed here on the assumption that the Working Party has already been exposed to the arguments on both sides (and the spectrum between them) of the debate.

If the Working Party decides to advocate the introduction of a termination of pregnancy service within the jurisdiction, crucial parameters will need to be set. Those usually considered are:

i) The medical indication for a termination of pregnancy
ii) The upper gestational age limit
iii) The normality or otherwise of the foetus

In this context ethical issues are of course paramount. We presume that the ethicists advising the Interdepartmental Working Group will have had some exposure to the changing context in Ireland concerning reproductive rights in our jurisdiction during the recent past. This raises the question how the State's legal framework responds in a changing social context. Should laws and ethics be absolutist or flexible? The question is not entirely semantic. Ethical issues are sometimes perceived as being dichotomous. Indeed there are two relatively dichotomous views concerning termination of pregnancy: there are those who argue that termination is always wrong and in any circumstance. Equally there are those who would argue that termination should always be a woman's choice. However there is evidence that the majority of people (including doctors) do not view the issue in such simple terms. For example, we submit, the vast majority of Irish people would find the termination of a healthy foetus at 23 weeks gestation (just prior to extrauterine viability) to be abhorrent. On the other hand the great majority of Irish people, we submit, should find the use of post coital contraception (tablets taken within 72 hours of intercourse) to be an entirely reasonable response to a potential crisis pregnancy for a teenage rape victim.

For a minority of people the few cells prevented from implanting in the uterus will constitute a human life which has been 'aborted'. However for the majority of women (and for most men) these two cases constitute entirely different ethical situations.

Indeed the widespread use and acceptability of post coital contraception in Irish society exists to support the contention that very early termination of pregnancy is acceptable to a large proportion of people including (indeed especially) women of reproductive age and their caring physicians. The widespread use of the intrauterine contraceptive device illustrates the point in a similar manner.

If the Working Party decides to advocate the introduction of a termination of pregnancy service within the jurisdiction we would argue that the appropriate upper limit of gestational age which is set should be in very early pregnancy (< 8 weeks) for very good health care reasons. A very early termination of pregnancy is superior to a late one from every angle: medical, physical, social, psychological, and fertility related morbidity.

5 Termination of pregnancy: a health issue with a requirement for clear parameters

It is clear that large numbers of women are having terminations of pregnancy and that these women are receiving substandard care as a result of there not being a systematic and well organised caring programme for these women. The fact that a large proportion of women do not receive any counselling beforehand or any post abortion medical care, contraceptive advice or post abortion psychological support is, we believe, unacceptable to a caring society. Furthermore we believe there is widespread support for improving the care afforded these women, whether or not an abortion service is established. If the Working Group decides to advocate the establishment of an abortion service in Ireland certain parameters will need to be set. In deciding which circumstances should prevail before it is legal to provide a termination of pregnancy the Working Group will need to consider the parameters described above (medical indication, gestational age and foetal condition). We believe that termination of pregnancy should be a health issue and that the care of women should be maintained within the context of confidential patient doctor relationship. We do accept and encourage the establishment of very clear parameters.

6 Lowering the gestational age at which Irish women with crisis pregnancies have termination of pregnancies

Preventing an unwanted pregnancy is far more desirable (by all concerned) than is termination of a pregnancy at any gestational age. But it is also true that a very early termination of pregnancy is superior to a late one from every angle: medical, physical, social, psychological and fertility related morbidity.

Whether or not the Working Group decide to advocate the introduction of a termination of pregnancy service in Ireland, there remains an imperative to care for those women who have, and who are at risk of having, an unwanted pregnancy.

We submit that the objective of lowering the gestational age at which women have a termination of pregnancy is a very worthy one and it will be achieved by the same strategies as those necessary to prevent unwanted pregnancies. These strategies incorporate information, education and accessibility programmes.

A brief examination of world-wide trends in abortion highlights the exceptional success that the Dutch Government has had in reducing the number of women requesting a termination of pregnancy. The real lessons to be learned from the Dutch experience are that it is necessary to provide comprehensive education, information and contraceptive accessibility programmes in order to achieve significant reduction in the number of crisis pregnancies. Closer examination of the Dutch story is worth consideration by the Working Party. Liaison with the Dutch Department of Health is worthy of consideration.

7 Medical aspects of termination of pregnancy

i) Medical termination of pregnancy Termination of pregnancy is no longer always a surgical phenomenon under general anaesthesia. Increasingly termination of pregnancy is achieved pharmacologically or surgically as an office procedure under local anaesthesia.

Pharmacological (i.e. tablets taken orally to induce a termination) termination of pregnancy is becoming more popular for pregnancies under 9 weeks gestation. In these circumstances pharmacological vs surgical termination of pregnancy has about a 50:50 split in terms of patient reaction. It is equally effective.

ii) Pregnancy testing During the last decade the recognition of pregnancy specific hormones in the serum and urine of women in very early pregnancy has become a more and more sensitive and specific test at an earlier and earlier stage following conception. Cheap reliable pregnancy tests are now available over the counter which can confirm or rule out pregnancy within a few days of a missed period. These tests are likely to get better and better and to be able to recognise conception reliably and reproducibly before a missed period in the very near future.

iii) Predictive pregnancy tests In 'The Management of Failed First Trimester Pregnancy' (S. Daly, W. Prendiville, *Irish Medical Journal*, 1997, 90(2), 52) the use of pregnancy specific hormones to recognise failed first trimester pregnancies in advance of symptoms of failure is described. This opens up opportunities to manage women with failed pregnancies in a far less invasive and more outpatient manner than hithertofore. In respect of women who do not wish to be pregnant and who have a positive pregnancy these tests should in the very near future be able to distinguish between those with a pregnancy which is destined to fail from those with a pregnancy which will thrive. As we know that about 15-20% of clinically recognised pregnancies will fail it should soon be possible to avoid a termination of pregnancy in the women who are going to miscarry anyway.

6 CONCLUSION

1 The debate over abortion is complex. It has medical, legal, theological, ethical, social, and personal aspects. It is also a highly emotional subject, for it touches on the mysteries of human sexuality and reproduction, and often involves acutely painful dilemmas.

2 This submission is designed to make a positive contribution towards improving the healthcare of all Irish women and especially women who face or have faced crisis pregnancies. The Adelaide Hospital Society as a Christian charitable organisation is committed to the sanctity of human life and the dignity of the person. We believe a Christian and caring approach is one that provides the very best healthcare for everyone including citizens who have made choices which others believe to be detrimental to their human dignity or to their health. We have to recognise that all abortions are due to unwanted pregnancies and that all unwanted pregnancies are due to a failure of some kind. These failures, if properly addressed, should reduce unwanted pregnancies and thus the tragedies involved in terminations of pregnancy.

CHERISH
26 OCTOBER 1999

CHERISH'S POSITION REGARDING ABORTION

The purpose of this submission is to outline Cherish's position in relation to abortion, including Cherish's recommendations to improve the situation regarding abortion in Ireland. These views are similar to the views expressed in our submission in March 1998, but are more detailed following our discussion of the recent Green Paper on Abortion, and following some recent changes in the practice of our Pregnancy Counselling Service.

BACKGROUND TO CHERISH

For the past 25 years Cherish has offered a comprehensive service to single women during and after pregnancy. Today, Cherish provides a non-directive pregnancy counselling service and a range of support services to single women parenting on their own.

The range of services Cherish provides include:-

- Information service on all aspects of single parenthood – social welfare, housing, legal matters, health services, taxation and child care
- Non-directive counselling for pregnant women and single parents
- Personal Development Courses
- Return to Work/Moving on Courses
- Parenting Courses
- Daily Drop-in facility
- Educational work with young people
- Practical help
- Monday meetings – an open meeting with invited guest speakers

In addition, Cherish deals with a large volume of correspondence from single parents, representatives from local group initiatives, research students and school children seeking information on a wide range of issues affecting single parents.

The abortion issue clearly has implications for two aspects of Cherish's work:

- Cherish's pregnancy counselling service, which aims to enable single women with a crisis pregnancy to make an informed decision about their pregnancy.

– Cherish's work with young people, which aims to enable young people to make informed choices about sexuality and relationships.

CHERISH'S PREGNANCY COUNSELLING SERVICE

Cherish draws a clear distinction between its pregnancy counselling service and general services for single parents. Pregnancy counselling is provided by a skilled counsellor who adheres to the principles of professional counselling methods. The purpose of effective pregnancy counselling is to facilitate a woman to determine the decision with which she feels most comfortable. This process is not about steering the client in any one particular direction but about creating a caring and non-threatening environment in which a woman with a crisis pregnancy can freely discuss her anxieties and fears in relation to her unplanned pregnancy.

The practice of Cherish in relation to the pregnancy counselling service has changed slightly in 1999. Formerly it was our practice to refer women seeking abortion information to the Irish Family Planning Association. This practice has now changed, and Cherish now provides this information directly, within the parameters of the Pregnancy Counselling relationship. Our service has expanded and now includes a Post Abortion Counselling service. The practice of referring to an adoption agency should this be required remains the case. It is recognised that for women choosing abortion it is essential that a referral for abortion be made with full reference to the woman's medical history.

In its provision of a non-directive pregnancy counselling service, Cherish recognises the importance of informed decision making. In our long history of practice we believe that, in order for a woman with a crisis pregnancy to make an informed decision, she must make her choice from as broad an information base as possible. It is therefore essential that information be provided an all the options: single parenthood, adoption and abortion. We firmly believe that to withhold information on any one option would be to engage in the promotion of ignorance. To proceed in this manner would increase substantially the risk of a decision being made in haste and panic. The provision of information on all the options will distinctly diminish such a risk and consequently will affect, in no small way, the current rate of abortion among Irish women.

WORKSHOPS IN SCHOOLS

Cherish acknowledges the importance of the function of education in the process of tackling crisis pregnancies. Cherish believes that all young people should be given the opportunity to gain for themselves the knowledge, skills and experience necessary to meet their own individual needs and those of others.

In order to facilitate this, Cherish has developed a programme that includes workshops on relationships. The aims of this programme are:

– to provide young people with an opportunity to discuss issues that concern them in relation to sexuality, contraception, assertiveness and gender issues.
– to encourage young people to discuss/analyse the expectations/pressures that they feel are placed on them by peer groups, parents, other involved adults and the media.
– to encourage young people to explore their feelings about sexuality and relationships through group discussions.

It is hoped that by participating in these workshops young people will gain a greater insight into their own individual needs in regard to relationships, will take responsibility within those relationships and will be able to make informed choices and decisions.

Cherish's workshops on relationships are open to young people – both in the formal and informal education sectors. The workshops are facilitated by a Cherish staff member.

CHERISH'S RECOMMENDATIONS

The core issue at the basis of Cherish's position on abortion is *choice*. We believe that all women, regardless of age, income, race, religion or culture etc, have a right to choose. The current legislation regarding abortion allows women to travel abroad for an abortion. Cherish has some concerns about this current situation. They are:

– The considerable expense involved in doing this, prevents women on lower incomes from availing of these services.
– Many women are traveling abroad without medical advice or counselling.
– Many women return from having an abortion unable, due to the secrecy element, to avail of post abortion counselling or medical follow-up.
– Due to the practical implications of travelling abroad women are more likely to have an abortion later in their pregnancy.

One of the main objectives of the Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995 is to ensure that any doctors or advice agencies who provide abortion information to pregnant women do so in the context of full counselling on all the available options, without advocacy or promotion of abortion. Cherish is in full support of this.

Cherish recommends that:

– Abortions be legislated for on a limited basis in Ireland. To continue the position where women must travel abroad for an abortion does not mean that abortion will disappear from Irish society, it simply ensures that the experience is more difficult for the women who choose it, and that it is really only an option for those women who can afford it,
– Abortion be accessible to all women, regardless of age, income, race, religion or culture etc.
– All women seeking abortion receive full medical advice and non-directive counselling before making their decision. Some women actively resist participating in a counselling scenario before getting information. There must be information provision available for these women also.
– Full medical and counselling services be made available to all women who have had an abortion.
– Cherish recommends that the Government do not go down the road of another abortion referendum, and legislate instead. Such referenda are divisive, hurtful and fail to help the community reach agreement or consensus on the issues.
– All young people have access to information and support, in order to make informed choices about their sexuality and relationships.

Cherish's chief concern is that women with a crisis pregnancy are given the necessary counselling, information and support required to make an informed decision about their pregnancy. We are also concerned about the number of women who currently travel abroad for an abortion *without* counselling. It is essential that women choosing to have an abortion have access to medical and counselling services, as well as good information and support.

ASSOCIATION OF IRISH HUMANISTS
SUBMISSION IN RESPONSE TO GREEN PAPER ON ABORTION

ABORTION – A HUMANIST PERSPECTIVE

Humanists are concerned with the quality of life and are keenly aware of the pressures that impel many women to seek abortion. We feel they should have access to safe legal abortion where the pregnancy constitutes a health risk or a crisis situation with which they cannot cope.

Yet humanists respect all forms of human life, including embryonic life, and the human person even more so. Consensus opinion places the development of the thalamus and its integration with the central nervous system at about the 20th week of pregnancy, after which higher brain function begins to develop and thus early human personhood. However as some primitive brain stem function begins around the 12th week of gestation, there is a strong case for early first trimester abortion rather than late second trimester abortion. We feel strongly that no bureaucratic or health service obstacles should impede access to early abortion.

Ideally we would like to see, with increasing education of women and early detection now more reliable, women coming for assessment before the fifth or sixth week of gestation, when implantation is still incomplete and before the stage of potential personhood is reached. Many might then opt for safe modern contragestive techniques such as RU 486, MVA etc.

Second trimester abortions can, with good programmes of education for life in schools, be reduced to a minimum. The Dutch have shown the way here in Europe with not only the lowest abortion rate, but the lowest second trimester abortion rate. Later abortions must be retained however for serious health conditions or serious genetic defects.

Humanists do not regard abortion lightly as another form of fertility control. In fact we are firm advocates of education for life from an early age, with ready availability of all forms of family planning, emergency contraception etc., in order to reduce the number of induced abortions.

WHOSE RIGHTS?

In an ideal world every child would be born wanted and loved, and free from serious mental or physical handicap. lt is not just irresponsible but morally wrong, to create a child out of negligence or for purely selfish reasons.

But this does not mean that society can have the right to make an unwilling woman have an abortion. Nor does society have the right to impose motherhood on a woman who does not want it or cannot cope with it. Also, society should not legislate that a severely handicapped child must be born if the parent/s cannot cope with this. In many such dilemmas, the parent/s wishes should be paramount.

In none of these situations can the moral status and rights of human persons be outweighed by consideration of a being which is yet to acquire the inherent rights of a human person. It is essential that facilities for prenatal diagnosis of foetal defects be made available within the health service for parents who request this.

Certainly the human embryo deserves respect, because of its importance to human persons. The respect due to the foetus grows as the foetus grows in significance. But respect carries no absolute rights comparable to the inherent rights of the people most involved in the foetus, i.e. the parents and most especially the mother.

WHEN IS ABORTION JUSTIFIABLE?

Abortion is always a question of balancing contrary considerations, and the balance changes during the process of foetal development.

We submit that there are no moral grounds for refusing abortion at the early stages. If the pregnancy poses a crisis situation for the woman, no good will come by forcing her to continue it. It is best for all involved that abortion should take place as early as possible as for up to 12 weeks a simple outpatient procedure can be used. Delays caused by legal restrictions or by poor medical facilities, harm the living and do not enhance respect for human life.

After this early stage of about 12 weeks, the foetus is becoming more firmly established in a number of ways, and it is right that the law lays down criteria which have to be satisfied before an abortion can proceed, or as the *Roe v Wade* judgement stipulated, 'in ways that are reasonably related to maternal health'.

At the later stages of pregnancy, the possibility of survival outside the womb becomes medically and morally significant. Whether a foetus is viable outside the womb is a question of medical technology, and currently the state of development of its lungs, and this limit has been falling significantly in recent years. After viability has been reached we feel it is right to make every effort, as in preparing for a premature delivery, to save the child as well as the mother. Viability should be genuine, and this comes about 24 weeks. In fact late abortions over 20 weeks are quite exceptional.

WHAT IS A HUMAN PERSON?

Brain birth and the dawning of consciousness

People disagree over abortion, mainly because they have different views of what constitutes a human person. Those who oppose it see the embryo as a person while it is still at an early stage in its development. We submit that this view is not justified on the basis of present scientific evidence.

Human beings develop slowly towards full personhood. It is not like the switching on of a light: it is a kind of dawning. The starting point is the single cell formed at fertilisation. This cell is biologically human and after subdivision becomes genetically programmed, but it is far from being a human person. Nature gives it a very uncertain existence in its early stages, as many as three

quarters failing to implant or spontaneously abort, in most cases because of a serious genetic defect. Minor genetic defects as in Down's Syndrome often allow the pregnancy to continue. Certainly this cluster of cells cannot be regarded as a person in any sense of the word, for at this stage with its cells being totipotent, its subdivisions can develop into separate beings with twins or multiple pregnancies resulting. lt can also develop into a Hydatid Mole from overgrowth of the placental cells. Not until three weeks after fertilisation does 'singleness' or individuation occur with development of the primitive streak in the pre-embryo, and with duplication of the latter, many identical twins originate at this stage.

While organogenesis begins about the 8th week and primitive brain stem function about the 12th week, human personhood is still far ahead. If at the other end of life, loss of capacity for spontaneous respiration is equated with 'brain stem death' there will be those who maintain that early brain birth in the foetus begins soon after the 12th week. The evidence for this is tenuous based on reflex reactions of the foetus to external stimuli as in decerebrate animals.

It would seem that it is not until the appropriate cells which make up the central nervous system have gathered where the neocortex will be, and have fully linked up, that the full biological processes necessary for awareness will be complete. The cells which will make up the central nervous system, including the thalamus, are not in position until 20 or 21 weeks. But even this is not sufficient and much further integration in the CNS must occur to allow higher brain function begin, estimated not to occur until after the 7th month. Only then can the nervous system start to function, and awareness begin to evolve. Only after this stage with some basic level of consciousness can one begin to confer the moral status of 'personhood'. The argument for potential personhood can be made much earlier, right back to sperm and ova in fact, but is unconvincing. Nevertheless some people will draw the line for elective abortion at the end of the first trimester, except in cases of serious genetic defects or health hazards to the mother.

THE RESPONSIBILITIES OF SOCIETY

A morally responsible society will legislate, and provide facilities, so that no woman will be forced to bear a child she does not want, or cannot care for, or which will cause risk to her mental or physical health.

We believe that society also has the duty to provide universal education for life which will include the responsibilities of sex and marriage and of conception, birth, parenthood and contraception. This positive approach is the moral way of reducing the number of abortions, which is exemplified in the Dutch experience, where such a programme is implemented in all schools from an early age, and whose induced abortion rate is among the lowest in the world.

SUMMARY

Humanists believe:

that abortion can be the morally justifiable option in many circumstances,

that the human foetus does not gain the characteristics or status of a human person until many months into its development,

that women should have control over their own bodies including their ova,

that society should provide safe legal abortion facilities,

that good sex education and education for life, will reduce the number of abortions,

that women should have ready access to full information and availability of all modern methods of fertility control.

Humanists do not believe:

that the embryo has the same rights as a human person,

that some people, because of their own belief that abortion is wrong, should take away the choice from other people,

that society should force women to go through an unwanted pregnancy,

that any obstacles should be placed in front of a woman wanting an abortion so that it has to take place unnecessarily late,

that where there is a serious threat to the mother's life, she should ever be denied ready access to legal abortion. In any such cases two lives may be needlessly jeopardised.

RECOMMENDATIONS TO THE ALL-PARTY COMMITTEE

1 Legislate to give effect to the *X* case judgement by allowing establishment of an Irish abortion facility.

2 Prepare the ground for another abortion referendum which will reduce second trimester abortions by allowing for safe, modern, early contragestive interventions with no legal barriers to first trimester terminations.

3 The committee might also look at how legislation or another referendum might require consideration of the role of the Medical Council – in so far as doctors' validation is concerned then doctors may require some legal protection.

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1.0 INTRODUCTION

1.1 The recently-published Green Paper on Abortion summarised its objective as follows:

> to set out the issues, to provide a brief analysis of them and to consider possible options for the resolution of the problem. The paper does not attempt to address every single issue in relation to abortion, nor to give an exhaustive analysis of each ...

1.2 The brevity of its analysis is most apparent in the discussion of the legal issues involved in each of the options put forward for dealing with the question of abortion. Since the All-Party Committee of the Oireachtas on the Constitution has now been called upon to consider each of these options and to report on them, there is an opportunity for a rather closer analysis of the legal issues involved.

1.3 This discussion document is intended to assist members of the Committee to an understanding of the legal dimensions of what is described as 'an absolute constitutional ban on abortion'. In particular, the paper is advanced to refute the contention that it is 'impossible' or 'impractical' to frame such a ban and at the same time keep intact existing treatment of mothers confronted with life-threatening illness.

1.4 An absolute constitutional ban on abortion appears to be favoured by a clear majority of the People and was urged by the vast preponderance of submissions[1] to the Inter-Departmental Working Group which prepared the Green Paper. Such an option is also consonant with the prevailing philosophy within Irish maternity hospitals which regard expectant mothers as being one of two patients: the unborn being the other. This philosophy has made Ireland one of the safest places in the world to have a baby.[2] It is the proposal which we would advance.

1.5 The paper endeavours to set out the operative legal ideas behind such a proposal in a manner that is readily comprehensible to lawyers and to non-lawyers. Inevitably, this involves some simplification. For example, in the interests of clarity, the word 'abortion' is used throughout the paper without its qualification by the addition of words such as 'direct' or 'induced' which would ordinarily distinguish surgical intervention from spontaneous, naturally-occurring abortions (or miscarriages). Instead, the concepts of 'intention', 'directness' and the definition of 'induced abortions' are discussed separately.

1.6 In addition, when discussing the distinction between the direct taking of life and acting in such a way that death indirectly results, as an unintended effect, it should be kept in mind that the distinction is so clear (in many cases) that it is instinctive. A doctor who gives a patient a particular treatment, with known side-effects, will not be guilty of an offence if those effects occur. Drugs given for the relief of pain may shorten a patient's life but are not unlawful on that account. This is not to say that there are no hard cases. Delineating any category will involve discussion and debate in relation to cases which are particularly close to the line of demarcation. However, this is a challenge to the legal system to define in terms which, while reflecting the widely-held respect for life at all its various stages, will allow appropriate treatment to continue. In outlining the legal principles which ought to be applied by the courts in construing such constitutional provisions generally and specific amendments in particular, this paper is descriptive rather than prescriptive. Nevertheless, there is no conceptual barrier to formulating a constitutional amendment which prohibits abortion but permits necessary treatment.

1.7 In the case of *Attorney-General v. X* [1992] 1 IR 1, the Supreme Court interpreted the wording of the Eighth Amendment to the Constitution in a manner which surprised both those who advocate an enhanced recognition of the rights of the unborn and those who favour the wider availability of abortion. This case would repay careful analysis by the Committee.

1.8 We do not propose to undertake a critique of the *X* case herein, other than to observe that the Committee may wish to accept the Court's invitation to define the terms used in any amendment by way of legislation accompanying the constitutional ban. This was the approach taken in the campaign to have the Fifteenth Amendment of the Constitution (the Divorce Amendment) accepted by the People – when the Government published both the proposed amendment and the legislative provisions which would apply if the amendment was accepted and divorce became available.[3]

1.9 There is no reason in law or in practice why a similar approach should not be adopted in the case of an absolute constitutional ban on abortion. This would put beyond doubt the interpretation of any such amendment by the courts and would reassure those who have expressed fears that such an amendment would prevent existing medical treatment for pregnant women. Indeed, the failure of the legislature to enact legislation of this sort was criticised by the Supreme Court in *Attorney-General v. X* with the implication that the Court's interpretation would have been guided by legislative provisions. The absence of legislation was adverted to by Finlay CJ but was roundly criticised by McCarthy J:-

> I agree with the Chief Justice that the want of legislation pursuant to the amendment does not in any way inhibit the courts from exercising a function to vindicate and defend the right to life of the unborn. 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.
>
> In the eight years that have passed since the amendment was adopted and the two years since *Grogan*'s case, the failure by the legislature to enact the appropriate legislation is no longer just unfortunate; it is inexcusable.

1.10 As McCarthy J. proceeded then to observe, '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.' Accordingly, where appropriate, this paper

1 See paragraph 5.02 of the Green Paper. In addition, it seems that the Working Group received petitions containing some 36,500 signatures, all of whom sought a total ban on abortion: para. 5.04.

2 See paragraph 1.04 of the Green Paper.

3 See *The Right to Re-marry ; A Government Information Paper on the Divorce Referendum* (Stationery Office,1995).

identifies those areas which might be supplemented by accompanying legislation in order to prohibit abortion without disturbing existing medical treatment. The paper also makes some observations on the form aspects of such legislation might take.

1.11 However, the question of such legislation must remain ancillary to a decision as to the protection to be afforded the unborn. If the unborn is accorded due recognition so that abortion is precluded, the terms of any accompanying legislation are no longer problematic.

2.0 THE SUBSCRIBERS

2.1 Those who have subscribed their names to this discussion document are practising members of the Irish Bar whose areas of expertise are both representative and highly-relevant: Constitutional and Administrative Law, Family Law, Criminal Law and Statutory Interpretation. In due course, it is proposed to place the paper before the legal profession. Although the results of this wider consultation are unlikely to be to hand in advance of the closing date for submissions to the Committee, they will, as a matter of courtesy, be forwarded to the Committee as well as being placed in the public domain.

3.0 AMENDMENT OF THE CONSTITUTION

3.1 The legal background to the Eighth Amendment of the Constitution is set out in Chapter 2 of the Green Paper and does not need to be restated here. In short, prior to 1983, the operative law was contained in sections 58 and 59 of the Offences against the Person Act, 1861. Judicial interpretation of these provisions in other jurisdictions (notably in *R v. Bourne* [1939] 1 KB 687) indicated that the carrying out of an abortion to save the life of an expectant mother was lawful. More to the point, where the consequence of the pregnancy would be to render the mother a mental and physical wreck, a doctor could properly be viewed as operating to preserve her life. In some spheres, the decision was thought to have been prompted by the Infant Life (Preservation) Act, 1929. However, a similar conclusion has been reached by courts in other jurisdictions, despite the absence of statutory provisions incorporating a defence to child-destruction based on saving the mother's life.[4]

3.2 Although there were some Irish decisions suggesting that the Constitution implicitly prohibited abortion (see *McGee v. Attorney-General* [1974] IR 284; *G v. An Bord Uchtála* [1980] IR 32; *Finn v. Attorney-General* [1983] IR 154 and *Norris v. Attorney-General* [1984] IR 36 – noted at 2.09 and 2.10 of the Green Paper) there was some concern that the courts of Ireland would interpret the existing statutory provisions in the same fashion as *Bourne*. As a result, the issue of abortion was made the subject-matter of a specific amendment of the Constitution.

3.3 Article 40.3.3, which was inserted by referendum held in 1983:-

> 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.

3.4 Nearly a decade later, the amendment was subjected to sustained scrutiny in the case of *Attorney-General v. X*. A majority of the Supreme Court overturned the decision of the High Court and held that (a) if it were established, as a matter of probability, that there was a real and substantial risk to the life, as distinct from the health, of an expectant mother and (b) this substantial risk could only be averted by an abortion, such an abortion was lawful.

3.5 By virtue of the fact that the legal reasoning employed by the Supreme Court admitted of the necessity for carrying out an abortion[5] and the factual decision that a threat of suicide constituted 'a real and substantial risk', the judgments in the *Attorney-General v. X* have made the present wording of the Eighth Amendment unacceptable to those who oppose the availability of abortion in Ireland. It is for his reason that the further amendment of the Constitution has been proposed.

3.6 In 1992, the twelfth amendment to the Constitution concerned itself with modifying the existing provision and the interpretation given to it by the Supreme Court. The proposed wording was:

> It shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life, not being a risk of self-destruction.

3.7 The amendment, which implicitly conceded the necessity for terminating the life of the unborn, was not accepted.

3.8 The Green Paper does not analyse specific wordings or their capacity to achieve a total prohibition on abortion whilst still permitting doctors to carry out medical procedures which are necessary in order to safeguard an expectant mother. However, it does quote some wordings.[6] These appear to fall into two groups. To these we have added a third proposal which has been placed in the public domain. It should be borne in mind that there are any number of possible wordings which would satisfactorily achieve a ban on abortion while allowing the appropriate treatment of an expectant mother. Equally, we have grouped our observations in what appears to be the most logical order after each of the proposals. This is not, however, to suggest that the observations made in the context of one proposal are irrelevant to the other proposals.

4 See, for example, *R v. Davidson* [1969] VR 667 reviewed in Elliot-An Australian Letter [1969] Crim. LR 511

5 Counsel for the Attorney General conceded that the Eighth Amendment contemplated abortion in circumstances where there was a risk of immediate or inevitable death. The legal justification for this concession has been questioned.

6 See paragraph 5.75.

4.0 AN AMENDMENT BASED ON A 'TERM OF ART'

4.1 The first category of wording cited in the Green Paper with which this paper will deal relies upon the use of ordinary medical terms of art, which have clear meanings assigned to them by members of the medical profession, in order to attain the objective of an absolute ban. The proposal reads :

> No new law shall be enacted and no provision of the Constitution shall be interpreted, to render induced abortion lawful in the State.

4.2 The relevant portion of the Oxford Companion to Medicine[7] defines 'abortion' as the 'termination of pregnancy, with expulsion of the products of conception, before the foetus has reached viability ... Abortion may be accidental (spontaneous) or induced (artificial).' The existing medical practice is quite clear as to what is meant by an induced abortion, namely any direct interference with the unborn (for further comment upon which, see below) which has the death of the unborn as its primary object. Where necessary medical treatment results in damage to, or the death of, the unborn, this is not classified as an induced abortion.

4.3 It would be a comparatively simple matter to frame legislation to accompany any such wording in order to put the meaning attributed to this, or any equivalent term of art which is commonly understood by the medical profession, beyond doubt and to underpin the absolute ban on abortion. The manner in which medical terminology has been transposed into legislation may be seen in the Offences Against the Person Act, 1861 ('miscarriage') and the Health (Family Planning) Act, 1979 ('procured abortion'). The Abortion Act, 1967, in England and Wales, also defines the termination of a pregnancy within the meaning of the Act.

4.4 The definitions used in a number of bills currently before the State legislatures of several American States are also instructive. For example, in House Bill 1362 and House Resolution 1014 of the State of Arkansas (requesting the University of Arkansas to carry out studies on foetal pain during different methods of abortion) 'abortion methods' are defined as 'medical procedures used to terminate pregnancies including dilation and evacuation, suction curettage, dilation and extraction with labor induction, hysterectomy, saline and suction aspiration.' Section 1 of House Bill 268 of the State of Alabama (modifying the parental consent provision for abortions carried out on minors) includes the following definition:

> Abortion: The use of any instrument, medicine, drug or any other substance or device with intent to terminate the pregnancy of a woman known to be pregnant, with intent other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead or dying unborn child.

4.5 Even where widely drafted, the terms of legislation specifying procedures which were banned might not keep pace with the development of abortion and or abortifacient techniques. This is an aspect which would require careful consideration. It might in part be remedied by a positive formulation of the duty owed by a doctor to his expectant patient, in the same fashion as the existing Medical Council Guidelines. These guidelines, together with a number of observations thereon, are quoted below. Another example of such a formulation, albeit rather too bald a statement to employ in Irish legislation designed to underpin an absolute constitutional ban, is contained in Senate Bill 160 of the State of Florida. Section 4 of this statute, which is intended to outlaw partial-birth abortion, reads:

> This Act does not prohibit a physician from taking such measures as are necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, provided that every reasonable precaution is also taken in such cases to save the fetus' life.

4.6 An amendment based on a term of art has certain attractions. By drawing a medically coherent dividing-line between an abortion, properly so called, and other medical procedures (undertaken for therapeutic reasons) even those which may cause spontaneous abortions, there would be no interference with existing medical treatments. If accompanied by suitable legislation which referred to specific procedures, as in the Arkansas Bill, it would also be possible to specify the acceptability (or not, as the Committee sees fit) of treatments such as the laparascopic treatment of ectopic pregnancy, which is often cited as the 'hard case' militating against an absolute ban on abortion. However, as stated, the terms of such legislation would require careful consideration.

5.0 AN AMENDMENT BASED ON 'DIRECTNESS' AND 'FORSEEABILITY'

5.1 Although conceptually over-lapping, two other wordings quoted in the Green Paper adopted a somewhat different approach to that which is based on a medical term of art. The wordings were:

> Add to 40.3.3, the words '... Nothing in the Constitution would render lawful the deliberate, intentional destruction of the unborn or its deliberate, intentional removal from its mother's womb before it is viable.'

and

> It shall be unlawful to terminate the life of an unborn unless such termination is the unsought side-effect of medical treatment necessary to save the life of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life.

5.2 Such wordings appear to echo the reasoning of the Medical Council's Guidelines which state:

> The deliberate and intentional destruction of the unborn child is professional misconduct. 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. Refusal by a doctor to treat a woman with a serious illness because she is pregnant would

7 Walton, Beeson and Bodley-Scott.

be grounds for complaint and could be considered professional misconduct.

5.3 The proposition that an abortion *per se* is never necessary to safeguard maternal health seems to be borne out by the available medical studies, although there is some anecdotal evidence to the contrary.[8] It is widely acknowledged, however, that there are treatments which a mother may require which may harm or even kill the unborn. Although the incidence of such treatments seems to be minute, the Green Paper acknowledges that there is no widespread support for their prohibition. As a result, the Medical Council Guidelines and the other similar wording quoted in the Green Paper urge that, in circumstances where such treatment may be necessary (such as an operation to treat an ectopic pregnancy or a hysterectomy in order to arrest cancer) a legal distinction be drawn between 'direct' and 'intended' abortions and those circumstances where the life of the unborn is terminated as an 'indirect' or 'unintended' consequence of the medical treatment given. These are separate, if related, concepts. Although certain commentators have suggested that these are distinctions which are unknown at law, each has been the subject of detailed legal debate. Each will be dealt with in turn.

'Unsought', 'Deliberate' and 'Intentional'

5.4 Intention, in its ordinary sense, must involve a conscious choice to bring about a particular state of affairs. A person can only mean something to happen when he realises that his conduct will bring it about. To this extent, terms such as 'unsought', 'deliberate' and 'intentional' have posed no conceptual difficulty. Debate only arises where the desire of the person is to bring one result about while he realises, even with regret, that another consequence will, in the ordinary course, flow from it.

5.5 At present, the terms of the Constitution do not include a provision which seeks to distinguish between 'intentional' and 'unintentional' actions. As the Green Paper states, therefore, the interpretation of such a concept in the constitutional sphere is an open question. Having said this much, the Paper proceeds to cast doubt on the reality of this distinction, although not expressly identifying the concepts involved, at paragraph 7.19 stating:

> In cases such as the laparascopic treatment of an ectopic pregnancy or the termination of a pregnancy in cases of severe pre-eclampsia, Eisenmenger's syndrome or the conditions mentioned in paragraph 1.22, it is difficult to see how the destruction of the embryo can be described as an unintended side-effect.

5.6 Leaving aside the assumptions upon which this characterisation of treatment is based, this passage seems to ignore the intensive judicial examination of the concept of intention generally (and the foregoing distinction in particular) in other areas of law and in other jurisdictions. A brief analysis of this scrutiny is not only helpful in determining how readily the Irish courts would interpret the concept in the sphere of constitutional law, but also gives considerable guidance as to the shape which accompanying legislation, carrying into effect an absolute ban on abortion while allowing medical treatment, might have.

5.7 To date, the widest-ranging discussion of the concept of intention has occured in the field of criminal law and particularly the law of murder. The kernel of this discussion has been the extent to which a person ought to be presumed to have intended his action when, although he denies having intended it, it was so plainly the consequence of his behaviour that he ought not be allowed escape legal responsibility for his actions. These issues have been vigorously debated in the courts of England and Wales. Quite clearly, this debate has not taken place in the context of a person admitting to having intended a certain result – but rather, where the accused denies that he intended the result but the result itself was self-evidently likely.

5.8 In the case of *DPP v. Hyam*, in the late 1950's, Lord Hailsham denied that a surgeon who inserted a scalpel into the flesh of his patient could be said to have intentionally wounded him and rejected the notion that the concept of 'intention' extended to those situations in which an object was not subjectively desired but the outcome was both foreseeable and probable.[9]

5.9 Had this remained the law, the inclusion of the word 'intentional' in any amendment would allow any treatment to be carried out with impunity, as long as a doctor subjectively viewed it as appropriate, regardless of its consequences. Such a situation would be equally undesirable to those who are opposed to abortion as it would be to those who favour an unrestricted right to choose. However, the view that foreseeable and virtually certain consequences (sometimes called 'oblique intention') are not 'intended' in the legal sense, was immediately subject to criticism. Glanville Williams,[10] an eminent criminologist, was opposed to such a legal formulation on the basis that it confused the concept of 'intention' with the defence afforded to a surgeon by the patient's consent. Williams proposed that the ambit of intention be amended by legislation, either by: '... relax(ing) the definition of intent sufficiently to allow oblique intent as a kind of intent ... (or) ... redefin(ing) all crimes of intention, when it is desired to bring in oblique intent, by making express provision for it.'

5.10 The former of these options is precisely that which was adopted in Ireland, where section 4 of the Criminal Justice Act, 1964 provides that an accused person 'shall be presumed to have intended the natural and probable consequences of his conduct; but this presumption may be rebutted.'

5.11 This formulation was subsequently mirrored by the development of the common law in England and

8 See Chapter One, Green Paper on Abortion, *passim*.

9 *DPP v. Hyam* [1975] AC at 77C.

10 1987 *Cambridge Law Journal* at 420.

Wales, where the balance has similarly shifted towards presumptive rather than automatic inferences of intent from foreseen and probable consequences. Accordingly, Lord Bridge in *R v. Moloney* [1985] AC 905 at 929B stated that an intention to achieve a particular end may, but need not necessarily, be inferred where a person foresees a consequence as being the natural[11] outcome of his action. Lord Salmond in *Director of Public Prosecutions v. Hancock* [1986] AC 462 put the matter emphatically when he observed that:

> the House made it absolutely clear that foresight of the consequences is no more than evidence of the existence of the intent; it must be considered, and its weight assessed, together with all the evidence in the case. Foresight does not necessarily imply the existence of intention, though it may be a fact which, when considered with all the other evidence, the jury may think it right to infer the necessary intent.'

5.12 Leaving to one side the possibility of modifying the existing presumption in any legislation dealing with abortion, what are the implications of the existing test? In what circumstances will the presumption of intent, on the basis of foresight, be rebutted?

5.13 Peter Charleton (*Criminal Law in Ireland* at 42) is of the view that the presumption will be rebutted if the means, by which the end complained of was achieved, are inherently lawful, excusable or acceptable. This appears to be borne out by a plethora of cases in both this jurisdiction and in England and Wales, involving both statutory offences and common law offences, as well as in the sphere of civil law.

5.14 In *Rex v. Steane* [1947] KB 997 a person who gave broadcasts which would assist the enemy, was acquitted of a charge of intending to assist them since his purpose had been to avoid the consequences of refusal, namely internment of himself and his family in a concentration camp.

5.15 In the civil sphere, there is evidence of similar reasoning. The Privy Council concluded, in *Sinnasamy v. Selvanayagam* [1951] AC 83, that a person who unlawfully occupied a house after receiving a notice to quit could not be convicted of the statutory offence of remaining in occupation with *intent* to annoy the owner if his dominant intention was to retain his home – even if he knew the owner would be (and was) annoyed by his actions.

5.16 The significance of these decisions lies in the fact that the accused was not penalised simply on the basis of a certain result being foreseeable. In the absence of an express or admitted intention, the requirements of the statutory offence were not presumed to have been met. One might almost call them a 'dominant purpose' test. It follows that there is no inescapable deduction that a doctor treating an expectant mother, in a manner which had the unintended side-effect of injuring her child, would be presumed to have intended to kill her unborn child simply on the basis that its death was the foreseeable outcome of his treatment.

5.17 Were such reasoning to be applied to the word 'intentional', or any synonym therefor in the Constitution, there can be little doubt but that the courts would have sufficient latitude to deem a doctor not to have intended to carry out an abortion, even in circumstances where the death of the unborn was a foreseeable consequence of the medical treatment. In fact, the potential latitude is so broad that it would be necessary to limit the concept (perhaps by the addition of a differentiation between 'direct' and 'indirect' interference with the unborn) either in the text of the amendment itself or by way of suitably drafted legislation, in order to prevent its abuse.[12]

5.18 To complete our brief review of the common law, it is worthwhile to consider other examples of how inherently acceptable means, resulting in a potentially culpable act, will mitigate the strict application of the presumption of intention. A case which is factually closer to the circumstances of an abortion is that of *R v. Adams* (1957) *Crim. Law Rev.* 365. Here, the court confirmed that a doctor who had treated an incurably ill patient with large doses of heroin and morphia did not, simply by process of logic, intend to kill her. As observed *per* Devlin J.:

> But that does not mean that a doctor aiding the sick or dying has to calculate in minutes or hours, or perhaps in days and weeks, the effect on a patient's life of the medicines which he administers. If the first purpose of medicine – the restoration of health – can no longer be achieved, there is still much for the doctor to do and he is entitled to do all that is proper and necessary to relieve pain and suffering even if the measures he takes may incidentally shorten life.

5.19 Although J. C. Smith[13] has suggested that this case turned upon notions of causation, no such interpretation can be placed upon *Gillick v. West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402. Here, the opinion was expressed that a doctor,

11 Williams traces the subsequent modification of this test (which, incidentally, does not affect the point under discussion) in a footnote to page 431 of his article: 'It was unwise to introduce the word "natural". If, as appears, Lord Bridge meant it as a synonym for "virtually certain" it was a poor choice, because the two expressions are not synonyms in ordinary speech. Lynn in 137 NLJ 871 gives an example: 'Conception is a "natural" consequence of sexual intercourse but it is not necessarily probable' – much less (we may add) certain. It was because they saw that "natural" does not even mean "probable" that the Lords later, in *Hancock* [1986] AC 462, disapproved the use of this word, when standing by itself without the addition of "probable" in instructing juries; they evidently thought that it could convey too wide a meaning. It follows that they did not think that 'natural' made a suitable synonym for "virtually certain"...'

12 Failure to do so would set a premium upon ignorance of the law and might multiply the number of decisions such as *The King v Ahlers* [1915] 1 KB 616, where the courts refused to convict a man accused of having intended 'to adhere to the King's enemies' where the evidence established that he had assisted in the re-patriation of German subjects in the belief that he was entitled to do so.

13 Smith and Hogan, *Criminal Law* (London 1999).

who knew that the provision of contraceptive advice to a girl under sixteen would increase the likelihood of sexual intercourse, was nevertheless not guilty of abetting the offence because his intention was to protect the girl, not to encourage unlawful sexual intercourse with her.

5.20 Although it is true to say that the reaction of the Irish courts is an open question, similar reasoning appears to have underpinned the decision of the Supreme Court in *In re a Ward of Court (No. 2)* [1996] 2 IR 79. This case involved a woman who had been left with limited cognitive function after a minor operation and was being fed by means of a gastrostomy tube. Upon application by the parents of the woman to withdraw the tube, the Supreme Court (Egan J. dissenting) permitted this to be done. It is incontrovertible that, with the tube withdrawn, the ward was inevitably and foreseeably going to die. Such an outcome did not, however, raise any question in the mind of the High Court or the Supreme Court as to whether the parents of the ward of court were intending to kill her. This distinction between cause and effect is noteworthy, although there are cogent reasons for disavowing the conclusions of the court in that case.

5.21 Finally, the Committee's attention is drawn to that portion of Mr Justice Hederman's dissenting judgment in *Attorney-General v. X* which states obiter dicta that:

> The death of a foetus may be the indirect but foreseeable result of an operation undertaken for other reasons. Indeed it is difficult to see how any operation, the sole purpose of which is to save the life of the mother, could be regarded as a direct killing of the foetus, if the unavoidable and inevitable consequences of the efforts to save the mother's life leads to the death of the foetus.

5.22 This remains the only judicial observation in this country which is directly in point. Differently put, the general tenor of Mr Justice Hederman's observations is that the consequences of a medical intervention (including the death of the unborn) will not impute an intention to carry out an abortion where it is carried out 'for other reasons' namely, 'the sole purpose of saving the life of the mother ...'

'Side-effect' and Indirectness generally

5.23 From the foregoing, one can see that foreseeability and 'directness' can be allied ideas. Indeed, the importance with which a common law jurisdiction will invest the distinction between legitimate and illegitimate side-effects is evident from the English judgment of *Re J (a minor)* [1990] 3 All ER 930 in language which is strikingly reminiscent of *R. v. Adams*. In *Re J (a minor)*, which was cited with approval by the House of Lords in *Airedale NHS Trust v. Bland* [1993] 1 All ER 821 (at page 845) Lord Donaldson MR observed (at page 938):

> The decision on life and death must and does remain in other hands. What doctors and the court have to decide is whether, in the best interests of the child patient, a particular decision as to medical treatment should be taken which *as a side effect* will render death more or less likely. This is not a matter of semantics. It is fundamental. At the other end of the age spectrum, the use of drugs to reduce pain will often be fully justified, notwithstanding that this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so. (judge's emphasis)

5.24 In the face of this reasoning, akin to that of the Irish courts in similar cases, the observation of Kingston and Whelan at page 59 of *Abortion and the Law* (Dublin 1997) to the effect that:

> The question of whether Irish law does recognise such a distinction (between direct and indirect abortion) has not been argued before an Irish court and so it cannot be said definitively that such a distinction in not legally recognised.

whilst true as far as it goes, may require some re-assessment.

5.25 As well as the overlap with the concept of intention, the insertion of the word 'direct' should import a more mechanical distinction. In other words, as well as elaborating the meaning to be attributed to 'intention' or its synonyms, it should be seen to refer to issues of methodology i.e the mechanism by which abortions are actually carried out. If the courts were to accept, or legislation in support of an amendment were to provide for, a distinction between intention and foresight, the relevance of whether the death of the unborn is effected directly or indirectly would lie principally in ensuring that an unscrupulous doctor could not claim to have the life of the mother in mind when carrying out abortions, properly so called, for social or other reasons. This dimension would need careful consideration in framing both an amendment and any accompanying legislation.

5.26 Abortion has already been defined in terms of the 'direct destruction' of the unborn (*Attorney-General v. Open-Door Counselling* [1988] IR 593) presumably in contradistinction to the indirect destruction of the unborn as a result of medical intervention on the mother's behalf. Accordingly, those amendments which propose a prohibition on *direct* **as well as** intentional interference with the right to life of the unborn should expressly narrow the circumstances in which interference with the unborn will be lawful and copper-fasten the distinction between abortion (which would be outlawed) and the acceptable treatment of a pregnant woman (even where this results in the death of the unborn) independently of the construction attributed to 'intention'.

The unborn

5.27 The comments of the Constitutional Review Group on the Eighth Amendment are included at Appendix 5 of the Green Paper. This Group criticised the absence of any:

> '... definition of 'unborn' which, used as a noun, is at least odd. One would expect 'unborn human' or 'unborn human being'. Presumably the term 'unborn child' was not chosen because of uncertainty as to

> when a foetus might properly be so described. Definition is needed as to when the 'unborn' acquires the protection of the Law. Philosophers and scientists may continue to debate when human life begins but the law must define what it intends to protect.

5.28 It is curious that, in discussing Article 45.4.1, the Constititution Review Group do not make a similar criticism of the words 'the infirm, the widow, the orphan and the aged.' Nor do they suggest that there is any doubt as to the meaning of 'the infirm' or 'the aged' nor that the use of such terms exhibited any uncertainty as to their humanity.

5.29 The Group proposed their own definitions of the term and repeated the desirability of 'separate legal provisions' (i.e legislation) to give explicit guidance to the courts on the topic of abortion and the infertility treatment. The possible approaches to this defintion are set out at paragraphs 7.04-7.13 of the Green Paper.

5.30 While noting that the concept has not posed a conceptual difficulty to the courts to date, this paper raises no objection to suitably-framed legislation clarifying that the 'unborn' commences existence with conception. It is worth noting that the present Chief Justice, as President of the High Court, specifically stated that sections 58 and 59 of the Offences against the Person Act

> ... protected and protect the foetus in the womb and ... that protection dates from conception. Consequently, the right to life of the foetus, the unborn, is afforded statutory protection from the date of its conception.[14]

5.31 Contrary to what is stated at paragraph 7.08 of the Green Paper, conception is a term which is capable of precise definition: see, by way of example, 'the fertilisation of the ovum by the spermatazoa'[15]; 'fusion of the male spermatazoa and female ovum'[16] or 'the fertilisation of the ovum by the spermatazoa and the beginning of the growth of the embryo'.[17]

5.32 The Human Fertilisation and Embryology Act, 1990, in England and Wales, adopts the following definition in section 1:

> (1) In this Act, except where otherwise stated-
>
> (a) embryo means a live human embryo where fertilisation is complete and
>
> (b) references to an embryo include an egg in the process of fertilisation and for this purpose, fertilisation is not complete until the appearance of a two-cell zygote.

5.33 Save insofar as it may be deemed necessary or desirable to modify this definition in the light of certain *in vitro* fertilisation procedures (perhaps by the addition of a saver which refers to the womb) such a definition would adequately deal with the concerns expressed by the Constitutional Review Group.

14 *Attorney General (Society for the Protection of the Unborn Child) v Open-Door Counselling* [1988] IR 583 at 588.
15 Steadman.
16 Black's Medical Dictionary.
17 Butterworths' Medico-Legal Dictionary.

6.0 AN AMENDMENT BASED UPON PARITY OF ESTEEM

6.1 In framing the form of words which ultimately became the Eighth Amendment to the Constitution, those who thereby sought to prevent the introduction of abortion to Ireland endeavoured to do so by according equal status to the life of the unborn and the mother. At the risk of over-simplifying the judgments of both the High Court (*per* Costello J.) and Hederman J., in *Attorney-General v. X* these judges accepted this proposition as the true basis of any construction of the amendment. In short, they were not prepared to countenance the certain death of the unborn in circumstances where it was far from certain that the mother would commit suicide. The majority of the Supreme Court took a different view and subordinated the rights of the unborn to those of its mother.

6.2 In an article published in the *Irish Law Times*, Mr Justice Roderick J. O'Hanlon (then President of the Law Reform Commission) contrasted the stance of the majority of the Supreme Court with the judgment of the House of Lords of England and Wales in *Regina v. Dudley and Stephens* (1884-5) LR 14 QBD 273. This case was the trial for murder of a number of sailors who, when castaways and facing certain death, had killed the youngest of the crew and survived by consuming his body. In delivering the judgment of the court in that case, Lord Coleridge, Lord Chief Justice of England, had stated:

> ... It is admitted that the deliberate killing of this unoffending and unresisting boy was clearly murder, unless the killing can be justified by some well-recognised excuse admitted by the law. It is further admitted that there was in this case no such excuse, unless the killing was justified by what has been called 'necessity' ... It is not needful to point out the awful danger of admitting the principle which has been contended for. Who is to be the judge of this sort of necessity? By what measure is the comparative value of lives to be measured? Is it to be strength, or intellect or what? It is plain that the principle leaves to him who is to profit by it to determine the necessity which will justify him in deliberately taking another's life to save his own. In this case, the weakest, the youngest, the most unresisting was chosen ... It is quite plain that such a principle, once admitted, might be made the legal cloak for unbridled passion and atrocious crime ...

6.3 In the light of this statement of the common law, had the majority in *Attorney-General v. X* recognised both the mother and the unborn as lives in being, deserving of equal protection,they would not have been able to reach the conclusion which they did. Accordingly, Mr Justice O'Hanlon proposed an amendment in the following terms:

> The unborn child, from the moment of conception, shall have the same right to life as a child born alive.

6.4 He did so expressly on the assumption that it would be unthinkable that any Irish court would ever hand down a judgment the effect of which would be to bring about the death of an innocent human being (i.e. a human person born alive) on the ground that

it was necessary to do so to preserve the life of another human being. On this basis his proposal sought to afford full protection to the unborn on the same basis as a person who has been born.

6.5 Such an amendment would not appear to involve treatment being witheld from an expectant mother. It is well recognised that, where one's life is threatened, one is entitled to take proportionate and appropriate steps to defend it. The principles are no less applicable to an expectant mother (such an ectopic pregnancy). The introduction of accompanying legislation would clarify this point.

6.6 This note of caution notwithstanding, a positive formulation (such as O'Hanlon J. proposed) would have the advantage of ensuring, in addition to a ban on abortion, that injury to the unborn, contrary to the wishes or interests of the mother, would be actionable. This would be consonant with the existing provisions of section 58 of the Civil Liability Act, 1961 and Article 10 of the Medical Exposures Directive.[18]

6.7 There is increasing recognition of this right in America where legislation has been brought before many State legislatures in order to ensure that unborn children who suffer injuries in car accidents and other negligent or criminal events, can maintain actions for suitable compensation. For example, section 1 of both Assembly Bill 6654 and Senate Bill 2171 of the State of New York, states that a

> 'Person' when referring to the victim of any assault, aggravated assault or vehicular assault, means a human being who has been born and is alive or an unborn child at any stage of gestation.

6.8 For the same purpose, section 1 of the Fetal Protection Act (Act 1273) in the State of Arkansas, defines 'person' as including 'an unborn child in utero at any stage of development.'[19]

6.9 Meanwhile, in Hawaii, House Bill 1346 proposes the amendment of the Revised Statutes by the creation of the offence of endangering the welfare of a foetus which is committed 'if the person is pregnant and, once the person has knowledge of the pregnancy, illegally uses any controlled substance, as defined and enumerated on schedules I through IV of Chapter 329.'

6.10 Ironically, in America, it is the desire to preserve an absolute entitlement to an abortion which has posed most difficulties in drafting provisions whose object is the recognition of pre-natal rights.[20]

7.0 CONCLUSION

7.1 The foregoing represents some of the salient legal concepts which will need to be considered in framing any constitutional ban on abortion and/or an accompanying legislation to 'flesh-out' such a ban. As previously stated, the discussion is not exhaustive, nor do the various approaches (or any combination of the three) represent every possible wording which would achieve the object of a ban on abortion. However, the paper is advanced as evidence to refute the contention that it is 'impossible' or 'impractical' to frame such a ban and at the same time keep intact existing treatment of mothers confronted with life-threatening illness. In the light of the issues of surpassing complexity with which the law is forced to deal on a daily basis, such a postion (though frequently articulated) is scarcely tenable. Nor is it true to say that a constitutional ban would rely upon principles unknown to Irish law. What is proposed can be crafted as a perfectly coherent extension or modification of existing legal concepts in a manner that harmoniously underpins existing medical practice.

18 97/43/Euratom. This Directive is to be passed into law by the member States of the European Union by 13th May, 2000.

19 See also Senate Bills 21 and 225 of the State of Louisiana which seek to authorise survival actions, bystander actions and other personal injury actions for an unborn child.

20 By way of example of the difficulties involved, see the provisions of House Bill 5718 of the State of Conneticut.

JOE FOYLE
29 NOVEMBER 1999

I would like an opportunity to develop orally before your committee the point made in the letter, a copy of which I attach.

Not only did the *Irish Times* not publish it, but the newspaper persisted, as recently as Friday last, with their incorrect summary of the present legal position.

It is remarkable that nowhere has the case for the retention of that position been made in our public media, print and electronic. The treatment of it in the document produced for you was quite defective, in my opinion.

I would therefore welcome an opportunity to discuss my opinion with your Committee and would make myself available therefore at a mutually convenient time.

Editor IRISH TIMES
8 November 1999

Pregnancy Terminations

Now that one-third of the electorate favour, as I do, the retention of the present legal position in relation to pregnancy terminations, it is surely high time that our media made a concerted effort to describe that situation accurately. Your Political Editor and Legal Affairs Correspondent today (Nov 8th) fail to do so.

The former says 'abortion is lawful where there is a real and substantial risk of suicide'. The latter says 'abortion is allowed in circumstances where a mother's life is in danger, including in the opinion of a psychologist or a psychiatrist if threatened by suicide'.

First of all, the word 'abortion' does not appear anywhere in current legislation nor in judicial interpretations. Reference is made solely to pregnancy terminations, and they are not necessarily abortions. Secondly, pregnancy terminations are allowed when necessary (i.e. there is no alternative) to save mothers' lives. The latter correctly sums up the present position, unless I am greatly mistaken.

CORK WOMEN'S RIGHT TO CHOOSE GROUP
NOVEMBER 1999

THE CORK WOMEN'S RIGHT TO CHOOSE GROUP

The aim of the Cork Women's right to Choose Group is to promote the reproductive rights of Irish women. The group is specifically concerned with lobbying for the provision of free abortion facilities in Ireland.

RESPONSE TO THE GREEN PAPER ON ABORTION

The Cork Women's Right to Choose Group welcomes the publication of the long-awaited Green Paper on Abortion. We call on the government to treat this issue as a matter of urgency and to speedily respond to the recommendations of the All Party Oireachtas Committee on the Constitution that emerge from submissions such as this.

1 Permit abortion on grounds beyond those specified in the *X* case

We call on the government to adopt the last of the seven constitutional and legislative approaches that are discussed in the Green Paper, namely, introduce legislation that will permit abortion on grounds beyond those specified in the *X* case. As we feel that the decision to have an abortion should not be subject to assessment by third parties (e.g. members of the medical profession), we urge the government to legislate for abortion on request, similar to the arrangements in countries such as Austria, Denmark, Greece, the Netherlands and Sweden.

We call on the government to introduce legislation that provides women with a statutory right to an abortion, free of charge. All ancillary abortion services, such as pre and post abortion counselling, should also be provided to women free of charge by the statutory health services.

2 Amendment of Article 40.3.3

In order to make legislation that allows for the provision of abortion, we call for a referendum to amend Article 40.3.3 of the Constitution. We call for the regulation of abortion purely by legislation

3 Repeal of Sections 58 and 59 of the Offences Against the Person Act, 1861

In order to decriminalise women who have abortions and doctors who perform them, we call for the repeal of Sections 58 and 59 of the Offences Against the Person Act, 1861

4 Interim measures

In recognition of the time that may be required to introduce legislation that permits abortion on request, we call for interim measures that should be speedily introduced. Firstly, legislation should be introduced that permits abortion in the circumstances defined in the *X* case. Secondly, following the C case, we call for immediate clarification concerning a woman's right to travel to have an abortion. In line with the 1992 referendum, we call for the immediate introduction of legislation that guarantees all women the right to travel abroad to obtain an abortion. In particular, the rights of asylum seekers should be guaranteed in this regard.

Submission prepared for the Cork Women's Right to Choose Group by: Liz Kiely; Máire Leane; Rosie Meade; Orla O'Donovan; Lydia Sapouna; Michelle Norris; Linda Connolly; Kathy Glavanis Grantham

THE WOMEN'S HEALTH COUNCIL
6 DECEMBER 1999
SUBMISSION TO THE ALL-PARTY OIREACHTAS COMMITTEE ON THE CONSTITUTION ON THE GREEN PAPER ON ABORTION FROM THE WOMEN'S HEALTH COUNCIL

The Women's Health Council is a statutory body set up in 1997 to advise the Minister for Health and Children on all aspects of women's health. Its mission is to inform and influence the development of health policy to ensure the maximum health and social gain for women in Ireland. An explanatory leaflet is enclosed for your information. The work of the Women's Health Council is based on three principles

- Equity based on diversity
- Quality in the provision and delivery of health services to all women throughout their lives
- Relevance to women's health needs.

The Women's Health Council submits its views only on matters which it considers to be within its competency. It approaches all issues from the standpoint of its mission and values, and considers all matters with a view to ensuring the maximum health and social gain for women.

The Women's Health Council contains within it a range of views as to the best option of the seven set out in the Green Paper to deal with the substantive issue of abortion. It also contains a range of views as to the moral and ethical aspects of abortion.

The Council is, however, unanimous in its view that choosing from among the options does not resolve the real issues. These include:

- Reducing the rate of crisis pregnancy
- Elimination of the negative effects on the health and social wellbeing of women resulting from crisis pregnancy.

TACKLING CRISIS PREGNANCIES

Regardless of the legal situation, Irish women do have crisis pregnancies and these often result in less than optimal outcomes, of which abortion is but one. Lone motherhood, adoption and abortion are three of the options that women who experience a crisis pregnancy consider.

All of these options have their own distinctive set of problems and each option carries its own personal cost for women, whatever their choice. The legal options set out in the Green Paper have various merits and demerits but the aspect they all share is that they will not by themselves reduce the rate of either abortion or crisis pregnancy among Irish women.

Given our responsibilities to address the issue from the perspective of women's health and social gain the

Women's Health Council considers that inadequate health gain and social gain has contributed to the current situation – a high rate of abortion among Irish women and a complex legal situation.

The Women's Health Council recommends:

- The development, as a Government priority, of a ten-year strategy to reduce the rate of abortion by Irish women
- As women are travelling for abortion presently and in the foreseeable future it is important to ensure that quality services and supports are in place to protect the health and social wellbeing of women who choose this solution to a crisis pregnancy.

STIGMA ATTACHED TO LONE MOTHERHOOD

A pregnancy develops into a crisis because of the personal, relationship and social issues that shape a woman's life at that time. Mahon et al (1998) described factors influencing the decisions of those women who decide to have an abortion. This research found that women frame their decision-making in the context of competing conflicts and demands on their lives. These demands come from women's roles as daughters, students or workers, prospective mothers, partners or ex-partners and, in some cases, as mothers already.

They concluded that 'a woman frames the competing demands, she determines that it is impossible to go ahead with the pregnancy, except by hurting others, or by not being able to afford to have a child in the future, so she makes her decision [to have an abortion]' (1998: 526). The study reported that 30% of women were impelled towards abortion by the social stigma attached to motherhood outside of marriage and the incompatibility of motherhood with other roles due to an absence of state sponsored child-care and other supports.

SOCIAL SUPPORTS

The negative image of single mothers should be addressed with practical programmes targeted to address economic and social factors. Economic and social policy development should reflect the reality that there is no longer always an adult working full time in the home. Statutory childcare provision, adequate social housing and access to training and educational programmes (providing childcare) are necessary to begin to change the perceived social and economic discourse of single parenthood.

PREVENTIVE MEASURES

Perhaps the most effective strategy to reduce the rate of both crisis pregnancies and abortion is to prevent unwanted pregnancies. Effective relationships and sex education and access to the effective use of contraception are vital to achieving a reduction in abortion and crisis pregnancy in general. Mahon et al. (1998) identified a range of issues which constrained women in their use of contraception.

These included:

- perceived sanctions against sexual activity
- perceived sanctions about contraception use among young, single women from authority figures, including parents and doctors.
- access to contraception.

Effective sex and relationship education

Women, primarily young women, often believe they will be stigmatised by parents, doctors or other figures of authority for being sexually active. Mahon et al (1998) described situations in which women who approached a doctor for contraception were refused because the doctor believed the women to be too young or because they did not approve of single women being sexually active. The right of doctors to have a conscientious objection to contraception has to be recognised. However, women (and men) are entitled to know the range of services individual GPs are willing to provide in order to be able to choose a GP who is appropriate to individual health needs.

The 1994 Cairo Conference on International Population and Development (ICPD) stated that 'full attention should be given to the promotion of mutually respectful and equitable relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality' (ICPD, 1994 para 7.3).

In Ireland the Department of Education and Science introduced a Relationships and Sexuality Education programme into the school curriculum in 1997. This is the first such programme implemented as part of the curriculum by the Department of Education and Science and is welcome. The Council is also aware of the Department's programme entitled 'Exploring Masculinity's' and looks forward to the introduction of same.

However, the programme should be monitored to ensure it is implemented on a national basis and evaluated for effectiveness. The Women's Health Council recommends the following:

- The implementation of comprehensive relationship and sex education programmes at all levels of the educational system. The programmes should cover inter alia sexuality, fertility, and methods of contraception, information on safe sex practices and a module raising awareness about violence against women. Male responsibility should be a major factor in any education programme concerning sex, contraception and reproduction.
- Relationship and sex education programmes should:
  - Build self-esteem and self-confidence;
  - Provide the opportunity to acquire accurate information;
  - Allow young people to clarify attitudes and values and explore potential consequences of decisions they might make;
  - Encourage young people to develop a sense of responsibility for their own sexual health;
  - Help young people to develop the communication and personal skills that are necessary when dealing with relationships as friend, partner, parent, medical professional etc.
  - Challenge tolerance towards sexual violence in dating relationships.
- As many young people do not complete second level education it is important that comprehensive relationship and sex education programmes are delivered in other appropriate settings, such as in health and social services, training and informal educational programmes.

- Training should be provided for teachers, parents, youth and community workers and others who work with young people so that more people are able to teach and explain effectively issues of sexuality and self esteem.
- Gender stereotyping impacts negatively on young women, reinforcing oppressive behaviours. As the Mahon et al (1998) study points out, sexually active young women are viewed quite differently to sexually active young men: 'the sluts and studs' paradigm which condemns young women and congratulates and admires men for similar behaviour. Gender stereotyping for young women in the area of sexuality assigns them to be passive not active, to respond, not initiate or at least negotiate their sexual behaviour. The issue of gender stereotyping should be included in training and educational programmes in schools, colleges, community settings and health boards.

Contraception

Wiley and Merriman (1996) found, that while two thirds of the Irish women are sexually active, only half consider that contraceptive advice is easily accessible in their area. The results indicated the perceived differences in the accessibility of family planning services by women in different parts of the country and in different social circumstances. More rural than urban women consider that family planning services were inaccessible to them, with the lowest perception reported for unemployed women, students and those who are ill or disabled. It is these women who are most likely to be affected adversely by a crisis pregnancy.

From studies undertaken in the 1980s and 1990s concerning Irish women who experience abortion the Green Paper reports that a significant number of women in the 20-24 age group are more likely than others to opt for abortion. The majority of these women became pregnant because of failure to use contraception or incorrect use of contraception. Mahon et al (1998) confirms these findings, their research suggesting that social and personal factors militated against consistent use of contraception. Regional gaps in service provision for family planning and factors such as cost which restricts access to contraception are factors in this phenomenon. The Women's Health Council recommends:

- Information on all forms of contraception should be available to all women. Consideration must be given to the format of the information produced and its dissemination to ensure it can be easily accessed, understood and absorbed by women including those with disabilities.

  The needs of marginalised groups such as Travellers, ethnic minorities etc should be met in any information campaign strategy.
- Information on the range of services offered by service providers should be available to the public. For example, information leaflets should be available in GPs surgeries on the range of contraceptive services provided including whether these services are available to young people. As for all types of information, formats and dissemination strategies should meet the needs of disabled and other marginalised women.
- All women should have access to safe, effective, affordable contraception with a choice of service provider, at accessible hours, throughout the country.
- Prospective users of contraceptive services should be assured of a high quality, women-friendly, community based health service, with a guarantee of confidentiality and lack of bias. Accreditation standards should be developed by the Department of Health and Children to ensure that all contraceptive services fulfil agreed criteria.

ADEQUATE HEALTH AND SOCIAL CARE FOR WOMEN WHO CHOOSE ABORTION

Mahon et al (1998) reports that since 1970 at least 72,000 Irish women have had abortions in England. The health and well being of women who choose abortion as a solution to their crisis pregnancy must be addressed before and after the procedure. Information and counselling are both critical and should be available to women experiencing a crisis pregnancy before a decision is made.

INFORMATION AND COUNSELLING

At present these are linked, as legislation introduced by the Department of Health (1995) regulated the dissemination of information on abortion, making it available exclusively within the context of full non-directive counselling. Mahon et al (1998) found that this could have a negative effect on women's experiences of crisis pregnancy. They described the route to pregnancy counselling agencies as circuitous, because of uncertainty about the legal situation, lack of awareness about counselling or information provision, a fear of delays, and the cost of counselling, all of which impeded women's access. Other women were ambivalent about counselling, and the requirement that they attend in order to receive information impeded some women in accessing reliable information as quickly as they would have liked.

These factors led Mahon et al (1998) to recommend that the availability of information exclusively in the context of counselling should be examined. They further noted that while women seeking abortion and those contemplating adoption were targeted by counselling services, women who had decided to continue their pregnancy, despite being in need of support, did not receive such a service. The Women's Health Council recommends:

- Information on all crisis pregnancy options including abortion should be available. This will involve severing the link between compulsory counselling and accessing information on abortion.
- Accessible free unbiased pregnancy counselling services should be available throughout the country for all women.
- A standard approach to the provision and content of both information and counselling services should be set up with accreditation, agreed codes of practice and evaluation built in. Although regulation has been introduced by the Department of Health (1995) on the dissemination of information on abortion no such directive has been issued for information on crisis pregnancy or counselling. For the reassurance of the prospective users the Department of Health and Children

should ensure that crisis pregnancy information and counselling meets agreed standards.

- The Women's Health Council supports the Irish College of General Practitioners recommendation on the establishment of inter-referral protocols between GPs to facilitate a comprehensive service within general practice. The service includes pregnancy counselling. A system is necessary to identify to GPs who provide this service from those who have a conscientious objection to abortion or contraception.
- Crisis pregnancy counselling services should also be available to women who are considering continuing the pregnancy. As Mahon et al (1998) noted in their study, the most likely outcome of a crisis pregnancy is lone motherhood. Women facing lone parenthood have to devise and negotiate new strategies and they need practical and emotional support to adapt to this role. Current pregnancy counselling services are perceived by the majority of the women in Mahon et al (1998) research as directed at women who are considering abortion or adoption. Not taking into account the women who are not considering abortion.
- Post-abortion check-ups must be easily available to women to protect their health and well being. It should be clear to women who need it where they can go for post abortion check ups in a non-judgmental set-up.

MENTAL AND PHYSICAL HEALTH

In many of the arguments discussed in the Green Paper a separation of a woman's mental health from her physical health is made. The Women's Health Council considers that is invidious, given the close interplay between physical and mental health, to suggest that one is more important or fundamental than the other. The Women's Health Council would be reassured by the elimination of such arguments from all debate on crisis pregnancy.

CONCLUSION

Whichever of the seven legal options proposed by the Green Paper is implemented, crisis pregnancy will remain a reality in twenty-first century Ireland unless a specific, targeted, coherent and cohesive approach is taken to tackling its root causes and current outcomes.

The Women's Health Council recommends that a National Strategy be developed with the aim of reducing the rate of crisis pregnancy significantly over a short time frame. Such a strategy should involve policies, actions and initiatives at national regional and local level, with a view to implementing evidence-based formal policy, procedures and programmes within five to ten years.

The Women's Health Council is willing to take a significant role in devising a National Strategy and would welcome the opportunity to progress this vital matter further. Only when the issue of crisis pregnancy is satisfactorily resolved will there be a real and lasting solution to the matter of Irish women seeking abortions.

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MAIRE KIRRANE, BL

29 NOVEMBER 1999

A SUBMISSION TO THE WORKING GROUP ON THE GREEN PAPER ON ABORTION

1 In 1992, a referendum on the substantive issue of abortion was deemed necessary by reason of the Supreme Court Judgement in the *X Case.*

2 The stated objectives of the then Government and An Taoiseach being – 'to make possible' the reversal of that Judgement so that abortion would be unlawful in Ireland.

3 However, the proffered wording did *not* offer the people such a choice. It merely addressed the secondary finding of the Court that in the circumstances of the *X Case* a threat of suicide constituted a sufficient risk to the life of the mother to allow her to rely on the provisions of Sub-Section 3º of Article 40.3 of the Constitution. It did not seek to challenge the first finding of that Court which was that the wording of that Sub-section was capable of being interpreted and was interpreted as permitting abortion within the State in certain circumstances.

4 I believe the interpretation by the Supreme Court in the *X* Case of the express wording of Sub-section 3º was correct but what made the Judgement as a whole bizarre was the total lack of any proper or adequate or indeed of any adversial Hearing. No corroborating medical evidence to support the finding that her life was at risk was heard by any Court. This begs the question why?.

5 I submit that the Judgement delivered by the Supreme Court in the *X* case of 1992 was made possible, not by 'Judicial Invention', as has been suggested, *but by the express words of the Sub-Section 3º*. I believe, that the original wording of the 1983 amendment to Article 40 at Subsection 3º of section 3 is fatally flawed in that, it *unnecessarily put two Natural and Inalienable Rights into Constitutional Rivalry*. Consequently if the wording of Sub-section 3º is continued in any new amendment to the Constitution, those words, however qualified, would continue to make abortion legal in Ireland, in certain circumstances.

6 I believe that the wording proposed in the 1992 Referendum caused many people to vote 'NO' to the substantive issue in the belief that they were thereby voting against abortion simpliciter – that of course was not the case. The overwhelming 'NO' vote on that issue effectively copper fastened the Supreme Court Judgement in the *X* case and so made possible the 1997 High Court Judgement in the 'C' case. This was so by reason of the fact that the High Court is bound to follow a Supreme Court ruling on a like issue where the facts are similar.

7 *The failure in the 1997 'C' case of the Attorney General* as protector of the Constitutional Rights, not only of the mother in the case but also of the life in her womb – *and further the failure of the Pro-life campaign* to avail of an Appeal to the Supreme Court, remains forever an indictment and shameful.

That Supreme Court was not bound by the previous Supreme Court Judgement in the 'X' Case. It is submitted that had an Appeal been heard, at the very least, the Supreme Court would be satisfied that the Decisions and Judgements of the lower Courts were unsafe by reason of the failure by both lower Courts to ensure that the grave matter at issue was afforded a properly adversarial Hearing, in that the parents of 'C' were prohibited by both Courts from having their daughter medically examined by a second Psychiatrist and if possible given treatment.

8 *I submit the only way to end the divisive debate on Abortion is to start afresh* – using the balanced wording of the 1861 Offences Against the Person Act so that the controversial words 'Direct' and 'Indirect' are completely avoided.

For this reason, *I have formulated a new Sub-section 3º, Article 40.3*. I believe this formulation has two advantages:

(1) It places the burden and the right to make decisions concerning medical treatment for pregnant women with Medical Doctors and so minimises the role of lawyers who can always be relied upon to find a legal loophole;

(2) It 'begins again'. By the deletion of the Original 1983 flawed Sub-section and substituting therefor a new Sub-section 3º making abortion as defined at a further new provision – Sub-section 4º – illegal, while preserving necessary Medical treatment for the pregnant woman.

9 This, I believe, protects the age old medical practice of providing a pregnant patient with all necessary medical treatment but *more importantly I believe it removes the conflict that must arise in any situation where one human life is deemed legally expendable on the mere interpretation of a form of words in a Constitution*.

10 There is no conflict where empirical medical evidence is available that the death of a foetus in a 'treatment of the mother' situation is an unavoidable loss rather than a deliberate preferring of one human life over another. Where such evidence is not available then of course the Criminal Law will take its wonted course.

I respectfully submit that this Government can finally end the agonizing debate by granting a referendum in the terms of the appended draft Bill.

DRAFT BILL FOR REFERENDUM

WHEREAS by virtue of Article 46 of the constitution, any provision of the constitution may be amended in the manner provided by this Article:

AND WHEREAS it is proposed to amend Article 40 of the Constitution:

BE IT THEREFORE ENACTED BY THE OIREACHTAS AS FOLLOWS:

1 Amendment of Article 40 of the constitution

Article 40 of the constitution is hereby amended as follows:

By the repeal of sub-section 3º of section 3 and by the insertion in substitution thereof of the following:

Sec. 3 subject to the provisions of sub-sections 4º and 5º of this section: it shall not be lawful to procure, or attempt to procure, or in any manner to aid or abet or assist any person to attempt to procure, or to procure the miscarriage of a pregnant woman [An Induced Abortion] within the State or in any place subject to its jurisdiction.

Sec. 4 For the purpose of this section an [Induced] Abortion is attempted or procured by any act or procedure carried out with the *intent* and for the sole purpose of procuring the miscarriage of a pregnant woman in any situation where such procedure is not medically necessary to save the life of the pregnant women.

Sec. 5 Nothing in this section however, shall be invoked to prohibit, control or interfere with any act, made, done or carried out by, or on the instructions of, a medical practitioner in the treatment of a pregnant woman patient in the ordinary course of medical practice, notwithstanding that such treatment would, or could, have as its consequence the termination of that patient's pregnancy.

2 Citation

(i) The amendment of the constitution effected by this Act shall be called the Amendment of the Constitution.

(ii) This Act may be cited as the – 22nd Amendment of the Constitution Act, 2000 AD.

MRS LELIA O'FLAHERTY
24 NOVEMBER 1999
SUBMISSION IN RESPONSE TO THE INVITATION OF THE ALL-PARTY OIREACHTAS COMMITTEE ON THE CONSTITUTION

Of the seven options listed in the Green Paper (pp 107-108) the only one which is acceptable is Option (i), that is, an absolute constitutional ban on abortion. This must be assured by the addition of a properly-worded pro-life clause to the existing clause 40.3.3 of the Constitution, in such a way that total legal and constitutional protection for the unborn child is copper-fastened in our Constitution for all time. The only way in which this can be achieved is by a referendum of the people.

Each of the other six 'options' presented in the Green Paper allows for varying amounts of abortion and none of them, therefore, can be considered by anyone who has any respect for human life.

Members of the All-Party Committee will have seen the photograph which appeared in the Irish Independent on 30 October last. The photograph showed the tiny hand of a 21-week-old unborn baby reaching out of her mother's womb during the course of an operation to lessen the effects of Spina Bifida. The surgeon reaches out to the baby, who grasps his finger. How could any person who claims to respect human life and human rights even contemplate the enactment of legislation which would make the killing of that baby a legal action?

Abortion is the killing of an unborn child at any moment from conception up to and including the moment of birth. Abortion also harms the mother physically, medically and psychologically. Ireland is the safest place in the world for a pregnant mother and her unborn baby and, as a doctor here uniquely has a simultaneous duty to two patients, in this situation there is no conflict of interest between the right to life of the mother or her baby. The Irish Medical council states that there is no medical condition whatsoever in the pregnant mother which can ever warrant the carrying out of the abortion of her unborn baby.

Neither does abortion 'cure' a rape which, in itself, is an horrific crime of violence against a woman, – but abortion is a further act of violence against her which, besides resulting in a dead baby, could also harm her physically as well as mentally. While we must have immense and genuine compassion for a woman who has been raped, killing her baby will not 'undo' the rape. Her baby is an innocent human being. Similarly, if a woman or girl threatens suicide then she must be given every care, medical attention, support and love. International studies show that when a woman or girl is pregnant, she is six times *less* likely to commit suicide than a non-pregnant woman or girl. Aborting her baby is the worst possible thing to do to her.

The Green Paper acknowledges the fact that abortion is never necessary to save the life of a pregnant mother. But, in Ireland, no medical treatment which is found to be required for a pregnant mother is withheld because it might be thought to be injurious to her unborn baby. In the case where, for example, a hysterectomy might be deemed to be absolutely necessary in order to save the life of the mother, the unborn baby might or might not survive – depending on age. Hysterectomy, however, is not abortion. On the contrary, every effort is also made to save the life of the baby.

Hysterotomy, however – removing an unborn baby from her mother's womb for the purpose of destruction of the baby's life – *is* abortion.

Anyone who is debating or discussing the subject of abortion can only legitimately do so if they have seen – in reality or on film, video, etc., – what abortion actually is. Can any person honestly say that abortion – whether at the earliest stage of the existence of the unborn baby ('suction' abortion) right through D&C, D&E, Saline (salt poisoning), Hysterotomy, and Prostaglandin (chemical), or at the moment of birth ('D&X' abortion) – should be tolerated and that provision should be made in law to allow such barbaric practices? Abortion is also euphemistically referred to as 'termination'. Using the word 'termination' doesn't sound quite as awful, does it, so that the reality of what abortion is and what it involves is denied. Abortion is the destruction of an unborn human being. Abortion is big business – it is a huge money-maker.

How can you have 'the widest possible consensus' on the subject of killing an unborn baby? It is easy to kill someone in the abstract.

If something is wrong, then no amount of discussion or deliberation or legal arguments or provisions, or anything else, can make it right. Abortion, 'termination', is wrong, because it is the killing of an unborn human being at any moment from conception up to and including birth. In recent times there has even been a suggestion in England that a baby might be killed up to three months *after* birth (this is called 'fourth trimester abortion'). This is the sort of barbaric scenario into which we would allow ourselves to be drawn if we were to allow abortion to be legalised in any form, to any degree, or for whatever reason or 'hard case'. The excuse given for allowing the Holocaust to happen is that 'we didn't know'. We *do* know now about the horror of abortion

At a time in Ireland when enormous efforts are being made to stop the killing of people, would it not be hypocritical to legalise the killing of *some* people – by abortion? When a society loses respect for life, it loses everything.

While the data given in the Green Paper concerning abortion in countries other than Ireland is interesting, but distressing, it does not follow that we should be influenced in any way by this information, except insofar as we in Ireland must be careful not to fall into the trap of 'a little abortion'. Rather, let us make known to the world that we respect all human life – from the moment of conception. Therefore, we must also put in place strategies so that, as the Green Paper puts it: '… every effort must be made to offer women with crisis pregnancies realistic and practical options … so that they will feel that they have real alternatives to abortion.' The reference to the role played by alcohol in the occurrence of unplanned pregnancies (6.12) is a very valid point. The sections on adoption (6.37-6.43) and lone motherhood (6.44-6.47) and, again, 6.57-6.67, are to be welcomed.

Having agreed with the statement quoted from the Green Paper, however, I must emphasise that the proposals put forward in the course of the Green Paper with regard to increased use of contraception and increased 'sex education' are unfortunate, and dangerous. The increased access to 'sex education' and the increased availability of contraception worldwide have resulted in an *increase* in 'crisis' pregnancies and an *increased* recourse to abortion. This is not a theory – it is a fact. Even the 'family planners' themselves (e.g. Alan Guttmacher) admit this fact.

The restoration of total legal protection for the unborn baby is absolutely necessary, and going hand-in-hand with this must be a caring, loving and protective approach to the problems of those women and girls in 'crisis' pregnancies, together with an education programme in the ethos of respect and – particularly in the case of young girls and boys – in chastity. It may come as a surprise but young people today appreciate the challenge to be chaste and to be able to say 'No'.

The Green Paper states that 'approximately 10,000 submissions were received in response …' to the invitation of the Interdepartmental Working Group on Abortion to interested parties and organisations, and that the vast majority '… expressed a wish for a referendum which

would seek to achieve an absolute prohibition on abortion.' Also, a figure of 36,500 signatures requesting a total ban on abortion were received. All of these figures must be given due recognition. I have a big difficulty with the Green Paper therefore, in that, despite its admission about the vast number of requests (over 99% of the total number received) for a properly-worded referendum which would seek to achieve an absolute ban on abortion, the Green Paper, throughout, appears to give equal recognition to the infinitesimally small number of submissions which called for varying amounts or degrees of abortion as it does to the 'vast majority'. Why? **The Green Paper fails to take a clear ethical stand with regard to abortion – it does not set out the views expressed in the submissions proportionately.**

The 1967 Abortion Act in Britain (following the case of *R v. Bourne*, where it was claimed that a young woman had been gang-raped) was accepted and passed on the understanding that it would be applied only in very limited and strict circumstances, but today the grounds for abortion are very wide**. Since 1967, approximately 5,000,000 (five million) unborn children have been killed by abortion in Britain. The vast majority of these were for 'social' reasons.**

In the U.S., following the 1973 *Roe v. Wade* decision (again, a rape was claimed in an effort to legalise abortion), **39,000,000 (thirty-nine million) unborn children have been killed by abortion. An analysis of U.S. abortion statistics from 1980 to 1996 shows that 'lifestyle', or 'social' reasons accounted for 99.32% of all abortions.**

It should be remembered, too, that both the *R v Bourne* case and the *Roe v Wade* case were subsequently admitted by those involved to have been based on false claims.

Can we seriously believe that if even the most restrictive and narrow legislation were laid down for any 'legalisation' of abortion in Ireland the same situation would not occur here? Abortion does not save a mother from anything. Instead, we must provide all the care and support that a pregnant mother needs.

The UN convention on the Rights of the Child, so often quoted in relation to the protection of children, and ratified by Ireland, states: '*Bearing in mind* that, as indicated in the Declaration of the Rights of the Child, 'the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth'.'

Abortion is not a 'complex issue'. Abortion is not a 'medical procedure'. Abortion is not 'therapeutic'. Abortion solves no problem.

MUINTIR NA hÉIREANN PAIRTI TEORANTA
24 NOVEMBER 2000

Muintir na hÉireann Pairti Teoranta wishes to make it known to the members of the All-Party Oireachtas Committee on the Constitution that the only acceptable option of the seven options presented in the Green Paper (pp. 106-107) is OPTION 1, that is, an absolute constitutional ban on abortion. Each of the other six options presented involves some degree of abortion and, therefore, none of these six options (options 2-7) can be considered.

Members of the Committee who wish to know more about the stance of Muintir na hÉireann Pairti Teoranta on the subject of abortion can read the detailed Submission sent in by our organisation to the Interdepartmental Working Group on Abortion, on our web-site (indigo.ie/~muintir). Alternatively, we would be very pleased to send a copy of that Submission to any member of the committee who so wishes.

We would further wish to comment on the fact that, although over 99% of the 10,000 submissions received by the Interdepartmental Working Group on Abortion in response to their invitation to do so – together with 36,500 signatures received by the same Group – requested a pro-life-worded referendum to restore full legal protection to the unborn child, nevertheless the Green Paper does not take any ethical stand whatsoever on the subject of abortion. Indeed, it even goes so far as to equate the over 99% of pro-life submissions with the remaining less than 1%.

It is the primary duty of Government to cherish all the citizens equally, and this duty is notably absent in the content of the Green Paper.

THE DE BORDA INSTITUTE
10 DECEMBER 1999
A MORE DETAILED SUBMISSION ON THE ABORTION QUESTION TO THE ALL-PARTY OIREACHTAS COMMITTEE ON THE CONSTITUTION

References: (a) *Green Paper on Abortion* (GPA)
(b) 1996 *Report of the Constitution Review Group* (CRG)
(c) *Bunreacht na hÉireann*

INTRODUCTION

As has been recognised in a number of instances in both the GPA and the CRG, a two-option referendum on any one particular proposal would probably not gain a majority. This Institute would go further and suggest the likelihood of such an outcome is almost guaranteed, and in the first part of this paper, it will seek to explain why. In contrast, Part II discusses both the practicalities and the constitutional ramifications of a methodology which with an equal degree of certainty *will* produce a fair outcome, the multi-option Borda preferendum, and we then turn our attention to the topic of abortion in Part III.

PART I – THE REFERENDUM

As was pointed out in para 7.93 of the GPA, the referendum 'debate became bitter and polarised'. The same could be said of the divorce referendum in 1986, let alone the 1973 border poll in Northern Ireland, not to mention the twenty odd referenda which have been held in the former Yugoslavia during the first years of this decade. It was with considerable surprise, therefore, that we read the statement in the report of the CRG which contradicted the above quotation: 'the referendum system has worked

well in practice'. (p. 469) Admittedly, their examination was confined to experience in the Republic of Ireland but even in that context, it would seem to be inaccurate.

The reason why those campaigns were 'bitter and polarised' was partially because of the use of the 'this-or-that', 'yes-or-no', 'for-or-against' referendum. Only two options were allowed. Therefore, people took sides, i.e. they became polarised. And given that the outcome of a referendum may at the end of the day depend on just a few floating voters, proponents of one side and/or the other were sometimes tempted to use every trick in the book, so it was almost inevitable that such campaigns became bitter.

Sometimes, those who draft the question for a referendum regard their final wording as a good compromise. Some would say such was the case in 1986. But, as already noted, that campaign also became bitter. The two options possible – the government's new proposal and the *status quo* – were seen as two opposites, and the campaign was bitter indeed.

Only in the most exceptional of referenda – as in Northern Ireland last year – will a vote be regarded as 'a compromise, yes or no', but that was definitely an unusual exercise, causing as it did the two extremes, the supporters of Paisley and O'Bradaigh, to be 'united'! In most other two-option referenda, the question itself polarises. (And/or, as with Parizeau in Quebec or Tudjman in Croatia, the chosen form of words is a cruel deceit.)

To show how the two-option vote does not work well, and cannot work well, let us first look at a dispassionate example, the Welsh referendum. You will recall that in a 50.1% turnout, 49.4% of the Welsh voters wanted the status quo (**S**), and 50.6% wanted devolution, (**D**). But we also know that Plaid Cymru wanted a third (if not a fourth) option to be placed on the ballot paper: independence, (**I**).

That result, therefore, tells us very little. 50.6% said they wanted **D**, but maybe some of them wanted **I**. In fact, maybe all 50.6% wanted **I**, and maybe nobody wanted **D** at all! We simply do not know. Furthermore, maybe some **I** supporters chose to vote for **S** in the knowledge that any victory for **D** might be the end of **I**, whereas a victory for **S** would mean the **D** supporters would continue to campaign for a further referendum, which *might* then include **I**.

From the results of that Welsh referendum, neither politician nor logician can draw any firm conclusions as to the wishes of the Welsh people. The only conclusion of any certainty is this: Tony Blair wanted **D**! Now it may well be that the Welsh people *did* want devolution; well, if a multi-option preferendum vote had been held, the answer under that process would still have been **D**. **But why does society use a methodology which could so easily produce an unfair result when other more accurate measures of social opinion are both available and practicable?** That is the question!

(Along with the Condorcet count), the Borda preferendum is just such an accurate measure. It is tried and tested. It is not perfect, of course, but is widely accepted by experts in the field as being the methodology most likely to identify that option which best represents society's collective will. Furthermore, according to Prof. Saari of Northwestern University, for example, it is the most difficult of all voting processes to manipulate! A majority referendum, on the other hand, almost forces those who set the question to dictate the agenda – i.e., manipulate, albeit perhaps benevolently – and that in turn prompts many of the electorate to vote tactically, and not as they would have wished.

We must note that the GPA recognised this deficiency of any two-option poll. 'It may also be speculated,' the authors wrote, 'that (there were) those opposed to the 1992 wording on the grounds that it was not liberal enough' (para 7.36), producing another Paisley/O'Bradaigh-type combination. On this point, too, the CRG is in agreement: '[The 1992 first proposal] was rejected, apparently by those who disliked its restrictiveness as well as by those opposed to abortion being legalised…' (quoted on p.166 of the GPA).

In conclusion to this section. therefore, we would argue that in a multi-option debate, unless preceded by a binding or non-binding multi-option ballot, the two-option vote does not work at all well. Any use, therefore, of such a two-option vote as the single and final decision-making process would be inappropriate. Furthermore, in such a situation where there are more than two options 'on the agenda', the use of such a for-or-against vote would be 'a fix'. The vote in Wales was exactly that! The conduct of the 1986 divorce referendum was admittedly rather more subtle, but even then, by reducing the number of options to two, it restricted the freedom of choice which democracy is supposed to embody. He or she, for example, who wanted to vote for the availability of divorce in cases of child sex abuse only – a perfectly valid aspiration – was left in a dilemma.

In the present abortion question, there *may* be a need for some sort of two-option vote at some stage, because of a widely held belief in majoritarianism and the actual wording contained in article 47 of *an Bhunreacht*, this should not preclude the use, however, of either a) (change to Article 47 and then) a multi-option vote, not only on this most controversial issue of abortion, but also on other complex multi-option matters such as electoral reform and neutrality, or b) as implied above, a multi-option vote prior to any final two-option ballot, (of which, more in a moment).

PART II – THE PREFERENDUM

'Why does society use a methodology which could so easily produce an unfair result, when other more accurate measures of social opinion are both available and practicable?' That is the question we asked on the previous page, and the answer lies in the multi-option preference vote in which all preferences cast are taken into account, as with the Condorcet criterion or a Borda methodology. As stated in our submission to the CRG, (see p. 642), there are quite a few forms of multi-option voting, and the best-known are:

plurality voting and two-round voting
alternative vote (AV) or single transferable vote (STV)
the Condorcet criterion
the Borda count and the Borda preferendum.

Plurality, two-round voting and AV

Plurality voting allows the voter only one preference, and although AV allows the voter to cast as many preferences as he/she wishes, only some of those preferences are then taken into account. These three methodologies have

been analysed elsewhere[1] and given their numerous imperfections, deserve no further consideration in this paper, except to say that they are an enormous improvement on the even more inaccurate for-or-against majority vote. Some examples of the successful use of multi-option referenda are shown in Appendix I.

Condorcet and Borda

In these two methodologies, voters are asked to vote for (one, some or) all of the options listed, in their order of preference. In a Condorcet count, pairs of options are considered in turn, and that option which wins the most pairings is deemed to be the fair outcome. The main disadvantage of a Condorcet count is that it may produce the phenomenon called a 'paradox of voting',[2] some examples of which are shown in Appendix II.

In a Borda count of, let us say, **n** options, voters are asked to give **n** points to the option they like the most, **n-1** points to their next favourite, **n-2** points to their third choice, and so on, down to **1** point for the option they like the least.

In effect, in both Borda and Condorcet, each voter is asked to state, not only what he/she wants, but also that which he/she finds acceptable, that which is tolerable, and so on. So each voter is asked to state his/her compromise position, and not just intransigent first preference.

Just as a two-option allows the individual who so wishes to abstain, so too a preferendum allows those who want to vote only partially, to do exactly that. If, however, a voter votes for only **m** options, he/she will exercise only **m** points for his/her most preferred choice, **m-1** for their next favourite and so on. Anyone who wants their most preferred option to get the maximum **n** number of points, therefore, is thereby *encouraged* – and this is another advantage of the Borda preferendum – to cast his/her preference points for several if not indeed for all the options listed.

The count takes all the points cast by all those who vote into consideration – it is, indeed, an inclusive methodology – and the outcome will be the option with the most points. If, in a 5-option ballot, a particularly divisive option gets several 5s, several 1s, and little else, it will get an average score of 3. If another option – a more generally acceptable proposal – gets a few 5s, numerous 4s, a few 3s and nothing less, it will get an average score of about 4; and it will therefore win.

The Borda methodology is the only voting procedure which a majority cannot dominate. Rather, it allows all to participate, and it is more likely to facilitate a rational, sensible and yet pluralist debate.

The constitutional position

Article 47.1 of *an Bhunreacht* talks of 'a majority of the votes cast …' We would suggest, therefore that there would be nothing unconstitutional in allowing for any of the following multi-option methodologies:

(1) A PLURALITY AND/OR TWO-ROUND REFERENDUM, which will always produce an answer, but it may or may not be fair;
(2) AN ALTERNATIVE VOTE which again will always produce an answer, but it too may not be fair; furthermore, AV can sometimes involve more than one option with majority support; indeed, if all voters vote with all their preferences, all of the options will each enjoy 100% support!
(3) A CONDORCET CRITERION, which *may* produce more than one answer, one of which might be fair.

Because the term used in the constitution is 'vote' and not 'first preference', it *could* be argued as follows:

(4) A Borda Process would also be constitutional, because all votes cast are by definition in favour, (just as all preferences cast in any STV or AV vote are regarded as being in favour), and the most popular option in a Borda ballot is therefore bound to have majority support (even if, as *can* happen, the outcome of a Borda count is not the Condorcet winner).

The theoretical possibilities, therefore, are several. From the many permutations and combinations, we suggest your Committee should recommend one of the following three formulae:

a)i) a multi-option binding Borda preferendum vote, with first a specific constitutional change to Article 47;
a)ii) a multi-option and binding Borda preferendum vote, without changing Article 47;
b)i) a multi-option and non-binding Borda preferendum vote, to be followed by a binding majority vote, and again, no change to Article 47.

In the a)ii) instance, with Article 47 of *An Bhunreacht* remaining as it stands, a challenge could occur if the result of a Borda preferendum did not coincide with the result of a plurality count. That could very easily happen. (There again, as the example of the Welsh referendum demonstrates, a similar challenge could also contest any two-option ballot!) Nevertheless, for those brought up to believe that 'democracy is based on a decision taken by a majority' {to quote the CRG, p. 398}, such a discrepancy could nevertheless be problematic.

The b)i) course of action, with an initial non-binding multi-option poll prior to any binding, two-option vote, might also be problematic. This procedure was used in New Zealand[3] – see Appendix 1 – with no subsequent dispute. Let us nevertherless consider the theoretical. If a non-binding preferendum vote suggests option D, say, is more popular than all the other options, including option T, it might happen that the T supporters are then able to whip up support to defeat option K in the subsequent and binding majority poll. That, of course, is possible. In practice, however, might we nevertheless express a faith in humankind – why else would one be democratic? – and hope that while Ts immediate supporters might vote 'no' in any subsequent binding poll, the Irish public would

[1] See *Beyond the Tyranny of the Majority*, but see also the example on pp 14-5 of *The Politics of Consensus.*
[2] The term is analysed at length in *Beyond the Tyranny of the Majority.*
[3] The figures used in Appendix 1 for the New Zealand multi-option referendum are taken from *Representation,* Summer 1994, but there appears to be a discrepancy between the 'for change' total and the corresponding four sub-totals.

realise that option K is indeed society's best option. Nevertheless, there could still be a sort of Paisley/O'Bradaigh 'unholy alliance' amongst those who consider the final option K too liberal, and those who feel it is not liberal enough. It is comforting to recall that, even in the divisive straits of Northern Ireland, that unholy alliance failed!

The wisest option, therefore, is to choose a)i). There again, it is also true to say that there is nothing in the constitution on the subjects of either preliminary non-binding votes or of Borda preferenda, and in most western democracies, anything which is not forbidden is allowed – only in the old communist regimes did the opposite apply! So a)ii) or b)i) are also possible.

No matter which of the three is adopted, however, one further aspect of the multi-option process must be emphasised, and that is as follows: because of the ballot's multi-optional nature, people would know that such a ballot was not a 'fix' designed to promote the government's favoured option.

We would like to add that the Condorcet method is also very good, and the Committee might well be asked to consider its use in either a binding or non-binding role. As noted earlier, however, a disadvantage of Condorcet is that it may lead to a paradox of voting, although this could then be resolved by taking the highest Borda count. (To rely only on a Borda count, therefore, would be a simpler approach; on the other hand, a Borda count may also be susceptible to that which is known as Arrow's irrelevant alternative,[4] in which case a simultaneous Condorcet count may be advisable.)

A second disadvantage/advantage of the Condorcet criterion concerns its majoritarian nature; this is a disadvantage in that the procedure can still be dominated by a majority, and an advantage, perhaps, in relation to the constitution. May we nevertheless conclude this section by advocating either the Borda preferendum or a Condorcet count, if need be in a non-binding role, and as will be obvious by this juncture, we regard the former as being the more inclusive.

Before proceeding to Part III, we feel compelled to add the following regret, namely, that in their examination of Article 47, the CRG considered either simple, weighted and/or qualified majority voting only, and despite the submission of this Institute to which we have already referred, the CRG chose not to examine the constitutional implications of any other decision-making voting methodology such as Borda and Condorcet. We hope the above summary will facilitate a more detailed examination by your Committee.

PART III – THE ABORTION QUESTION

Whenever a multi-optional poll is conducted, it is crucially important to ensure that only one topic is under consideration. In this particular instance, the electorate is to choose a policy on abortion. Whether that policy is then enacted through the legislature or enshrined in the constitution is a separate (though related) question. There may therefore be a need for two polls, one to decide the policy, a second to decide its implementation. In this section we concentrate only on the abortion question.

The GPA has identified seven main options, and sometimes a number of variations within an option; option seven, for example, has five variations, each of which could lead to a number of combinations and/or permutations.

But maybe the whole issue is more complex than it should be, and partly because the GPA considers some of these other related topics such as the historical background. Many of today's voters, however, were not very old in 1983, and might not have followed that first debate. Might we suggest, therefore, that in producing a list of options for any further discussion, every effort should be made (to make no reference to any earlier stance, and) to confine the proposals to the issue of abortion only!

As it stands at the moment, we feel the GPA has identified nine options, and these we summarise as follows, with the italicised terms all taken from the GPA:

A *Absolute ban*
B *Absolute ban* subject to *indirect* abortions
C Abortion permissible when necessary to save the life (but not to prevent the suicide) of the mother
D The status quo, abortion permissible when necessary to save the life of the mother, (and this includes the prevention of suicide)
E Abortion permissible under option D, and also to protect the *physical and/or mental health* of the mother
F Abortion permissible under option E, and allow for women *pregnant as a result of rape or incest*
G Abortion permissible under option F and also for women *with congenital malformations*
H Abortion permissible under Option G and also for *women where certain specified criteria* of their *social or family circumstances were met.*
I *Abortion on request*

It may be that another option is required, namely, one to allow for an age distinction (as was the case, of course, with Miss X). With the possible addition of that option, we nevertheless consider the above list to be both inclusive and comprehensive. Admittedly, other combinations are possible, such as 'Abortion permissible under options D and F but not E'. If such combinations were included, however, the list would become too long (and somewhat confusing). Accordingly, we have taken these variations in the order presented in the GPA.

Nine options is rather a lot. We therefore suggest the numerous complexities of the debate should be reduced by Dail Éireann and/or The All-Party Committee, or again, by a designated commission established for this purpose, to a limited number of about five definite proposals, each to be a specific constitutional wording. These could then be summarised in something like the above phrases {it is not the job of this Institute, of course, to define the options, but as mentioned earlier, we would be more than willing to assist in this task, not least to ensure that the final list is balanced}.

This list could then be presented as a ballot paper for use in Dail Eireann, and/or as a five-option summary to be used in the country at large. In a national poll, might we suggest that the actual ballot paper should include just these simple phrases of'one/two liners', but that each phrase would relate to a specific constitutional wording, numerous copies of which would be readily available.

[4] See *Beyond the Tyranny of the Majority*, p. 94.

Preferendum on Abortion

Place 5 points opposite the option you like the most
Place 4 points opposite your second choice
Place 3 points opposite your next favourite
And so on, as you wish.

If you list all five options, the option you like the most will get 5 pts, your second choice will get 4 pts, and so on.

If you list only four options, the option you like the most will get 4 pts, your second choice will get 3 pts, and so on.

If you list only three options, the option you like the most will get 3 pts, you second choice will get 2 pts, and so on.

If you list only two options, the option you like more will get 2 points and your second choice will get 1 pt.

If you list only one option, that option will get 1 pt.

The option which gets the most points will be the winner.

	OPTION	Points
A	*Absolute ban* subject to *indirect* abortions	
B	Abortion permissible when necessary to save the life (but not to prevent the suicide) of the mother	
C	The status quo, abortion permissible when necessary to save the life of the mother, (and this includes the possibility of suicide)	
D	Abortion permissible under para C, and also to protect the *physical and/or mental health* of the mother	
E	Liberal regime as in Sweden	

APPENDIX 1
SOME EXAMPLES OF MULTI-OPTION REFERENDA

1931 FINLAND — Prohibition: 3-option, plurality vote; 44% turnout

A	B	C
71%	28%	1%

1948 NEWFOUNDLAND — Constitutional status: 3-option, two rounds

	Confed. with Canada	'Responsible Govt.'	Commission Govt.
(i)	45%	41%	14%
	88% turnout		
(ii)	52%	48%	–

1967 PUERTO RICO — Constitutional status: 3-option; 66% turnout

Commonwealth	Statehood	Independence
60%	39%	1%

1982 GUAM — Constitutional status: 6-/7-option, two rounds; 38% turnout

	Statehood	Independence	Free Assoc.	Territorial with US	C'wealth with US	Status Quo	Other (specify)
(i)	26%	4%	4%	5%	49%	10%	1%
	91% turnout						
(ii)	27%	–	–	–	73%	–	–

1980 SWEDEN — Nuclear power: 2-/3-option; 74% turnout

FOR		AGAINST
Go 6 to 12 reactors	Go 6 to 12, but state ownership	Go 6 to 0 in 10 years
19%	39%	39%
58%		39%

1992	Electoral Reform: 5-option, two rounds				
NEW	Non-binding – 55% turnout				
ZEALAND	FOR				AGAINST
	MMP	PR-STV	AV	AMS	FPP
(i)	58%	16%	6%	5%	15%
1993	Binding – 83% turnout				
(ii)	54%	–	–	–	46%

APPENDIX II
PARADOX OF VOTING

Where voters I, J and K express their preferences on three options: A, B and C	VOTERS		
	I	J	K
1st preference	A	B	C
2nd preference	B	C	A
3rd preference	C	A	B

This means that, in majoritarian terms: A > B > C > A …

(which reads, 'A is more popular than B which is more popular than C which is more popular than A which is more popular than B …', and one goes round and round in that which is therefore called a cycle).

Where voters I to P express their preferences on three options: A, B and C	VOTERS						
	I	J	K	L	M	N	P
1st preference	A	A	A	B	B	C	C
2nd preference	B	B	C	C	C	A	A
3rd preference	C	C	B	A	A	B	B

and again: A > B > C > A …

Where voters I to P express their preferences on four options: A, B, C and D	VOTERS						
	I	J	K	L	M	N	P
1st preference	D	D	D	B	A	C	C
2nd preference	A	A	A	C	B	D	D
3rd preference	B	B	C	D	C	A	A
4th preference	C	C	B	A	D	B	B

A:B = 6:1 B:C = 4:3 C:D = 4:3
A:C = 4:3 B:D = 2:5
A:D = 1:6

and this time: A > B > C > D > A.

MULTI-OPTIONAL VOTING

In the following voters' profile, 24% give their first preference to option A, their second preference to option D, etc.; meanwhile, 22% give their first preference to option B and their second preference to D, and so on. If such were the voters' preferences, then, in a plurality vote, option A would win with 24%. In a two-round ballot, the second round would be held between options A and B, and A would win by 60%. In an AV poll, option E would be eliminated and those votes transferred to D, and D would be the winner on gaining 54% on the elimination of C. If, however, just 3% of D's supporters gave their first preference to B instead, option D would be eliminated at the first count, and option A would win instead, by 60%. AV is far too capricious. In a Condorcet poll, D is more popular than all the other options, but there is still a cycle of E > A > B > E for second place. In a Borda count, option D wins (418 pts), A and B are joint second (286), E is fourth (270) and C fifth (240). (A cycle can occur quite easily in a Condorcet count, no matter what the size of the electorate; in a preferendum count, the chances of a tie decrease quite rapidly as the size of the electorate increases.)

	VOTERS				
	24%	22%	20%	18%	16%
1st preference	A	B	C	D	E
2nd preference	D	D	D	B	D
3rd preference	E	C	A	E	A
4th preference	B	E	B	A	C
5th preference	C	A	E	C	B

In some circumstances, as when all options may be laid out as it were on a line and where the voters tend to have single-peak preferences, voters may have a slightly more logical voting profile, as shown below. In this instance, a plurality vote would give A as the winner, a two-round vote would produce B, and so would an AV count. A Condorcet and Borda count, however, would both give C, as shown below:

	VOTERS				
	24%	22%	20%	18%	16%
1st preference	A	B	C	D	E
2nd preference	B	C	B	C	D
3rd preference	C	A	D	E	C
4th preference	D	D	A	B	B
5th preference	E	E	E	A	A

Condorcet	A:B = 24:76	B:C = 46:54	C:D = 66:34
	A:C = 24:76	B:D = 66:34	C:E = 84:16
	A:D = 46:54	B:E = 66:34	
	A:E = 66:34		D:E = 84:16
C > A	C > B	C > D	C > E

In this instance, then, C > B > D > A > E, and there are no cycles. Meanwhile, as shown overleaf, a Borda preferendum also highlights C, as the most popular, with 380 points.

Option	5pts	4pts	3pts	2pts	1pt
A	24	–	22	20	34
B	22	44	–	34	–
C	20	40	40	–	–
D	18	16	20	46	–
E	16	–	18	–	66

Option	5pts	4pts	3pts	2pts	1pt	Total
A	120	–	66	40	34	260
B	110	176	–	68	–	354
C	100	160	120	–	–	380
D	90	64	60	92	–	306
E	80	–	54	–	66	200

In a more realistic, single-peak scenario, voters would split evenly to left and right, as shown below, and while plurality, two-round votes and AV give an answer of options, A, B and B respectively, Condorcet and Borda counts again suggest the most popular outcome is option C.

	VOTERS							
	%							
	24	11	11	10	10	9	9	16
1st preference	A	B	B	C	C	D	D	E
2nd preference	B	C	A	B	D	C	E	D
3rd preference	C	A	C	D	B	E	C	C
4th preference	D	D	D	A	E	B	B	B
5th preference	E	E	E	E	A	A	A	A

Condorcet	A:B = 24:76	B:C = 46:54	C:D = 66:34
	A:C = 35:65	B:D = 56:44	C:E = 77:25
	A:D = 46:54	B:E = 66:34	
	A:E = 56:44		D:E = 84:16
C > A	C > B	C > D	C > E

Borda preferendum

Option	5pts	4pts	3pts	2pts	1pt
A	24	11	11	10	44
B	22	34	10	34	–
C	20	20	60	–	–
D	18	26	10	46	–
E	16	9	9	10	56

Option	5pts	4pts	3pts	2pts	1pt	Total
A	120	44	33	20	44	261
B	110	136	30	68	–	344
C	100	80	180	–	–	360
D	90	104	30	92	–	316
E	80	36	27	20	56	219

TK WHITAKER
NOVEMBER 1999

1 As Chairman of the Constitution Review Group I studied the abortion issue (Article 40.3.3) and subscribed to the section of our report 'Rights to Life (Unborn and Mother)' which is reproduced as Appendix 5 of the Green Paper on Abortion.

2 I admire the careful, comprehensive and balanced analysis in the Green Paper of the issue and the relevant options. My personal views below are not at variance with that analysis and are offered only by way of supplement or emphasis.

3 I am opposed to abortion but I am also opposed to waste of public energies and resources. Given that the freedom to have recourse to abortion elsewhere would continue, I would prefer to focus national resources on organised help for women in 'crisis' pregnancies – help for them to bring their 'unwanted' children safely to birth and help for them to find foster, or adoptive, parents afterwards, if necessary. I welcome the attention given to services for such women and to strategies to reduce recourse to abortion in Chapter 6 of the Green Paper.

4 Not surprisingly, experience has confirmed the impos-

sibility of upholding equality of rights to life, if and when they come into conflict. Most of us, I believe, favour priority for the mother's right when it is seriously endangered. It is not possible to accept the claim that abortion (in the broad sense of termination of pregnancy) is never necessary to save the life of the mother. Medical procedures which result in termination of pregnancy are regularly performed in the vital interests of mothers, e.g. in cases of cervical and womb cancer. For those who make this claim, 'abortion' appears to be understood in the limited sense of termination of pregnancy otherwise than as an unavoidable consequence of medical action to save the life of the mother. The word 'abortion' has not, as far as I know, been defined in legislation in that limited sense, nor is it so defined in any dictionaries I have consulted. That it still has a broad, neutral sense is indicated by the proposal that it be qualified in any constitutional ban by the adjective 'induced'. The older term 'procurement of miscarriage' appears to have had a similar breadth of meaning: what the 1861 Act prohibits is the 'unlawful' procurement of a miscarriage, the inference being that procurement of a miscarriage could in some circumstances be lawful.

5 Allied to the presumption that 'abortion' is to be understood in a restricted sense is a belief in the existence of a recognised and legally-valid convention protecting necessary medical treatment of the mother even when it results in termination of her pregnancy. In the context of any constitutional ban on abortion, it would seem most advisable that the wording should make this protection legally explicit.

6 By the 1861 Act and the 1983 Amendment of the Constitution, abortion is banned in Ireland, subject to the exception allowed by the *X* case decision, i.e. where there is grave danger to the life of the mother, even if this (as with threatened suicide) may be a danger posed by herself. Most people would, I think, still want to give prior protection to the mother in a life-threatening situation but many would not recognise suicide as such a situation. Suicidal dispositions can be feigned and, in any case, psychiatric illness tends to be less well understood than grave physical illness. The result is a confused and divided public opinion as shown by the 1992 referendum.

7 In essence, what the advocates of a new referendum desire is to annul the *X* case decision. Legislation is opposed on the supposition that it would extend from the particular to the general the application of that decision and thus confirm the legality of abortion in Ireland where necessary to avert a real and substantial risk to the life of the mother. Generalising the effects of the *X* case decision does not, however, appear to be the only legislative option. It would seem that legislation could significantly restrict access to the *X* case authorisation, e.g. by requiring that a number of medical experts, including, in threat of suicide cases, at least two psychiatrists, certify that termination of the pregnancy is unavoidably associated with medical treatment or action necessary to protect the life of the mother; it could also provide for a delaying treatment and counselling course for a suicidal mother; and it could confirm the legal protection for doctors mentioned earlier. The result would be both a substantial qualification of the effects of the *X* case and a reinstatement of the intent of the 1983 amendment of the Constitution.

8 If a referendum is decided upon, the wording will need the most careful consideration. There should be as few adjectives and adverbs as possible because their meaning is arguable ('induced', 'indirect' and 'intentional' are examples). My own attempt at a formula is the following:

> It shall be unlawful to terminate or put at risk the life of the unborn except where this is unavoidably associated with medical treatment or action necessary to protect the life of the mother.

This formula would provide the desired protection for doctors. In any disputed case, it would be for medical experts to confirm that the terms 'unavoidably' and 'necessary' validly apply.

9 The question arises whether 'unborn' should be defined in the Constitution, or whether the Constitution should devolve expressly on the Oireachtas the power of definition. It is to be feared that either course would stir up contention, given the definitional difficulties and implications. 'Unborn' implies 'on the way to being born' or 'capable of being born': implantation might be thought to satisfy this condition more surely than conception. What of in vitro fertilisation? While the Oireachtas should not be paralysed by the difficulties, it should accept that its definitional efforts might not be conclusive – might have to be amended or extended later – and would be subject to judicial, and even, perhaps, constitutional review.

PSYCHOLOGISTS FOR FREEDOM OF INFORMATION
8 MAY 2000

SCIENTIFIC BASIS FOR RESPONSE

Psychologists for Freedom of Information is a group composed of research psychologists and psychologists in practice, all of whom are trained in research methods and who aim to base judgements on research findings. We therefore do not address moral issues in this response to the Green Paper.

As researchers and practitioners we are committed to as clear and objective an evaluation of evidence as possible. We recognize that biases inevitably enter the research process where it is applied to complex medical and social problems. However, we have drawn on research which has been conducted to high scientific standards and published in peer-reviewed professional journals.

It is clear to us that it is impossible to draw unambiguous and universally agreed conclusions from research in the area of abortion. There are research studies conducted to the highest standards which provide often complex and sometimes contradictory results. This is indeed a reflection of the complexity of the reality of abortion and crisis pregnancy. Therefore it is only possible to discuss the weight of the evidence and to make probabilistic statements.

We find it both scientifically and philosophically unjustifiable to argue that there can never be a case where abortion is necessary to save the life of the mother. We view this as scientifically unjustifiable because there clearly are views within the international scientific and medical community that there are cases where abortion is necessary to save the life of the mother. We view it as philosophically unjustifiable because of the principle of falsification: even if no case to date had occurred where abortion was necessary to save the life of the mother, it is still possible that such a case might arise in the future.

A distinction that is important here is that between epidemiological or statistical research which draws generalisation based on populations and samples, and the clinical context which is based on specific cases. Sample and population studies provide evidence of general trends, but there can never be certainty that such general trends will hold true for a single case.

SUICIDE

It is the official view of the Psychological Society of Ireland, with which we agree, that suicide is not simply a medical condition, nor is it only an outcome of a psychiatric condition. It is an outcome of medical, psychological, social and environmental factors. We have already discussed this in our submission to the Interdepartmental Working Group on Abortion.

In any professional or clinical context, the threat of suicide must be treated with utmost care. It is our view that suicide clearly presents a threat to life, and indeed it is treated as such in most clinical settings worldwide.

The risk posed by a threat of suicide can be comprehensively assessed, although it is still difficult to predict the likelihood of a completed suicide based on a threat of suicide. Assessment includes assessment of suicidal ideation, including frequency, duration and intensity of suicidal thoughts, final acts such as giving away possessions, and previous history of attempted suicide. Assessment of mood, coping skills, interpersonal support, and stress are also included, with methods including psychological tests, interviews, checklists and rating scales. Clinical psychologists in particular are highly trained in assessment, and psychologists in Ireland are currently involved in assessment and intervention in relation to suicide through their work in the health services and the prison service.

We conclude that the clinical assessment of the risk posed to life by a threat of suicide is possible, and that indeed clinical psychologists are highly trained and competent to perform such an assessment. The possibility of false threats, which can themselves be assessed should not be a deterrent to acknowledging the serious risk to life posed by the threat of suicide.

We can further state that it is our view that there is little evidence that pregnancy *per se* provides protection against suicidal ideation or suicidal behaviour. The evidence regarding suicide and pregnancy is highly tentative, and has been obtained primarily in countries where abortion is available. Therefore where there are low rates of suicide among pregnant women, this may be attributed to the fact that those who are suicidal have had abortions. On the other hand, there is considerable evidence that crisis pregnancies clearly present a high stress situation, although obviously that does not necessarily result in suicide. However, the *X* case quite clearly presented a case where pregnancy was experienced as so traumatic as to result in a suicidal state.

In short, crisis pregnancy may result in a suicidal state which poses a risk to the life of the mother. We therefore support the judgement of the Supreme Court in the *X* case.

RAPE AND INCEST

There is very strong evidence from both clinical and statistical studies that rape is experienced as highly traumatic. There is also considerable understanding of the healing process, and of the factors which facilitate healing from the trauma of rape. Similar points can be made about incest.

The immediate after effects of rape include intense fear of being raped or assaulted again which prevents the woman from relaxing even in her own home, and produces a state of hypervigilance, where she is constantly watchful and suspicious. Flashbacks of the rape or assault can occur which are extremely distressing emotionally. Feelings of shame and guilt almost always occur even if the woman does not blame herself, often accompanied by obsessive thoughts about how and why the rape occurred. Even when these immediate after-effects subside, there are longer term effects. Fear of assault continues, although not as intensely as in the acute phase. Other reactions which continue in varying degrees are nightmares, flashbacks, insomnia, sense of detachment, inhibited emotions, lack of trust, loss of interest in sexual activity, reduced interest in socialising and inability to form lasting intimate relationships. Pregnancy as a result of rape or incest in most cases exacerbates the trauma of rape or incest, and prevents the process of healing. The traumatic effects of rape and of incest can last a lifetime and can be passed to the next generation, resulting in impaired mental health both in victims and in offspring of victims.

As in the case of suicide, we believe that comprehensive assessment by trained professionals of the threat to mental health is possible in cases of rape or incest. Furthermore, we do not accept that the threat of false claims of rape should prevent permitting abortion in these circumstances, as the grounds for abortion are based on the threat to the mental health of the mother, rather than on rape or incest *per se*.

We conclude that research clearly shows that the traumatic impact of rape and sexual assault can be exacerbated by pregnancy, and that these traumatic effects may be of sufficient severity to pose a risk to the mental health of the mother. We therefore support the availability of abortion where pregnancy poses a threat to the mental health of the mother by exacerbating and prolonging the traumatic effects of rape or incest.

RECOMMENDATIONS

1 That there should be legislation to regulate abortion in the circumstances defined in the *X* case.

2 That abortion should be permitted where there is a threat to the mental health of the mother posed by the traumatic impact of rape or incest.

PROFESSOR PATRICIA CASEY AND
MS BREDA O'BRIEN
14 May 2000

RECOMMENDATIONS

Positive Images of Motherhood

Research from the United States (Swope 1996) has demonstrated that women see nothing good coming from crisis pregnancy. The choice is perceived as being between the mother's 'life' (in the sense of dreams, hopes and aspirations) and the child's life. Explaining the dynamic, Swope says 'unplanned parenthood represents a threat so great to modern women it is perceived as equivalent to a death of self'. On the basis of this research, advertising campaigns, primarily on television and in the cinema have been designed to show motherhood in a positive light, to confirm that there is life after pregnancy and that the woman is not a victim for continuing the pregnancy but a survivor.

For example, one advertisement shows a woman jogging under a threatening sky full of rainclouds. In flashback we see that her family and partner have been unsupportive. But she sets her chin, and determines that she and her baby will make it through this together. The final image is of a strong determined woman who will survive against the odds. The advertisement concludes with a helpline number. Research has shown that these advertisements have been successful in reducing the abortion rate in states where they have been shown.

– On the basis of this, images which are culturally appropriate to the Irish situation should be incorporated into an advertising campaign, aimed not just at women in crisis, but at the public, whose attitude may subtly influence women's attitudes to themselves when confronted with an unplanned pregnancy.

Adoption

There has been a dramatic decrease in the number of national adoptions since the 1980s whilst in tandem more women are seeking abortion as the solution to crisis pregnancy. Negative images of adoption, particularly in the media, have contributed to this.

In the Women and Crisis Pregnancy study, it is stated about those who chose abortion:

> Adoption was a far more complicated alternative, one in which the final outcome was unpredictable and one which they could not easily entertain.

Adoption is a less simple outcome, but it is interesting that many women were so negative towards even contemplating it. While recognising that many women will not choose adoption, there is nevertheless a pressing need to provide women with information on all the options available to them. This would involve:

– An assessment of the understanding and knowledge of those working with women who are pregnant, e.g. public health nurses, social workers, counsellors, and general practitioners.
– The provision of resource material for these women and their partners, both verbally and in written form to facilitate assimilation after the consultation, in view of the effect that distress has on absorption of verbal information in particular.
– An attempt should be made to change the general attitude to adoption, which at present derives largely from the negative images of the 1950s and '60s. Thus information on modern adoptive practices should be part of the Social Personal and Health Education programmes in schools.
– As part of the policy of changing the negative images, the Health Promotion Unit should design a public awareness campaign on modern adoption, using the positive experience of the many birth parents, adoptive parents and adopted people for whom adoption has been a great success.
– Similarly, exposure to such positive experience would be incorporated into the training/formation programmes for those professionals working in the area of crisis pregnancy, e.g. public health nurses, social workers, counsellors, general practitioners and so on.

Education

Social personal and health education at second level
Countries such as The Netherlands are realising that giving young people skills to avoid early sexual activity is crucial, that information is not enough. Relationship and Sexuality Education programmes which focus on empowering young people to say 'No' to early sexual activity should be researched. The Transtheoretical Model of Health Education is an interesting one, utilising as it does multimedia interactive programmes. The US Government recently mandated millions of dollars for programmes geared towards delaying sexual activity in an implicit recognition that teaching for responsibility is a crucial part of RSE.

Alcohol is a key factor in teenage pregnancy. It is time to evaluate the effectiveness of the Substance Abuse Programmes such as 'On My Own Two Feet' in order to assess effectiveness.

Adoption should be dealt with more fully at junior and senior age groups at second level. A scheme of speakers to promote positive images of adoption, to include birth mothers, adoptive parents and adoptees could be set up in conjunction with adoptive associations such as Adoptive Parents of Ireland.

Boys are often completely neglected in RSE. Modules should be developed emphasising the role of fathers, their responsibility attached to every act of sexual intercourse, and so on.

Given the increase in sexually transmitted disease, there should be an emphasis informing young people so that they can make informed choices. The American National Institute for Allergies and Infectious diseases declares that in order to reduce the risk of infection

> Delay having sexual relations as long as possible. The younger people are when having sex for the first time, the more susceptible they become to developing an STD. The risk of acquiring an STD also increases with the number of sexual experiences over a lifetime.

This is particularly relevant given the increase in Human Papilloma Virus, which is implicated in cervical cancer and against which a condom does not protect.

Parents are currently a neglected resource. In the context of Evelyn Mahon's study which showed that fear of parental disappointment was a key factor in choosing

abortion, parental involvement should be part of any RSE programme on an ongoing basis, not just part of a consultative process in formulating school policy. According to the US National Longitudinal Study on Adolescent Health, parental disapproval of their teen being sexually active is a significant factor that influences the delay of the onset of sexual activity in teenagers. (Source: Resnick, MD et al. 1997, *Journal of the American Medical Association*, 278(10), 823-832.) Parental seminars designed to give parents a forum to discuss fears regarding teenage pregnancy, and strategies to prevent it could be provided by schools.

Third level education

Access to abortion information was such a focus of students' unions during the eighties that information of alternatives to abortion was neglected. While most third level institutions are sympathetic, response to crisis pregnancy tends to be ad hoc. A working group on alternatives to abortion should be set up on each campus, with the aim of providing clear unambiguous information on the supports available to those continuing pregnancies in areas where students convene, student handbooks, websites and so on.

Counselling

Currently, women who choose abortion do so almost immediately and resent what they perceive as the imposition of counselling. This imposes a distrust of the counselling process. Research should be conducted as to the training and accreditation of counsellors. Deficiencies have already been shown, for example, in their understanding of present adoption practices.

Currently, the only model available is non-directive counselling. Some believe strongly that there is no such thing as non-directive counselling, only non-manipulative counselling. Would a more honest approach be to attempt to provide women and men with the clearest available information on surgical procedures, potential risk to physical and mental health, stage of gestation and so on?

In this context, Right To Know Laws such as passed in American states should be investigated. A mother must be given state produced materials at least twenty four hours before an abortion. These include pictures of foetal development, information about the nature of the medical procedure, its risks both physical and psychological, information about alternatives and lists of local social service organisations which provide assistance to pregnant women. At the moment, a woman receives medical information, if at all, just before she is required to sign consent for the operation.

Right to Know Laws passed in Pennsylvania resulted in an 18% drop in first time abortions.

Even in the case where a woman chooses abortion, receiving respectful care and counselling can decrease the risks of subsequent medical and psychological difficulties.

Post abortion counselling should be provided free, with due recognition of the psychological complications of the procedure.

Research

While the Women and Crisis Pregnancy Study was groundbreaking, it also highlighted how much more needs to be done. There is a great need for inception cohort and longitudinal studies. We simply do not know enough about what motivates women to choose abortion or abortion alternatives, and what the long-term outcomes are.

PATRICK MOLLOY
29 NOVEMBER 1999

Of the seven options outlined in the Paper, only number one would allow the Irish people to decide, by referendum, whether they accept or reject the Supreme Court decision in the X case, which ruled, incorrectly, that the 1983 Eighth Amendment of the Constitution, (Article 40.3.3), allows for the deliberate intentional killing of the unborn child where the mother's life is at risk from her pregnancy. The other six options would all permit the legalisation of induced abortion in certain circumstances, leading eventually to abortion on demand – as in other countries.

The Green Paper indicates that the vast majority of the 10,000 submissions received from individuals and organisations expressed a wish for a referendum which would seek to achieve an absolute prohibition on abortion. This is a very valuable and significant finding which should be given great weight by your own committee. You will be aware, no doubt, that opinion polls carried out by the Pro-Life Campaign, over recent years, have consistently shown a similarly high majority in favour of a referendum where there would be a clear choice between induced abortion and no induced abortion. (1997 62%, 1998 70%, 1999 72%).

Taking these figures into consideration, and bearing in mind that the Irish people are entitled to a referendum on the issue, under Article 6(1) of the Constitution, it is difficult to see how the electorate can be denied an opportunity to comment, by referendum on the X case, and on the substantive issue of abortion itself. The various other options, and the arguments supporting those options must, in the circumstances, be irrelevant.

It has been argued that an absolute constitutional ban cannot be placed on direct intentional terminations because, in certain very rare cases doctors are obliged to deliberately kill the foetus in the course of medical attempts to save the mother's life, and would be open to accusations of malpractice if a total ban was applied. This argument overlooks the fact that the foetus is already doomed in these cases and that the intention of the doctor would be to save the lives of both mother and child if this were medically possible. No legal case would ever be instituted against a conscientious doctor who acted for the best in such circumstances, nor would the case succeed if taken to court. It would be a very different matter if the doctor deliberately destroyed a viable foetus for social convenience genetic, congenital or other such reasons.

There was never any need to choose an amendment wording, such as that of Article 40.3.3, with the term 'unborn' instead of 'unborn child', and the two subclauses, 'as far as practicable' and 'with due regard to the equal right to life of the mother'. This wording, in the absence of clarifying legislation, was bound to require interpretation, which, as we know, transpired. To correct the

misinterpretation it is necessary to make an addition to Article 40.3.3. May I suggest the following:

> Abortion shall be unlawful in the State unless it is an unwelcome feature of standard medical treatment of the mother, imparted by qualified medical practitioners, where only the mother's life can be saved in the situation, and where the intention would be to save the lives of both mother and child if this were medically possible.

A longer and more detailed version of this wording would be as follows:

> Abortion shall not be lawful in the State, for social, convenience, economic, ethnic, genetic, eugenic, congenital, familial, marital reasons, or because of the mother's mental health, or because of circumstances relating to the unborn child's conception, or because of the mother's right to privacy or her right to choose. However, should a child in utero lose its life as an unwelcome feature of standard medical treatment of the mother, imparted by qualified medical practitioners, where only the mother's life can be saved in the situation, and where the intention would be to save the lives of both mother and child, if this were medically possible, then this shall not be unlawful.

There is no mention of 'direct' and 'indirect' abortions in these wordings, nor is there any reference to 'side-effect' or the 'unborn', or the equal rights to life of mother and child, all of which terms have caused endless controversy, doubts and confusion. The use of the term 'feature' instead of 'sideffect' eliminates any possibility that existing medical practices would be restricted by the new amendment.

The Green Paper indicates that 99.9% of the abortions, carried out on Irish residents in 1996, in England and Wales, were for reasons other than to preserve the mother's life or health. This confirms, what we knew already, that legalised induced abortion is being sought in Ireland, and around the world, on spurious grounds, in order to provide a lastditch, backup service to deal with an epidemic of unwanted pregnancies. Irish women do not travel to Britain to have life-threatening ailments treated in abortion clinics, they book themselves into Irish hospitals, where they receive topclass medical treatment. Viewed in this light, the Irish abortion situation, at its most fundamental level, is not at all complicated.

The complications, which exist in the current situation, have arisen because the Supreme Court gave a false pro-abortion interpretation to the 1983 Eighth Amendment, in the 1992 X case, and because the then government, and subsequent governments, have failed to deal democratically with this wrong judgment. The 1996 Constitution Review Group Report, which recommended that induced abortion be legalised, completely ignored the irregularities of the X case judgment, and the 1999 Green Paper also deftly avoided the issue. It is to be hoped that the Committee on the Constitution will realise that the way forward has to be in line with the people's democratic right to vote for or against induced abortion in a properly formulated referendum and that any other recommendations would be not only wrong, but also impossible to implement.

GEARÓID R Ó DUBHTAIGH
2 DECEMBER 1999
SUBMISSION TO THE ALL-PARTY OIREACHTAS COMMITTEE ON THE CONSTITUTION

I request that **Option One**, contained in the Government Green Paper on Abortion namely, '*an absolute Constitutional ban on abortion',* be put before the people by way of Referendum.
I wish to advance the following supporting arguments for my position.

1 Abortion is never necessary

Abortion is never, a necessary prerequisite for giving a mother all the medical treatment she needs or which could possibly benefit her health.

In this context it is important to state that it is abhorrent to accuse mothers or the medical profession of abortion:

(i) where a miscarriage is the unsought side-effect of medical treatment necessitated by the mother's condition, or
(ii) where the child is lost owing to the removal to an ectopic pregnancy.

2 Abortion is a horrendous reality

Life begins for each of us personally, at conception.

Advances in modern medical techniques virtually provide us with a window on the womb, enabling us to know and to respond so much more effectively to the needs of our baby.

Abortion is a perversion of medical care, a horrendous intrusion, which involves the mutilation (dismemberment) of a living human being.

3 Abortion traumatises women

Post Abortion Stress Disorder, regret and broken relationships, are all too frequent consequences of abortion, suffered by women and those closest to them.

Studies show that pregnant teenagers, who threaten suicide, are 5 to 7 times more likely to take their own lives, if they have an abortion.

Rape victims also find it beneficial towards overcoming their traumatic experience to carry the child to birth.

While advocates of abortion present it as a quick-fix solution, in reality it merely exacerbates the underlying psychiatric problems and delays recovery.

4 Cherishing human life

In addressing the abortion issue ours is a choicce of working for life or to facilitate its destruction.

Choosing life, means supporting mothers through those difficulties and fears, which drive many to the abortion industry.

Apart from the necessity to support motherhood in a credible way, laws play an important role in directing respect for all members of society.

5 Laws guided by best medical practice

Laws founded on medical reality are a basic requirement of a civilised society.

The current legal situation does not reflect medical realities.

The Ethics Committee of the Irish Medical Council is the body charged with over-seeing medical practice in Ireland. Its members comprise those elected by the medical profession (including psychiatrists), and those appointed by the Minister for Health.

Following 18 months of deliberation, during which they received a vast amount of submissions, and consulted world experts, on all the complications that can possibly arise during pregnancy, the Irish Medical Council concluded (1993), that abortion was never necessary in order to treat a pregnant mother.

In their most recent review (1998) of this ruling this body declared that carrying out an abortion would be considered professional misconduct.

Given that these are the standards, which govern medical practice in this country, it is significant that a UN survey found that our maternity health-care record is second to none.

While the Green Paper refers to the above, it fails to acknowledge the Ethics Committee as the only, appropriate, legally recognised body, competent to establish and pronounce upon the medical considerations pertaining to this issue. The facts have been established, and they have been unambiguously set forth.

6 Let the people decide

Given that the Supreme Court 1992 judgment

(i) was so out of step with the will of the people as they sought to express it in 1983, and
(ii) undermines the whole foundation of civilised law, namely the upholding of the rights of the weak and innocent where these are threatened or violated.

it is incumbent upon the Oireachtas to provide the people with an opportunity to redress the situation.

There is nothing extraordinary about this request, as successive governments have made recourse to referendums in recent years, where other Supreme Court decisions were considered unfavourably: for example those on Adoption, Articles 2 & 3, Bail laws, Cabinet Confidentiality, and the Single European Act.

Successive opinion polls show overwhelming support for referring this matter to the people by way of a clear-cut Referendum.

I am of the opinion that it is particularly pertinent to your committee's deliberations that I set out my views regarding the 1992 Supreme Court Decision and its aftermath. There was in my view a gross miscarriage of justice, which can *only be rectified* by consulting the electorate by way of a Referendum.

In 1983, as a result of popular demand, and in spite of hostility in media and political circles, there was over-whelming support for an amendment to the Constitution, having as its aim the prohibition of legalised abortion in this country. Those who supported it and those who opposed it at that time, did so in the belief that it would have this effect.

In 1992, in the X-case, the Supreme Court gave the go ahead for the abortion of the baby of a fourteen-year-old teenager. In other words the Court gave the go ahead for the killing (terminating the life) of a *completely innocent* human being.

In the Court case the counsel for the Attorney General (of the State) conceded without argument that the Constitution allowed for abortion. The Court was told in evidence that the teenager was threatening suicide. Apparently on the grounds that the teenager's life (and by extension the unborn baby's life) was at risk, the Court came down on the side of those seeking to terminate the life of the baby. In arriving at its ruling:

(a) the court failed to consult medical opinion, concerning the condition of the teenager, and the most beneficial medical treatment available to her.
(b) the court failed to assign legal representation for the wellbeing of the unborn baby.

It is incredible that the legal professionals involved in the Court case, did not call upon medical advice despite the fact that the Court was presumably endeavouring to base its life or death decision, upon what was medically desirable. While the Court heard the witness of a clinical psychologist, it should be noted that a psychologist is not a medical professional. A psychiatrist is the appropriate medical professional, having being trained both to diagnose and to prescribe medicines to treat those with psychiatric conditions.

In presenting abortion as medical treatment, the court falsely gave the impression that the teenager would benefit medically from her baby being killed. The Green Paper failed to find evidence to support to this contention, while they mention many sources of evidence and testimonies to the contrary. When viewed in the light of the most authoritative medical (including psychiatric) deliberations the judgment in the X case has been found to be grossly in error.

The credibility of our Courts rests in their resolute determination to call upon the faculties of the State to ensure protection for the vulnerable in our society. Should they abdicate this role, they can no longer be seen to be part of a justice system.

I do not find this last point anywhere in the Green Paper. Yet it is of extraordinary importance. In my view it is the kernel of the matter. It is on account of this that people have written, marched, and pursued this issue.

I wish to express my willingness to address your committee on this matter.

Finally, if you can find any flaw with my analysis of the situation in which we find ourselves, I would be most grateful if you would let me know.

JOSEPH G. O'BEIRNE, M CH ORTH, FRCSI,
FRCS ED ORTH
30 NOVEMBER 1999
SUBMISSION ON ABORTION

I am writing in response to the invitation for submissions on the subject of abortion. I believe the approach being taken now is wise, in view of the fact that the whole question has become unnecessarily confused and complicated in recent years, and a fresh look needs to be taken in order to sort it out.

It would be useful initially to go back to the 'de facto'

position as it was prior to 1983. It was generally accepted both on moral and medical grounds that:-

- It is unjustifiable to **directly** take the life of an unborn child, i.e. abortion as generally understood.
- There is no condition in which direct abortion is necessary to save the life of the mother.
- There are rare circumstances in which life-saving treatment has to be carried out on the mother which may have the unintended side-effect of loss of the unborn life. The most obvious examples are Carcinoma of the Cervix (which required treatment by hysterectomy), and ectopic pregnancy. This consideration also applies to pharmacological treatment, e.g., chemotherapy, which may have an unintended deleterious effect on the unborn.

Until 1983, the only legal basis for all of the above was the reference to abortion in the 1861 Offences against the Person Act. The purpose of the 1983 amendment was to give constitutional effect to the right to life of the unborn, with regard to the three principles outlined above. The phrase 'with equal regard to the right to life of the mother' was included in order to allow for the 'double-effect' principle.

The problem was that a constitutional article cannot be more than a general statement of principle; what should have then happened was that legislation should have been enacted spelling out the position in detail, in accordance with the basic thrust of the amendment. The fact that this did not happen left the matter unsatisfactorily open. This in turn resulted in the bizarre interpretations put on the amendment in the recent Supreme Court cases, 'X' and 'C', which leave us in our present difficulty.

It is clearly unsatisfactory to accept that, if a pregnant mother threatens to commit suicide unless an abortion is carried out, one must therefore accede to her wishes and carry out the abortion. In psychiatric terms, one does not treat suicidal ideation by giving in to the demands made by the patient while in the suicidal state. Put simply, to do so would be nothing more than giving way to blackmail.

The problem now is that articles in the Constitution mean whatever the Supreme Court says they mean; therefore, article 40.3.3. in its present form mandates the availability of abortion with very liberal terms of reference. This means that if we want to restore the position to that defined by the three principles I have outlined at the beginning (and in accordance with the intention of the 1983 amendment), the Constitutional position cannot be left as it is.

I believe there is no reason to move away from these basic principles; they have formed the basis for sound medical practice for many years, and in fact continue to do so. I believe that the great majority of Irish people are opposed to abortion as they were in 1983, and if given the chance to address the issue in these straightforward terms would reaffirm that opposition. There have of course been several attempts to confuse and therefore sway public opinion on the matter with spurious arguments. The most common is to justify abortion 'in order to save the life of the mother'. It has been shown that the Irish maternal mortality rate is extremely low in international terms, despite our being one of the few countries left without legalised abortion. If there were in fact any condition which required abortion in order to save the life of the mother, the pro-abortion lobby would long ago have pointed it out!

It comes down in the end to a matter of basic values, on which, according to the Constitution, the people have the right to decide. Due to the recent Supreme Court decisions, the 'de facto' Constitutional position defines a situation which very few people wish to see. Therefore the people ought to be given the chance to make the necessary alteration in the Constitution to allow for the view of the great majority in this matter.

The alternatives are either to delete Article 40.3.3. entirely, or replace or augment it with a form of words which prohibits direct abortion. The disadvantage of the former course is that it leaves the unborn with no Constitutional protection at all. In times past, this was no bad thing, but recent history has shown that the absence of such a provision could leave the way open for a court challenge to the 1861 Act, with the same effect as the *Bourne* case (1938) in the UK, or *Roe v. Wade* (1973) in the US.

The better course would be the insertion of a new provision prohibiting direct abortion. The point has been made that it is impossible to frame a wording which is immune to 'surprising' interpretation by the Courts. I would comment then that we could ask the advice of those very Supreme Court judges as to the form of words which best expresses the intentions as set out at the beginning. Moreover as I said previously, Constitutional articles cannot be more than statements of principle anyway; it is then up to the Legislature to filling the detail in accordance with the overall thrust of what the Constitution is saying.

In conclusion, therefore, I would argue quite forcefully that there is no justification for abandoning our long-established position that direct abortion is unjustifiable; due to a bizarre set of circumstances, the current Constitutional position is unsatisfactory in this regard. It is therefore impossible for legislation alone to remedy the situation. The people must be given the chance to make the necessary alteration in the Constitution, and legislation must then follow to spell out the position in sufficient detail so that further difficulties such as those encountered in recent years will not re-emerge.

RODERICK J. O'HANLON SC
FORMER JUDGE OF THE HIGH COURT
SUBMISSION TO THE INTERDEPARTMENTAL WORKING GROUP ON ABORTION

Pope John Paul II, at the commencement of the Year of the Family (1994) declared that –

> Families are placed at the centre of the great struggle between good and evil, between life and death, between love and all that is opposed to love. To the family is entrusted the task of striving to unleash the forces of good, the source of which is found in Christ.

He spoke in similar terms about the three year period leading up to the Third Millennium, as a time of 'epochal transition', a time when humanity is at a cross-roads:

> A great drama is taking place which will decide the future of the world and with the approach of the third

> millennium, humanity must choose between the 'civilisation of love' and one based on individualism and self-interest.

The issue of abortion is also central to that great struggle between good and evil, between life and death, of which the Holy Father has spoken. It may be beneficial to consider it in the light of Questions 1 and 2 of the old-style Penny Catechism:

1	Who made me?	**A**	God made me.
2	Why did God make me?	**A**	God made me to know, love and serve Him here on earth, and to be happy with Him forever in Heaven.

God is the Author of life. Human life can never be taken away in circumstances which conflict with the law of God. How do we know what is the law of God? It was taught to us by the prophets before the coming of Jesus Christ, and then by God Himself, in the person of Jesus. 'God did not abandon us after the death of Jesus, but gave us his Church to watch over us and guide us here on Earth and Jesus remains present in His Church and will do so until the end of time.

Over 91 per cent of the people of the Republic of Ireland profess their belief that the Catholic Church is the one true Church of Christ, while respecting the sincerity and integrity of those who are unable to share their belief. If sincere in their profession of belief in the Catholic Church as the Church of Christ they are bound to accept the teaching of the Church on all matters concerning Faith and Morals, and this is the teaching of Magisterium of the Church – the Pope and the Bishops.

THE MORAL LAW ON ABORTION AS TAUGHT BY THE CATHOLIC CHURCH

The law of God in relation to abortion has been enunciated over and over again by the Catholic Church in very clear and unequivocal terms, and from the earliest times. Here are some of the relevant texts:-

Catechism of the Catholic Church

> 2270. Human life must be respected and protected absolutely from the moment of conception. From the first moment of his existence, a human being must be recognised as having the rights of a person – among which is the inviolable right of every innocent being to life …
>
> 2071. Since the first century the Church has affirmed the moral evil of every procured abortion. The teaching has not changed and remains unchangeable. Direct abortion, that is to say, abortion willed either as an end or a means, is gravely contrary to the moral law:
>
> > 'You shall not kill the embryo by abortion and shall not cause the new born to perish' (Didache 2,2).
> >
> > 'God, the Lord of Life, has entrusted to men the noble mission of safeguarding life, and men must carry it out in a manner worthy of themselves. Life must be protected with the utmost care from the moment of conception: abortion and infanticide are abominable crimes.'
>
> 2272. Formal co-operation in abortion constitutes a grave offence. The Church attaches the canonical penalty of excommunication to this crime against human life. 'A person who procures a completed abortion incurs excommunication latae sententiae' (Codex 1 luris Canonici), 'by the very commission of the offence' and subject to the conditions provided by Canon Law. The Church does not thereby intend to restrict the scope of mercy. Rather, she makes clear the gravity of the crime committed, the irreparable harm done to the innocent who is put to death, as well as to the parents and the whole of society.

The Declaration on Procured Abortion, issued with the approval of Pope Paul VI in 1974, stated that, 'whatever the civil law may decree in this matter, it must be taken as absolutely certain that a man may never obey an intrinsically unjust law, such as a law approving abortion in principle. He may not take part in any movement to sway public opinion in favour of such a law, nor may he vote for that law. He cannot take part in applying such a law'.

The Charter of the Rights of the Family, issued by the Holy See, with the approval of Pope John Paul II on October 22, 1983, declares, in Article 4:

> Human life must be respected and protected absolutely from the moment of conception.
>
> a. Abortion is a direct violation of the fundamental right to life of a human being.

A statement from the Catholic Archbishops of Great Britain, issued in 1980, declared as follows:

> The Church speaks out against abortion, as it has from the beginning, because it acknowledges the human rights and dignity of all, including the unborn, and is committed to their defence … What we have to say about abortion is consistent with the whole Christian teaching about the right of the innocent to live. The teaching is central to our whole civilization. Without it, no other rights are secure.

A statement issued by the Irish Bishops' Conference (published Nov. 6, 1992, on the eve of the Referendum), stated:

> Two issues confront us. The first – the moral principle – is not open to question. The intentional destruction of innocent human life, at any stage from conception to natural death, is gravely wrong. This principle admits of no exceptions. It does not depend on a particular religious conviction. The unborn child's right to life 'is a primary, natural, inalienable right that springs from the very dignity of every human being' (Pope John Paul II to the Irish Bishops, September 25th, 1992). This is a principle which ought to guide conscience and behaviour, whatever the Constitution or Law may say.

In the Encyclical Letter, *Evangelium Vitae*, Pope John Paul II wrote:

> Abortion and euthanasia are crimes which no human law can claim to legitimize. There is no obligation in conscience to obey such laws; instead there is a grave and clear obligation to oppose them by conscientious objection. 'We must obey God rather than men.'
>
> In the case of an intrinsically unjust law, such as a law permitting abortion or euthanasia, it is never licit to obey it or to take part in a propaganda campaign in favour of such a law, or to vote for it.
>
> Christians, like all people of goodwill, are called upon under grave obligation of conscience not to co-

operate formally in practices which, even if permitted by civil legislation, are contrary to God's law. Such co-operation occurs when an action, either by its very nature, or by the form it takes in a concrete situation, can be defined as a direct participation in an act against innocent human life or a sharing in the immoral intention of the person committing it.

Laws which authorize and promote abortion and euthanasia are radically opposed not only to the good of the individual but also to the common good; as such they are completely lacking in authentic juridical validity. Disregard for the right of life, precisely because it leads to the killing of the person whom society exists to serve is what most directly conflicts with the possibility of achieving the common good. Consequently, a civil law authorising abortion and euthanasia ceases by that very fact to be a true, morally – binding civil law.

Among all the crimes which can be committed against life, procured abortion has characteristics making it particularly serious and deplorable. **The Second Vatican Council** defines abortion, together with infanticide, as 'unspeakable crimes'.

But today, in many people's consciences, the perception of its gravity has become progressively obscured. The acceptance of abortion in the popular mind, in behaviour, and even in law itself, is a telling sign of an extremely dangerous crisis of the moral sense, which is becoming more and more incapable of distinguishing between good and evil even when the fundamental right to life is at stake.

The moral gravity of procured abortion is apparent in all its truth if we recognise that we are dealing with *murder* … The one eliminated is a human being at the very beginning of life. No one more innocent could be imagined. (Reasons put forward) however serious and tragic, can never justify the deliberate killing of an innocent human being.

Responsibility likewise falls upon the legislators who have promoted and approved abortion laws. Doctors and nurses are also responsible when they place at the service of death skills which are acquired for promoting life. We are faced with an immense threat to life; not only to the life of individuals, but also to that civilisation itself. We are facing what can be called 'a structure of sin' which opposes human life not yet born.

These extracts give a clear and unequivocal account of the teaching of the Catholic Church in relation to the moral law as applied to the question of abortion. It is significant, however, that this understanding of the moral law is shared by others of the great religions of the world – witness the united front presented by Catholic countries and Islam at the Cairo Conference when a proposal supported by the United States, led by President Clinton, to make abortion more readily available on a world-wide basis was defeated; witness also the united front presented by different Christian parties in Northern Ireland against in extension of the liberal abortion law of Great Britain to that part of the United Kingdom. A joint statement issued from the House of Commons by Dr. Joe Hendron MP and the Reverend Martin Smyth, MP, who was then Grand Master of the Orange Order, declared that any such proposal would be totally unacceptable to the people of Northern Ireland. In Asia, Buddhists are in the forefront of the struggle against legislation for abortion. The world-wide opposition to abortion is supported by members of different beliefs and by persons with no religious beliefs. The obligation to protect innocent human life against attack is not merely an article of Faith recognised by the Catholic Church, but a moral principle capable of being recognised by all human persons who are sincere in their search for truth in their lives.

THE PRESENT STATE OF THE LAW REGARDING ABORTION IN IRELAND

The whole Christian ethos underlying the Constitution of Ireland is impossible to reconcile with any attempt by judicial interpretation or patchwork amendment of the text of the Constitution itself, to permit by law the carrying out of abortion in Ireland or to facilitate by information or constitutional guarantee of a right to travel abroad, those who wish to leave the jurisdiction for the specific purpose of bringing about the death of the unborn child in the womb of the mother.

The decisions of the Supreme Court in the 'X' case, and of the District Court and the High Court in the 'C' Case, along with the amendments on travel and information pushed through in 1992 and the infamous Abortion Information Act which followed, can only be described as a series of aberrations which are in open conflict with the whole text and Christian philosophy of the remainder of the Constitution. It is not surprising that the Constitution Review Body finds it necessary to recommend that large areas of the existing text of the Constitution as originally enacted be now exercised, in an effort to bring about a situation where the document will not be seen to contradict itself in matters of fundamental importance.

The Preamble to the Constitution which contains the all-important words of enactment of the entire document, recites that it is being adopted and enacted '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 … Humbly acknowledging all our obligations to our Divine Lord Jesus Christ who sustained our Fathers through centuries of trial …'.

How, in Heaven's name, can we possibly adopt, enact, and give to ourselves a Constitution in the name of the Most Holy Trinity, and of our Divine Lord Jesus Christ, which contains an express guarantee, protected by the Constitution itself – the fundamental law of the land – of the right to travel abroad to procure an abortion – correctly described by Pope John Paul II as *murder*, and a similar express guarantee of the right of access to information required for the same evil purpose?

How could any court of law conclude that abortion can be lawfully carried out within the jurisdiction in certain circumstances, invoking the name of the Most Holy Trinity and our Divine Lord Jesus Christ in support of what the Church to which over 90% of our people claim allegiance, has described as 'an abominable crime' admitting no exceptions?

Where does the truth lie? Does it lie in the teaching of the Church or does it lie in the judgement of the judges and the handiwork of the political parties who have debased and degraded a noble and splendid constitutional document in the manner described?

Article 6 of the Constitution, dealing with the powers of government, declares that: 'All powers of government legislative, executive and judicial, are derived, *under God*, from the people', once again giving express recognition

to the belief that all authority to make or enforce laws is derived from God and must be exercised in harmony with the Divine will.

The concluding words of the Constitution are: 'Dochum Glóire Dé agus Onóra na hÉireann' – 'For the glory of God and the honour of Ireland'. How can a Constitution which is interpreted as sanctioning 'a moral evil', 'an abominable crime', a 'crime against human life', profess at the same time to uphold the glory of God and the honour of Ireland? The Constitution Review Body appear to observe a discreet silence in relation to this final proclamation.

Article 40-44 of the Constitution, dealing with Fundamental Rights, refer on a number of occasions to 'inalienable and imprescriptible rights, antecedent and superior to all positive law' (Art. 41.1): the 'inalienable' right and duty of parents to provide for the education of their children (Art. 42.1); the 'natural and imprescriptible rights of the child' (Art.42.5); 'the natural right antecedent to positive law to the private ownership of external goods' (Art. 43.1.1.)

The text of the Constitution thereby gives express recognition to the further principle that there are certain rights of so fundamental a character that they cannot be surrendered and cannot be taken away. Of these rights, the right of innocent human life to be protected against attack must be the most fundamental. Yet it was denied this protection by the Supreme Court in the 'X' Case; by the District Court and High Court in the 'C' Case; by the Supreme Court in its ruling on the Abortion Information Bill, and again by its judgement in the case where it decreed that nutrition and liquids could be withheld from a Ward of Court and that her death could be brought about by this process. In giving these judgements the Court turned its back on a whole series of judgements and statements of principle in preceding years. See for example what was said by Mc Carthy J. in *Norris v. Attorney General* 1984 IR:

> The provisions of the Preamble would appear to lean heavily against any view other than that the right to life of the unborn is a sacred trust to which all the organisations of government must lend support …

– and Chief Justice Finlay in *SPUC v. Grogan*, 1990 IR, dealing with attempts to disseminate information about abortion in the United Kingdom:

> This application … consists of an application to restrain an activity which has been clearly declared by the Court to be unconstitutional and therefore unlawful and which could assist and is intended to assist in the destruction of the right to life of an unborn child, a right acknowledged and protected under the Constitution. That constitutionally guaranteed right must be fully and effectively protected by the courts.

– and again in *A.G. v. Open Door Counselling*, 1987 IR:

> The right to disseminate information cannot be invoked to interfere with such a fundamental right as the right to life of the unborn, which is acknowledged by the Constitution of Ireland.

These, and other similarly trenchant assertions of the protection which must be given to the right to life of the unborn, have been described by members of the present Supreme Court as 'flawed', but they are *not* flawed. What in fact were flawed were the majority judgements in the 'X' Case; the judgement of the Court in the reference of the Abortion Information Bill, when it put forward the indefensible proposition that any purported change in the Constitution which had the support of a majority in a Referendum could not be challenged but was to be regarded as the fundamental law of the State, even if it trampled underfoot all human rights, even the right to life itself.

In response to the media-driven clamour for abortion in Ireland, whether under the guise of the deplorable decisions in the 'X' Case, and the 'C' Case, or by way of further amendment of the Constitution, the answer should be that given by the apostles before the Sandhedrin: 'We must obey God rather than men'. (Acts of the Apostles, 5:29).

The Sandhedrin were enraged and wanted to kill them, but for the intervention of Gamaliel, who said:

> In the present case I tell you, keep away from these men and let them alone; for if this plan or undertaking is of men, it will fail; but if it is of God, you will not be able to overthrow them. You might even be found opposing God.

These words are full of significance at the present time. The 'abominable crime' of abortion, which Pope John Paul II has not hesitated to describe as murder of a human being at the very beginning of life, as been recognised as a legal and permissible procedure by the majority judges in the 'X' Case; by the District Judge and High Court Judge who dealt with the 'C' Case; by every member of Dail and Senate who took part in the enactment of the Abortion Information Act who failed to oppose it by every means open to them; by President Robinson in signing and promulgating the Bill as law.

To each of these persons, and in particular to each one of them who professed the Catholic Faith, another course was open – that taken by King Baudouin of Belgium when he abdicated from the throne of Belgium rather than ratify a law which was directed against the right to life of the unborn child. They chose voluntarily to ignore the warning of Gamaliel and have been found to be opposing God.

This is the message which the Bishops and priests of Ireland should preach in season and out of season. Our Lord said: 'That which I have told you in secret, proclaim from the housetops'.

Unfortunately, on the eve of the 1992 Referendum, the statement issued by the Irish Bishops' Conference, while commencing with the admirable statement of the moral principle involved which has already been referred to, went on to dilute the effect of their message to the point where it was headlined in the *Irish Times* as: 'Bishops accept both "Yes" and "No" votes'. This equivocal approach may well have had a disastrous effect on the outcome of the referenda.

A really inspiring statement emanated from the Irish Bishops' Conference in 1995, reported under the heading 'Bishops See Supreme Court Ruling in X Case to be a Corruption of Law' (*Irish Times*, 1 July 1995). What a pity it did not come three years earlier, when it could have helped to avert the open defiance of the law of God which was involved in the majority vote in favour of a right to travel and a right to information, for the purpose of bringing about the death of the unborn child.

Ralph Hodgson was a poet with a special love for animals. He wrote:

> 'Twould ring the bells of Heaven
> The loudest peal for years
> If parson lost his senses
> And people came to theirs
> And he and they together
> Knelt down with angry prayers
> For tamed and shabby tigers
> And dancing dogs and bears
> And wretched blind pit ponies
> And little hunted hares.

Love of animals is laudable and to be encouraged, but it seems much more likely that it would ring the bells of Heaven the loudest peal for years if every bishop and every priest and every true follower of Jesus Christ all over Ireland knelt down with angry prayers for the thousands of unborn children killed by abortion every day of the year – many of them brought from Ireland to the abortion mills of England – and stood up determined to rid our legal system of this cancerous growth which is introducing the culture of death into Irish life.

SCHEDULE

1 Suggestions re form of draft Amendment which should not be put to the people by Referendum.
2 Copy article – 'The Nation's Burden of Conscience' by Professor James V. Schall, SJ, of Georgetown University (Fellowship of Catholic Scholars Quarterly, Fall, 1996).
3 Copy message addressed by Mother Teresa to the People of Ireland 23 November 1992.
4 Copy Article – 'Choose Life!' – by Barbara O'Hanlon, BCL, BL, published in Position Papers, 1995.

PROPOSED AMENDMENT OF THE CONSTITUTION

1 An opportunity should be given to the people to rule out abortion once and for all so far as Irish law and the Law of the Constitution are concerned.

I have seen draft amendments prepared by the Pro-Life Campaign, and by Youth Defence, and would support the adoption of either formula.

I would recommend the addition of an opening sentence to whatever formula is adopted, as follows:

> **The unborn child shall, from the moment of conception, have the same right to life as the child born alive.**

2 It is always permissible to incorporate in a statute a preamble explaining the intention of the legislators in adopting the statute and this course could help to prevent later misinterpretation by the courts.
3 It has also been accepted by the High Court and Supreme Court, e.g. in the challenge to the constitutionality of the Rent Restriction Acts, that the courts may have regard to what was said in the course of the Oireachtas Debates if this can be helpful in interpreting the legislation and deciding questions of constitutionality. This course could have been followed in the 'X' Case had any of the parties of the court itself thought of doing so, and would (in my opinion) have left the court in no doubt that all parties dealing with the 1983 Amendment saw it as one intended to outlaw abortion under all circumstances in Irish law. In the case of any proposed amendment for the future it would be desirable that the intended purpose and meaning of the amendment be spelt out clearly in the course of the debates in the Oireachtas.
4 Having regard to what has been said in the enclosed Memorandum, the people should be given a further opportunity to reconsider their decision in relation to travel for abortion and information about abortion, and – if they think fit – to repeal the Amendments adopted in 1992. It seems unlikely that they foresaw that the adoption of the Abortion Information Bill would be followed within a few days by the circulation to doctors all over Ireland by the Irish College of General Practitioners of detailed information about abortion clinics in England, with particulars of the prices charged for exterminating unwanted babies, including a sliding scale increasing in cost according to the size and weight of the baby to be exterminated. The passing of the Act has been followed by a significant increase in the numbers of expectant mothers presenting for abortions in England and giving Irish addresses when doing so.
5. The total confusion which existed in the minds of the voting public at the time of the 1992 Referenda was made quite apparent by the extraordinary number of spoiled votes – 80,000 in relation to each of the two issues of travel and information.

SEAN MAC GIOLLARNATH, OCARM
30 NOVEMBER 1999
ALL-PARTY COMMITTEE ON THE CONSTITUTION
SUBMISSION ON ARTICLE 40.3.3

CHOICE OF SUBMISSION
OPTION ONE : AN ABSOLUTE CONSTITUTIONAL BAN ON ABORTION

Primary task of government and law

I want to begin this submission by asking the members of the Committee to reflect on the primary tasks of a state's government and law. I suggest that one such primary task is to prevent any injustice of the kind involved in violations of fundamental human rights, and punitively to restore the public order of just rights whose disturbance is entailed by every such violation. Of course, the responsibility of the state government and law goes beyond this indispensable minimum. However, if the State, through law and government, is not only permitting but actually facilitating such violations of fundamental rights, it is failing in its duty. Positive law is essentially a human enterprise of practical reason seeking to promote human goods and practical truths. Laws permitting violations of the fundamental rights of the person in one part of the law fail to respect the proper task of positive law and lead, willy-nilly, to injustices in other parts. What Oxford legal philosopher, John Finnis, has called 'the juridical concern for connectedness' comes into play. So, for instance, abortion for motives of physical health broadens to include

motives of psychological health, which in turn broadens to include motives of mere powerful desire and aversion.

Governments under scrutiny

Recent years have seen the workings of government and law-makers in our country come under close scrutiny. Various tribunals, such as Flood and Moriarty, have yet to complete their work. So, all the data is not in yet. Notwithstanding that, I think that it can safely be said that the institutions of government have taken a battering, such that, amongst younger people in particular, there has been a huge growth in cynicism and apathy towards those who participate in public life and the practice of politics. Participation in politics has come to be seen as climbing aboard a gravy train of sorts, where one can dispense favours and riches to close friends and to those who might assist in various partisan causes. This perception is not entirely justified but it strikes me that it is widespread.

Immense potential for politics

Politics is a broad field, and there is immense potential in it for good work. It envisages multiform activity – economic, social, legislative, administrative, cultural – and it has a its objective the promotion of the common good in an organic way and through institutions. Members of the committee will have, to a greater or lesser degree, some experience in many of these areas. Apart from the task mentioned already, that of securing the protection of fundamental rights and the basic goods of the human being, other tasks of the government and the legislature are (i) to ensure the proper functioning of State structures, (ii) transparency in public administration, (iii) impartiality in public service, (iv) just and honest use of public funds, and (v) rejection of illicit means to obtain and keep power.

Work of tribunals; work of committee; interconnectedness of the common good

The work of the Flood and Moriarty tribunals touch on many of these areas, as did the Beef Tribunal, under Mr. Justice Liam Hamilton. The work of the Oireachtas on the abortion issue deals more specifically with the protection of the fundamental human rights and basic goods of the human being. Yet given the interconnectedness of our world, the other tasks of government may also be at stake. What Martin Luther King called 'the inescapable network of mutuality' means that these areas of the common good are tied in and linked together. Public funds, for instance, which come from the taxes imposed on our citizens, should not be used in a way that allows distortion of the public debate on the issue. It would be a great mistake if biased, incomplete, misleading, and unscholarly research funded by taxpayers, and dealing with the issue of abortion, were to be presented by elected representatives, their press agents and assistants, as 'knowledge' to an unsuspecting public during a debate on the abortion question. Transparency in public administration is another aspect of the common good. The *Green Paper on Abortion* was preceded by a process of consultation, during which submissions from the public were requested. It appears that an overwhelming majority of the submissions made clear that a total ban on abortion was desired. The authors of the paper however, did not reveal these statistics, and adopted a value-neutral and even muddled stance in describing abortion, preferring the ambiguous term, 'termination of pregnancy'. Transparency in public administration is hot helped by such practices.

The Fundamental Rights and Goods of the Person

The most obvious impact of government on the abortion issue is in the area of fundamental human rights. The work of the legislature and government in this area will speak, symbolically and practically, of the attitude of the State to the protection of human rights in the country. It seems to me that the only reasonable option is the restoration of a culture which protects the unborn child. Due to a variety of recent court cases and legislative responses, such as the *X* case, the *C* case, the 1992 amendments regarding 'travel' and 'information', the Noonan abortion information bill, and the Supreme Court decision in the Article 26 reference by President Robinson, our commitment to the unborn child has been obscured and even rendered nugatory. A restoration of a culture of life can only come about if the unborn child is protected from the moment of conception against unjust attack. This means changes in the text of Article 40-3-3. It means the restoration of the public order where just rights have been violated, one of the central tasks of law and government.

Politicians must take a clear stand

Every society takes a public stand on the question of abortion. It is not possible for the legislature to drag its heels indefinitely. It behoves politicians to lead on an issue, and to demonstrate a competence in facing the injustices in our laws on abortion. So far, politicians have tended to run for cover on the issue, claiming that the divisiveness of the issue prevents them taking action. The claim of divisiveness is quite superficial. Inevitably, when facing up to injustice, some resistance will be met by vested interests. Nelson Mandela met such opposition in South Africa. Martin Luther King met it in the USA. Unionism resisted fair play for nationalists in Northern Ireland until the very recent past. Statesmen are made when they succeed by dialogue and persuasion in convincing those resisting the demands of justice that there is a better way. David Trimble might not have envisaged sitting around a table with Gerry Adams four years ago – are the members of the Oireachtas up to taking a brave stance against killing the innocent unborn children? This challenge is posed also to those who close their minds harshly and arbitrarily against the rights of the unborn child, the silent victim in this conflict.

THE PRESENT INJUSTICES

Injustice in the Supreme Court

The Supreme Court ruled in the *X* case that abortion is permitted where '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'. The judgement offered no clear guidance as to how this rather ambiguous test would be applied in practice. The test reflects poorly on the Court, as it did not consider the clinical reality in relation to suicide in pregnancy, nor the treatment of

pathologies in pregnant women in Ireland. This was known at the time, and has been repeatedly set forth in Medical Council's ethical guidelines. No evidence has been produced to warrant a medical justification for abortion, as *A Guide to Ethical Conduct and Behaviour and to Fitness to Practice (1994)* from the Medical Council made clear. **Paragraph 39** reads:

> It has always been the tradition of the medical profession to preserve life and health. Situations arise in medical practice where the life and/or health of the mother or of the unborn, or both, are endangered. In these situations it is imperative ethically that doctors shall endeavour to preserve life and health …
>
> While the necessity for abortion to preserve the life and health of the sick mother remains to be proved, it is unethical always to withhold treatment beneficial to a pregnant woman, by reason of her pregnancy.

Medical ethics

The more recently published *A Guide to Ethical Conduct and Behaviour (December 1998)* continued the honourable tradition of medicine in this country in its rejection of procured abortion. It took this stance, despite the pressure from within and without to resolve the supposed impasse between the horrendous *X* case and *C* case and the ethics of medicine. It wisely stated, *inter alia*, in Section A, 1.3 that medical care 'must not be used as a tool of the state, to be granted or withheld or altered in character under political pressure'. Politicians should remember this when exploring the issue of abortion. What if those doctors in corrupt regimes such as Nazi Germany or Soviet Russia who did the bidding of their masters and allowed their code of ethics to be undermined because of political corruption had instead resisted? Doctors in Ireland are likewise called to witness to the fact that when they deal with an expectant mother, in whatever circumstance, they have an obligation to both mother and child. I hope that no political pressure comes from any quarter which undermine the first principle of medical ethics – *primum non nocere.*

Lebensunwertes Leben – life that is not worthy of life

Natural law played a large part in the elaboration of rights in Ireland up to the Supreme Court decision in May 1995. In that case, the unborn child effectively became Lebensunwertes Leben, life that is not worthy of life. The Court permitted information to be given which would have the direct consequence of destroying the expressly guaranteed constitutional right to life of the unborn. Since then, the numbers of Irish women going for abortions have continued to rise. The Minister responsible for the bill, Michael Noonan, TD, claimed that there would be a reduction of about 25% in the numbers of abortions abroad. For the first six months of 1995, the number of abortions followed the downward trend of Northern Ireland, England and Wales, but it surged in the latter half of 1995 following the enactment of Noonan's law. Contrary to predictions of Mr. Noonan, the numbers have continued to climb, by up to 20%. The message that has gone out is that it is acceptable for a doctor to refer women to clinics in the United Kingdom, where abortion is the quick fix. This legislation allowed the legal dissemination of contact details for foreign abortion centres. Politicians, just as they take credit for the benefits of arrangements and activities resulting from their plans, must ask themselves if they share in some responsibility for the increase.

Abortion referral and abortion assistance

However, the fact that doctors are now effectively referring for abortion, and assisting women to arrange abortions, undermines the commitment to life and healing which is the *raison d'etre* of medicine. I would refer the members of the Committee to the *Irish Medical Times* of 7 November 1998, Vol 32, No 45, which cites a report prepared by Dr Elizabeth Keane, the Director of Public Health, in the Southern Health Board Area. According to the report, 55% of GPs in the region provide addresses of abortion centres in the UK, and almost half of those who do not provide this information refer their patients to a family planning clinic. I am convinced that the *Regulation of Information Act, 1995*, has resulted in a slippage in standards amongst certain doctors, who refer women for abortions. I am not convinced, however, that these doctors are giving full and frank information to their patients about the possible serious side-effects of an abortion. This may be due to an oversight rather than wilful blindness to reality, but the effect, either way, is very serious. Do politicians have to consider whether they have contributed to this destructive practice?

Was not the prohibition of abortion assistance and referral more conducive to the well-being of both patients, mother and child?

Why oppose abortion? A link with refugees and asylum seekers

What is the basis of opposition to abortion? The reason is that every human individual, from the moment of conception, should be treated with the full respect due a person, and so is inviolable. A human being is always a he or a she, an I or a you, never an object, a mere something. For many in Ireland, the life of a human being is not understood to be theirs alone. It is an existence dependent on God, who makes us in His own image and likeness, and who calls us to share the fullness of life with Him. He is directly involved in the coming-to-be of each one of us. So, to end this life deliberately and intentionally is to offend God, who judges all the actions of men and states (cf. Preamble to *Bunreacht na hEireann*). Of course, there are those who do not profess any religious belief and who also hold that it is wrong to deliberately and intentionally take the life of an innocent human being. In the last few years, Ireland has become more heterogeneous in its ethnic and racial mix. Some politicians and their constituents have not embraced this very well, and have made destructive comments. Nonetheless, there has been some admirable support for those who are facing great difficulties in countries torn by civil strife and violence, and who seek a new life here. It would be hypocritical and even deceitful if the community expanding trajectory of some recent legislation on refugees and asylum seekers was matched on the abortion from by legislation which counted the unborn child as *persona non grata*.

Medicine and the unborn child

The medical reality today is that from a month or so after conception, the condition, individual appearance, characteristics, movements can be tracked by ultrasound equipment. Their medical problems can be attended to in much the same way as after their birth. Medical practitioners engaged in such activities routinely say and think that they have two patients. Only a month ago, the *Irish Independent* (Saturday, 30 October 1999) featured in its Weekend Supplement an amazing photograph showing such a procedure. Justine Mc Carthy was awake to the obvious connection between the debate in Ireland and such procedures. The committee can ask itself – 'how can the law countenance the destruction of such lives by medical staff while doctors in other units of the same hospital work to help the unborn child?'

Abortion and sexual assault

Particular problems arise for women who are pregnant due to a sexual assault. It is thankfully a relatively uncommon event, but it is frightening for the woman involved. Research in this area is rather limited, due to the sensitivity of the subject. I think however that it needs to be emphasised that the unborn child is not an aggressor, still less an unjust aggressor. The concept of aggression involves action. The unborn child, as has been pointed out, is alive 'through no initiative and no breach of duty of its own, (and) cannot be reasonably regarded as intruder, predator or aggressor; its relation to its mother is just that: mother and child'. ('The Legal Status of the Unborn Baby', John Finnis, *CMQ*, August 1992, 5-11.) In certain cases, that of incest, for example, the availability of an abortion may allow the assailant to escape detection, and attack the integrity of the woman again.

In studies carried out on cases, much emphasis is placed by mothers pregnant as a result of sexual assault on the fact that abortion is another act of violence, directed against an innocent person. By contrast, the message given by the Courts in 'X' and 'C' was that another act of violence was an appropriate response. Instead of any necessary care for trauma and psychiatric difficulties, send the assaulted minor/child for abortion. I do appreciate that the situation for any girl or woman in such a situation is extremely difficult – indeed, it is difficult to imagine a more appalling scenario. However, the fact remains that the unborn child is innocent.

Abortion and physical health of women

Abortion, as well as killing the unborn child or unborn children, may cause significant damage to women's health. In an article 'The frequency and management of uterine perforations during first trimester abortions', Steven Kaali et al. outlined significant amounts of uterine perforations. The risk was 19.8 per 1,000 abortions, near to 1 in 50 cases. They actually said that their data 'suggests that the true incidence of uterine perforation is significantly underestimated'. (Cf. *American J. Obstetrics and Gynaecology*, Steven Kaali, et al. 1989, 161: 406-408.) Dr Kaali has been involved in abortions, yet freely admitted these difficulties. Legislators should consider if the 1995 act permitting abortion referral has harmed women in this way. Are the Health Boards aware of this data? Do referral agencies advise women of these risks? Another article outlining these risks was carried by *American Journal of Obstetrics and Gynaecology*, 1972, pp. 1054-1059. Dr Nathanson, the author, indicated that because uterine perforation is a surgical accident which occurs veiled from the observer's eye and because abortion is a one-man procedure, 'it is probably wise to assume that perforations reported in the various series are those which are the most obvious and that many remain unreported by design or through ignorance.' Nathanson was involved, by his own estimation, in about 70,000 abortions so his is a voice carrying some weight. He correctly saw abortion as 'essentially a blind procedure by one pair of hands only, and it is impossible to teach it and supervise it as thoroughly as one can any type of open operation.' Those who so flippantly call for the legalisation of abortion in Ireland seem blind to these realities.

Abortion and psychiatric health of women

On the psychiatric side, Professor Patricia Casey of the Mater Hospital and U.C.D. has pointed out that between 10-20% of women who have had abortions meet the criteria for depressive illness. They suffer sleep disturbance, appetite disturbance, inability to feel emotion, crying fits, anxiety, tension, panic attacks, guilt, feelings of worthlessness, anger and suicidal thoughts. It has been found that the use of avoidance, memory suppression or denial were the most likely reactions to lead to later psychiatric disorders. Again, questions need to be asked of those who would favour legislating for abortion on this aspect of the abortion experience. See http://www.galwayforlife.ie/students/Professor – Casey-talk.html.

Abortion and social oppression of women

Angela Kennedy, a member of the British Labour Party, has shown the link between the functionalist arguments for abortion as expressed by Simone de Beauvoir and Germaine Greer, and the arguments, of such people as Peter Singer, for infanticide. Such arguments for infanticide are possible because abortion advocacy has become 'such an entrenched doctrine in Western society.' The distinction between a baby in the womb awaiting birth and a baby just born is becoming blurred. Because some abortion advocates are so determined to promote abortion, it is becoming more difficult to assign to babies the protective status of 'personhood'. The arguments for abortion and infanticide all express 'an implicit approval of cultural organisation, in which women are expected to internalize oppression and perpetuate practices 'for the good of others', whether individual men, or cultures as a whole. The phychological bonds that women might feel for their children, born or unborn, are completely disregarded in most of these narratives. Abortion and infanticide are closely linked to other practices or mutilation or coercion of women, such as footbinding, female circumcision, suttee, and even modern day cosmetic surgery'. (See Angela Kennedy, 'Conclusion', pp 109-116 at p. 110, *Swimming against the Tide – Feminist Dissent on the Issue of Abortion*, Ed. Angela Kennedy, Open Air Books 1997.) In the case of abortion being legislated for according to the criteria in the *X* and the *C* case, women would be asked to bear the burden of this oppressive practice of abortion. Abortion facilitates men who do not wish to face up to their responsibilities as fathers. They will not

have to suffer any physical effect of the procedure. They will not have to support their child morally, in the realm of education, in the realm of nourishment and health. Meanwhile, the mother may live for years with the scars of abortion.

A way forward

Mary Ann Glendon, the Harvard Law Professor, at the Bejing Conference in 1995, issued this rallying cry. 'Once again, concerned women must take the lead in the fight against societal practices which facilitate the irresponsibility of men while stigmatising women, and against a vast industry that extracts its profits from the very bodies of women, while at the same time purporting to be their liberators. (See Bejing Conference Address, 5 September 1995, http://www.columbia.edu/cu/augustine/arch/glendon.txt) She asked that a girl who is frightened, pregnant and alone be offered a better alternative than the destruction of her unborn child. Those who favour the legalisation of abortion should reflect on these words. Professor Glendon speaks from a jurisdiction which permits the destruction of 1.5 million babies every year as a constitutional liberty. Do those favouring legislation permitting abortion want our liberties directed in this way? I hope that the women of the Oireachtas come out behind a social policy on abortion, which does not repeat the facile solutions tried in the USA and the United Kingdom, where Courts and Parliament alike have embraced a culture of death. Instead, let them support the law protecting mothers and their children from the abuse of abortion.

A value-neutral approach? The purpose of law – again

In terms of the law adopting a 'value-neutral approach', and permitting abortion, one could imagine the proponents of such a law arguing that there is no obligation on anyone objecting to it being involved. I was very struck by the experience of Catherine Spencer, an editor of *Hansard* at the House of Commons. She has undergone an abortion, and written about it. She has argued that it is sophistry to argue that it is an area in which the State merely declares itself neutral on the question.

She writes: 'We do not say that about stealing, we do not say it about child abuse. We do not even say it about cruelty to animals. If I was being asked to separate myself from my society, disregard its mores and drag myself free of its influence – declare myself an independent territory – then I say that I, and most other people, are incapable of doing that. Abortion was not just my decision, it was my society's. Some or most feminists may deride my feeling that I needed protection and support when I was pregnant, not the right to choose the death of my unborn baby. I myself find it hard to admit. Yet I think it is the truth' (Catherine Spencer, 'Obstinate Questionings: An Experience of Abortion', pp. 96-108 at 106-107 in *Swimming Against the Tide – Feminist Dissent on the issue of Abortion*; Angela Kennedy, Editor, Open Air Press, 1997.) Realist philosophers of law recognise the fact that we humans are not perfect and require an instrument to assist in the performance of virtue. Permitting the killing of the innocent is a perversion of the proper purpose of law – to help us become good – as well as an abuse of human rights.

Law by its fully public character, clarity, generality, stability, and practicability treats us all as partners in public reason. Due to an incoherent decision in the *X* case, and an inadequate and ill-considered response by government and legislature since, the law certainly lacks clarity and stability. The proper way to restore this clarity and stability is the re-assertion of the equal right to life of both mother and unborn child, with a total ban on procured abortion and a constitutional ban on abortion referral and abortion assistance. This is required for constitutional harmony. No one should be discriminated against on the basis of size, appearance, age or such other factors as are usually considered irrelevant in dealing with fundamental values.

From Walker Percy's *Signposts in a Strange Land*, edited with an introduction by Patrick Samway, Bellew Publishing, London, 1991, pp. 350-351.

> Once the line is crossed, once the principle gains acceptance – juridically, medically, socially – innocent human life can be destroyed for whatever reason, for the most admirable socio-economic, medical, or social reasons – then it does not take a prophet to predict what will happen next, or if not next, then sooner or later. At any rate, a warning is in order. Depending on the disposition of the majority and the opinion polls – now in favour of allowing women to get rid of unborn and unwanted babies – it is not difficult to imagine an electorate or a court ten years, fifty years from now, who would favour getting rid of useless old people, retarded children, anti-social blacks, illegal Hispanics, gypsies, Jews …
>
> Why not? – if that is what is wanted by the majority, the polled opinion, the polity of the time.

This letter was written by celebrated New Orleans novelist, Walker Percy (1916 – 1990) to the *New York Times*. Despite a reminder from Percy, the paper did not publish it. The letter makes clear that society's prohibition of intentional killing is the cornerstone of law and social relationships. It protects all of us impartially, embodying the belief that we are all equal.

THIS SUBMISSION BACKS OPTION ONE
OPTION ONE
AN ABSOLUTE CONSTITUTIONAL BAN ON ABORTION

JOSEPH McCARROLL PHD

29 NOVEMBER 1999

SUPPORTING WOMEN, PROTECTING CHILDREN – TWO SIDES OF THE COIN
SUBMISSION TO THE ALL-PARTY OIREACHTAS COMMITTEE ON THE CONSTITUTION

1 The aim of this submission

This is a personal Submission to the All-Party Oireachtas Committee on the Constitution in response to its request for comments on the options listed in the *Green Paper on Abortion* to inform its work of considering the issues presented, the problems raised and the solutions proposed in the *Green Paper on Abortion*.

The aim of my submission is to evaluate the analysis of the issues and options presented in the *Green Paper on Abortion* in terms of their compatibility or incom-

patibility with the core value on which the Constitution and Irish society itself as a constitutional democracy, are founded.

I urge the All-Party Oireachtas Committee on the Constitution to acknowledge explicitly that the equal and inherent worth of every human life and equality before the law are the very foundation of democracy and should be the key guiding principles in seeking a resolution to the abortion issue.

I urge them, further, to adopt explicitly a social policy position on abortion, stating that it is incompatible with assuring the dignity of the unborn individual, the constitutive core value in the Constitution, and calling for the adoption by the Government of a consistent social policy that rejects legal abortion on the grounds that it is fundamentally and radically incompatible with equality and social inclusiveness.

I urge them, finally, to recommend a balanced, even-handed approach, on the one hand, introducing adequate support for women facing crisis pregnancy, and, on the other hand, restoring adequate legal protection for the unborn by holding a referendum to ban abortion completely.

2 The core value of Irish democracy – the dignity of the individual

The Preamble to the Constitution states as its first aim, 'that the dignity of the individual may be assured'.

This is the core value on which the whole Constitution, and our society itself, are founded. This was the primary end that the People had in giving itself the Constitution. This remains the primary end for the achievement of which the Irish people, as society in history under God, exists – to be, and become ever more, a society which assures the dignity of the individual.

3 Equal and inherent worth of all human life and equality before the law

The Irish Republic as a constitutional democracy is based on the equal and inherent value of every human life and the equality of all before the law.

They are fundamental in the sense that without them, we cannot be and are not in any real sense, a democracy. Other values are based on them; unless they are respected, the values based and built on them cannot be respected.

Our society as a constitutional democracy is *based* on the equal and inherent worth of every human life and equality before the law in the external sense that these values have to be acknowledged explicitly and formally in the laws and social policies. But what makes us truly a constitutional democracy is the presence of these values *in us*, but especially in those who act on our behalf in the legislature, the judiciary the executive.

If these values are written into law and social policy but are not living in us as respect for equality and social inclusiveness, then we are a democracy only in name, a democracy at risk.

If these values are *not* respected, if they are violated, and if that violation is written into law and social policy, then, to that extent, we are no longer a democratic people, a democratic society, in substance, even though the institutional and procedural appearances may still remain.

If is the nature of social and legal principles to extend their influence throughout a society and a people, both interiorly in the way people think and feel and act, and exteriorly in the laws and social policies they demand and tolerate, pressuring towards a policy and legal framework that is consistent embodiment of its animating principles.

The pressure towards consistency in social and legal principles means that once a denial of equality and social inclusion is accepted formally into a society, it will exert a pressure on public opinion, legal reform and social policy to reshape all other provisions in its own image.

Thus, if a denial of the equal and inherent worth of every human life and of equality before the law is present and active in the minds and hearts of the people, and if it demands or tolerates the writing of this denial into law and social policy and implemented throughout the public life of the society, the extent of the denial will not be contained to just one area, but rather will expand and extend its applications gradually throughout the society corroding ever more extensively the foundational values of democracy and the democratic nature of the people and their society.

4 The unborn child is a human individual

The primary constitutive value of the Irish as a people organised in history under God is, in the words of the Preamble to the Constitution, 'the dignity of the individual'. But the unborn is a human individual. Therefore there is a constitutional obligation on the State to enact such provisions and policies as are needed to 'assure' that dignity.

At the very least, this obliges the State to put in place an adequate range of supports for women in crisis pregnancy so they feel they have real alternatives to abortion, and to enact adequate legal protection for the unborn against abortion.

But three objections have been raised against this view. Is the unborn a human individual: is he or she not part of the mother so that she may dispose of them as she wishes as part of her legitimate control of her own person? Is the term 'the unborn' clear in its meaning? Unborn what? And when does the life of a new human individual begin? From what point should his or her right to life be protected by the law?

(i) The unborn is a distinct human individual, not part of the mother Those who seek the legalisation of abortion sometimes do so on the basis that everyone has a right to rational and responsible self-determination; that, as an instance of this, a woman has a right to control her own body; and that, since the unborn child is a part of the woman's body, she should be allowed to have it removed and destroyed by legal abortion if she wishes, as an exercise of her right of personal autonomy. The flaw in this argument is that the unborn child is not part of her body. This was made clear in the judgements of Lord Mustill and Lord Hope in *Attorney General's Reference (No. 3 of 1994) (H.L.(E)) [1998].*

Lord Mustill rejected the proposition that 'the foetus is part of the mother'. His reasoning is as follows (p.255, paragraph breaks added):

> Obviously, nobody would assert that once M. had been delivered of S., the baby and her mother were in any

> sense 'the same'. Not only were they physically separate, but they were each unique human beings, though no doubt in many features of resemblance.
>
> The reason for the uniqueness of S. was that the development of her own special characteristics had been enabled by and bounded by the collection of genes handed down not only by M but also by her natural father.
>
> This collection was different from the genes which had enabled and bounded the development of M, for these had been handed down by her own mother and natural father. S and her mother were closely related but, even apart from differing environmental influences, they were not, had not been, and in the future would never be 'the same'.
>
> There was of course an intimate bond between the foetus and the mother, created by the total dependence of the foetus on the protective physical environment furnished by the mother, and on the supply by the mother through the physical linkage between them of the nutrients, oxygen and other substances essential to foetal life and development.
>
> The emotional bond between the mother and her unborn child was also of a very special kind. But the relationship was one of bond, not of identity. The mother and the foetus were two distinct organisms living symbiotically, not a single organism with two distinct aspects. The mother's leg was part of the mother: the foetus was not.

Lord Hope of Craighead took the same view for the same reason (p. 267, paragraph breaks added):

> The creation of an embryo from which a foetus is developed requires the bringing together of genetic material from the father as well as from the mother.
>
> The science of human fertilisation and embryology has now developed to the point where the embryo may be created outside the mother and then placed inside her as a live embryo.
>
> This practice, not now uncommon in cases of infertility, has already attracted the attention of Parliament: see the *Human Fertilisation and Embryology Act, 1990*. It serves to remind us that an embryo is in reality a separate organism from the mother *from the moment of its conception* (italics added)
>
> This individuality is retained by it throughout its development until it achieves an independent existence on being born. So the foetus cannot be regarded as an integral part of the mother in the sense indicated by the Court of Appeal, notwithstanding its dependence upon the mother for its survival until birth.
>
> The point in both of these judgements is that it is a matter of *scientific* fact that the unborn is a living human individual distinct from, even though living within and dependent upon, his or her mother, from the moment of conception.

(ii) The 'unborn' means the living human individual not yet born Chapter 7, sections 4 to 13 of the *Green Paper on Abortion* discusses the meaning of 'the unborn' in Article 40.3.3.

Those who support the holding of a referendum to ban abortion completely have no difficulty understanding the term 'the unborn'. The *Green Paper on Abortion* notes that in 1983 those who supported Article 40.3.3 'were satisfied that the term 'unborn' provided constitutional protection from the time of conception/fertilisation' (7.08, p. 105). It also adds that 'the issue has never directly arisen for consideration by the Courts', and that the questions raised about the meaning of the term 'the unborn' 'have not troubled the Courts or the medical profession to date.' (7.13, p. 106)

Those who want to be allowed to kill human embryos with legal impunity have argued that there are problems about the meaning of the term 'the unborn'. These problems are not real – the real problem is the willingness to kill or harm or put at risk human embryos in IVF and embryo research. Thus, some of those who support legalisation of abortion in some instances have argued that the word 'unborn' is an adjective and that there is doubt as to what it refers to. It is not an adjective, but a substantive in adjectival form, meaning individual human lives not yet born.

It refers to unborn human beings, not plants or animals. It refers to human individuals not to life as a continuum. It refers to human individuals that are living not dead.

There is no serious doubt as to its meaning. Article 45.4.1 pledges the State to come to the support of 'the infirm' and 'the aged'. There is no doubt that the adjectival form or these terms does not prevent their being understood without difficulty as referring clearly to living individual human beings who are inform or aged.

In determining the meaning of the term 'the unborn', the Irish language version of the Constitutional text takes precedence, and it refers to those whose right to life the State is acknowledging and guaranteeing to respect, and as far as practicable to defend and vindicate by its laws, as 'na mbeo gan breith', 'the lives' without birth, so in the definitive Irish language version, the unborn are the lives already in existence, the human individuals already living, but not yet born.

And as Lord Hope makes clear from his judgement cited above, modern genetic science has established as a matter of scientific fact that the unborn at whatever stage of development is a unique living human individual from the moment of conception.

(iii) The 'unborn' means the living human individual from the moment of conception The *Report of the Constitution Review Group* argued that the way 'the unborn' is defined centres on when it is considered that the life of a new human individual begins.

It contended that it was essential to define when pregnancy begins. The *Green Paper on Abortion* (7.07, p. 105) lists four possible definitions of the unborn, in terms of the point at which the unborn is considered to have begun its life, and so to be protected against the deliberate, direct and intentional destruction of that life by legal abortion, fertilisation, implantation, some other time after fertilisation and viability.

There is no reasonable way to make a case that the unborn life begins at viability, which is currently around 24 weeks. The foetal heartbeat is detectable at 24 days. The new being is obviously present long before viability. 'Some other time' is patently an arbitrary point, and so unacceptable. Implantation in the womb is also an arbitrary point to select because, as Lord Hope of Craighead made clear in his ruling, in IVF, what is implanted in the womb is already a living human individual.

That leaves fertilisation or conception as the moment

at which the life of a new human individual begins. A new human life clearly starts at fertilisation or conception. This is made clearer by the fact that in IVF a new human life is universally understood to have begun when the spermatozoon and ovum unite.

A new living human individual begins to exist at the moment of fusion of the membranes of the spermatozoon and ovum. From that point onwards, there exists a new unity-identity-whole, bounded by one membrane, containing the new unique full complement of chromosomal material different from that in the spermatozoon or the ovum, and self-developing, moving according to its own inner self-unfolding finality, bringing together the chromosomal materials and beginning cell division and differentiation.

To assert that human life begins at implantation is a dishonest piece of legal special pleading that flies in the face of established scientific fact. It was designed to allow IVF practitioners and those engaged in research on human embryos to operate without fear of litigation.

By legally defining the start of pregnancy or human life at implantation, a litigation-free-zone is established, (in Britain it is up to 14 days after fertilisation, the obvious starting point of a new life), during which IVF practitioners are exempt from prosecution when they carry out eugenic selection of IVF generated human embryos, deliberately, directly and intentionally destroying those thought likely to be bodily disabled, a practice that is routine in IVF. The 14-day period also allows those engaged in embryo research to carry out non-therapeutic, harmful and lethal research to take place on a range of human embryos.

So the notion that human life or pregnancy begins at implantation or the establishment of a 14-day period during which experimentation on live human embryos is legally allowed, are legal devices to secure partial exemption for the IVF and embryo research industry from the legal obligation to respect the right to life and bodily integrity of the unborn.

5 The pro-abortionist, pseudo-neutralist language of the *Green Paper on Abortion*

The biggest shortcoming in the *Green Paper on Abortion* is its failure to take a stand on the ethical rightness or wrongness of abortion. The document is deliberately written in an ethically debased language that is partly pro-abortionist, partly pseudo-neutralist and not once pro-life.

The choice of this language is by far its most worrying feature, as it betrays the ethical mindset of those who chose it. As page 9 informs us, the text of the *Green Paper on Abortion* was decided by the Cabinet Committee that oversaw the work of the Interdepartmental Working Group. The members of that Committee were Mr Brian Cowen TD, Minister for Health and Children, Chairman, Ms Mary O'Rourke TD, Minister for Public Enterprise, Mr John O'Donoghue TD, Minister for Justice, Equality and Law Reform, Mr David Byrne SC, Attorney General up to July 1999, Mr Michael Mc Dowell SC, Attorney General from July 1999, and Ms Liz O'Donnell TD, Minister of State at the Department of Foreign Affairs.

The language is ethically debased because it is the purpose of language to articulate the truth about reality, whereas the purpose of the language used throughout the *Green Paper on Abortion* is to discuss the issues raised by abortion in a manner that avoids taking a stand on whether abortion is ethically right or wrong.

The *Green Paper on Abortion* is a publication, a formal, official and public action, of the present Government. If the Government brought out a similar Green paper on rape and listed as the options for dealing with it as a complete legal ban on rape, legalising some rape, legalising rape in a wide range of circumstances, and abolishing rape as a crime altogether, there would be outrage and rightly so, because rape is an act of violence. But abortion is also an act of violence.

The use throughout the *Green Paper on Abortion* of pro-abortionist and pseudo-neutralist language is a deeply disturbing indication of the stance of the Cabinet Committee that chose that language.

One example of pro-abortionist language is the use throughout of the deliberately vague term 'termination of pregnancy' for induced abortion. When a baby is born alive after the full pregnancy, that is a termination of pregnancy. When a baby dies during the birth and is removed from the womb, that is also a termination of pregnancy. If the unborn baby dies as a side effect of the removal of a cancerous womb, this is also a termination of pregnancy. But none of these is an induced abortion. The Cabinet Committee knew this well but chose nonetheless to use a term which included many procedures that are acceptable to medical ethics along with induced abortion which is not.

The Cabinet Committee also decided on a final text that failed to recognise the legitimacy of the well-established common sense, medical and legal distinction between direct and indirect effects of medical treatment, despite the fact that this language has been explicitly used in the Cox case in Britain.

The pseudo-neutralist language is evident in the stance adopted and maintained throughout the whole text of reviewing the different approaches towards abortion as if they were all ethically equivalent. But abortion is not an ethically neutral act like having a tooth extracted. It is a serious act of interpersonal injustice in which a child is killed, and a woman is harmed and exposed to the risk of serious harm.

To discuss in 'neutral' language, provisions for making this evil legally available, even on a very wide scale, without saying that this is unacceptable because it is contrary to the core values in the Constitution shows a disturbing fear on the part of the authors of having to take an ethical stand in public.

6 The refusal of the parties in the Dáil to articulate opposition to abortion is a symptom of a serious democratic deficit in Irish politics.

The decision of the Cabinet Committee to employ this devalued form of ethical discourse is yet another symptom of the growing crisis of political representation in Irish democracy.

The majority of the electorate is against abortion and does not want it legalised. But this majority is not reflected numerically in the main political parties. They simply do not represent the people on this key issue.

The political establishment knows well that the majority of people regard abortion as ethically wrong and want it banned completely – professional opinion polls have confirmed that a substantial majority want abortion banned in all circumstances not legalised in certain circumstances.

This was reflected in the numbers of submissions made to the Interdepartmental Working Group on the *Green Paper on Abortion* – out of the 10,000 submissions received, less than fifty supported the legalising of abortion; the others, over 9,950, supported the holding of a referendum offering the people a clear opportunity to ban abortion completely.

But the political establishment refuses to *represent* this majority wish, to give it effect, and why, because the political establishment is more concerned to avoid taking a course of action that would bring down on them the wrath of the commentators in the media who are pro-abortion.

This grave democratic deficit is illustrated by the fact that in the lifetime of the present Government, no member of the Government has stood up in the Dáil and said that abortion is ethically incompatible with the core value on which our Constitution is based, the dignity of the individual because it destroys an unborn human life, harms women and puts them at risk of serious harm, and that law and social policy are obliged under the Constitution to prohibit the performance, advocacy or promotion of abortion.

7 The proper democratic response to the divisiveness of the abortion debate is for leaders to stand up in public for the core values at stake.

The opening paragraph of the *Green Paper on Abortion* twice describes the public debate on abortion as 'divisive' (p. 5) This reflects the palpable fear among politicians of having to take a clear stand on abortion because it will draw down on them the ire of those within the media who support the legalisation of abortion. The politicians sense that these media commentators can inflict harm on them and so they go to great lengths to avoid taking any position that attract their negative attention.

This is an irresponsible and undemocratic attitude raising the suspicion of a lack of courage. Politics is about resolving social conflicts without having to have recourse to violence. Where there is a real problem, then it has to be addressed, whether or not addressing it is popular or unpopular, whether or not what needs to be done is opposed by tiny but powerful cliques like the media commentators.

Social issues are divisive because they arouse heated disagreement, and they arouse such strong emotions because they reach down and involve fundamental values. But that is not a reason for not addressing them.

It is worth asking what exactly it is that is said to cause the divisiveness of the debate on abortion. Is it that Irish women are seeking abortion; is it the large number of those seeking abortions; is it that abortions are taking place in Britain, thus entailing travel and accommodation costs there?

It is not the fact that the abortions are taking place in Britain. Every abortion is a tragedy for the women and for the child involved, but the tragedy does not consist in the fact that the woman has to travel to Britain to have it done. They would be just as tragic if they took place in Ireland.

The large number of women seeking abortions in Britain is deeply disturbing. But that number would increase significantly if Ireland legalised abortion because the greater ease of access, the greater number of local Irish abortion clinics, would be followed by a sharp increase in the numbers seeking abortions.

Those, like myself, who are putting forward the democratic case for the holding of a referendum to ban abortion completely, are often told that it is a divisive proposal. But if arguing for a new pro-life referendum can be described as divisive, arguing for the introduction of abortion by means of enacting legislation in the Oireachtas is equally divisive. Similarly, if holding a referendum would be divisive so too would enacting legislation. It is an unfair and dishonest tactic to attempt to smear those who are putting forward the case for a pro-life referendum as if they were somehow deliberately being divisive while those who support other options are somehow not being divisive.

In my opinion, the pro-abortion voices in the media are among the worst offenders in the use of immoderate language to characterise those who are putting forward the case for a new pro-life referendum, and I urge all the All-Party Oireachtas Committee on the Constitution to urge the media commentators to exercise self-restraint and temperance in the language they use about those with whom they disagree.

I urge the All-Party Oireachtas Committee on the Constitution to acknowledge that the Supreme Court ruling in the *X* case is regarded as unsatisfactory on three mutually exclusive reasons – because it allows any abortion, because it does not allow a greater range of abortion, or because it does not decriminalise abortion completely – and because these three grounds are incompatible, there is simply no common principle by which these three positions can be reconciled, no social policy or legal measure by which all three of them can be implemented.

So there has to be a choice among them. One out of the three approaches must be adopted, either ban abortion legally altogether, or legalise some abortion, or decriminalise abortion altogether. I urge the All-Party Oireachtas Committee on the Constitution to acknowledge this bluntly.

The divisiveness associated with the debate is accentuated by the procrastination on the part of the political establishment, the fudging and the refusal by the political parties in the Oireachtas to state clearly where they stand. The very invitation by the All-Party Oireachtas Committee on the Constitution to the public to make a new round of submissions is widely seen by political commentators as, to a large extent, another delaying device.

The underlying social principles adopted for resolving the abortion issue will largely determine which of the three approaches is chosen. I would urge the All-Party Oireachtas Committee on the Constitution to put an end to this dithering and to take a clear and unambiguous stand on the principles that should be adopted in addressing the abortion issue, and on which of the three options they favour, a complete ban on abortion, legalising some abortion, or decriminalising abortion altogether.

I would ask the All-Party Oireachtas Committee on the Constitution to articulate the principles on which they believe the issue of abortion should be addressed. I would urge them to adopt as the key principle the core value in the Constitution, the dignity of the individual, the fundamental values on which constitutional democracy is based, the equal and inherent worth of every human life, and the equality of all before the law.

The approach I am urging the All-Party Oireachtas Committee on the Constitution to consider is a balanced, even-handed approach of supporting women in crisis pregnancy and restoring legal protection for unborn children by a new referendum to ban abortion completely. Supporting women and protecting children are the two sides of the coin of care.

Such a referendum would consolidate public commitment behind the putting in place of an adequate range of personal, professional and practical supports for women facing crisis pregnancy so they feel they have real alternatives to abortion. A referendum to ban abortion completely, and a wholehearted commitment to supporting women in crisis pregnancy so they have real alternatives to abortion, are, together, the best and most effective way to remove the divisiveness associated with abortion because they would unite everyone in society in a common commitment to care for both the woman and the child.

8 Why legalising abortion is ethically wrong in a constitutional democracy

Democracy is a form of society in which conflict is resolved without recourse to violence, on the basis of a mutual respect for, and commitment to, the dignity of the individual. Democracy as a political form springs from, and depends for its continued existence upon, a democratic spirit, a common social substance that, being shared, constitutes and unites us into a people in history under God.

The core value, respect for the dignity of the individual springs from and is sustained by an underlying shared acceptance of the equal and inherent worth of every human life and their equality before the law.

Respect for the equal and inherent worth of every human life is the very oxygen of democracy, equality before the law is the ozone layer that protects the climate of democracy from the corrosive effects of the tendency, always strong and tending to get stronger, to deny the equal and inherent worth of those lives that stand in one's way.

It is the duty of political representatives to oppose that tendency resolutely whenever it threatens the weak, even where this requires them to go against the current of applauded opinion among media commentators.

Abortion is wrong and should be legally banned in Ireland because it directly takes an innocent human life which is always and everywhere unjust and against the law of God; because it violates the dignity of the unborn individuals, being incompatible with their equal and inherent worth as human beings and treating them unequally before the law. Abortion involves doctors, nurses and psychiatrists in the taking of innocent human life, thereby corrupting ethically the medical professions.

Where it is legalised, every citizen is implicated, sharing ethically to some degree the responsibility for every abortion carried out in the State and under its laws.

Legalised abortion alienates from the society those who are opposed to it on ethical grounds.

They understand that by legalising the destruction of a category or class of innocent human lives, the society has thereby and to that extent withdrawn itself from the principal ethical imperative of the Constitution, assuring the dignity of the individual, from respect for the equal and inherent worth of every human life, from the equality before and under the law, from the rule of law itself that is the very cornerstone of democracy.

Legalised abortion creates a justice-free, sanction-free killing zone, a zone of legal impunity within which innocent human lives may be deliberately, directly and intentionally destroyed. This undermines public acceptance of democracy and the rule of law as a whole, and threatens liberty by legalising a category of lethal attacks on the right to life.

By treating human lives unequally before the law, legalised abortion corrodes human equality, the vital and indispensable sense of brotherhood and sisterhood that binds us all together into one society, leading us to respect one another and treat one another fairly.

The sense of brotherhood and sisterhood provides the principle of balance in a democracy, the homeostasis in the social ecosystem, persuading each one to accept the inevitable limitations on his or her desires on the basis that the common good that demands such limitations is ethically good and so entitled to demand generosity, self-sacrifice, self-restraint, moderation, tolerance, co-existence, live and let live.

The legalisation of abortion sends a very different social message, that it is legally and socially permissible in our society to exclude absolutely, to the point of destroying their lives, those whose lives stand in our way. The social meaning of legalised abortion is a rejection on principle of live and let live, of co-existence, of tolerance.

As suggested above, social principles expand according to their inherent logic. The legalisation of abortion introduces a false and pernicious principle into the law, namely that it is lawful deliberately, directly and intentionally to take the life of a fellow human being. Once introduced into the civil law, that principle will expand and extend its applications throughout the law until it is removed.

It is for these reasons that I believe another pro-life referendum should be held to ban induced abortion completely in Ireland.

9 The right of the people under Article 6 'in final appeal, to decide all questions of national policy, according to the requirements of the common good'

In the 1983 pro-life referendum the people intended to ban legalised abortion here completely.

The Supreme Court ruling in *X* overturned this decision of the people. Commentators like Kevin Meyers and John Bowman, who would not necessarily be supportive of the holding of another referendum, acknowledge that the *X* ruling reversed what the people had sought to bring about in the 1983 referendum.

According to Article 6 of the Constitution, it is the right of the people 'in final appeal, to decide all questions of national policy according to the requirements of the common good'.

But whether or not abortion should be legalised is a question of national policy, and it is the constitutional *right* of the people to make that decision.

They should make it 'according to the requirements of the common good' but as the Preamble makes clear, the primary core value that determines the common good is assuring the dignity of the individual.

From this it surely follows that the most democratic way to address the abortion issue is to consult the people again to see whether they wish to reassert their original 1983 intention. To this end, a referendum should be held giving people a clear opportunity to reverse the *X* case ruling and ban all legalised abortion in the Republic.

10 Legalised abortion is incompatible with the rights of the child in the United Nations Convention on the Rights of the Child

I believe there are a number of valid and compelling ways of showing that abortion is wrong and should be banned completely in a secular democracy such as the Irish Republic.

It may be shown from reason and from revelation, from starting points that are religious and from starting points that are not.

In view of the fact that Ireland is a secular democracy and that it is desirable to secure as wide a consensus as possible on the principles in terms of which the question of legalised abortion should be approached, I intend to set out a case against legalising abortion based on the rights of the child as set out in the *UN Convention on the Rights of the Child*. This is not a religious document, but rather a secular and international legal Convention. Furthermore, Ireland has ratified it *without reservation*. This is particularly significant given the reservation lodged by Britain in a declaration accompanying its instrument of ratification of the Convention. The *Green Paper on Abortion* cites the British reservation (n. 13, p. 43:)

> The United Kingdom interprets the Convention as applicable only following a live birth.

The Irish Government ratified the Convention without any such reservation, so it must be taken that it accepts that the rights set out in the Convention apply equally to unborn children.

This way of setting out a case against legalised abortion recommends itself to me in particular *as a parent*. Legalised abortion is profoundly offensive to me not just as a reasonable human being, not just as a philosopher, not just as a Catholic, and not just as a democrat, but also in a unique way, as a parent who is also a child, because it involves parents in a socially legitimised taking of the life of their own child and in the violation of the most intimate human bonds of all, the relationships between mother and father and child.

When we examine the Preamble to the *United Nations Convention on the Rights of the Child* and its Articles and the commitments undertaken by the States who are signatories to it, we see that its underlying vision and various provisions are absolutely incompatible with legalised abortion.

> Considering that, in accordance with the principles proclaimed in the *Charter of the United Nations*, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.

Ireland ratified the Convention on 21 September 1992 without lodging any reservation like the British one excluding the unborn from the rights set out in it, so the State is committed to the *Convention*'s view of the inherent dignity of the child and of the equal and inalienable rights of the child and to its view of the responsibilities, duties and undertakings to which the States that ratified the *Convention* have committed themselves.

Thus, the Irish Republic and its government are committed to the recognition of the inherent dignity of *all* members of the human family. This must include unborn children. If they are excluded, then the dignity of some is not recognised.

This commitment to the recognition of the *inherent* dignity of all members of the human family rules out any legalisation of abortion because abortion denies the *inherent* worth of the unborn child and instead allows others to decide whether or not the unborn life shall be a life of value, a life worthy to be lived, a life that will be allowed to be born, or alternatively is a life that can be disposed of and destroyed, and thus has no value, at the decision or wish of others.

Rights are reasonable and fair demands of one person on others to do or refrain from doing certain actions that would infringe on his or her existence or proper development. As signatory of the *Convention*, the State is thereby committed to recognising and respecting the equal and inalienable rights of *all* members of the human family. This must include unborn children. If not, the rights of *all* are not being respected.

According to the *Convention*, these rights are possessed by all the members of the human family *equally*. They are thus possessed and to the same extent, by unborn children. This rules out legalised abortion as that attacks and destroys the life and right to life of the unborn. If the State were to legalise abortion, then unborn children would not possess the right to life and to the protection of that life equally with other members of the human family.

Again, these rights are possessed by all the members of the human family inalienably, that is, of such a kind and in such a way that they cannot be taken away from them. This again rules out legalised abortion which certainly takes away the unborn child's life.

> Bearing in mind that the peoples of the United Nations have in the *Charter*, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom.

As a signatory to the *Convention*, Ireland has reaffirmed its faith in fundamental human rights and in the dignity and worth of the human person. If this is to be anything more than an empty promise, it has to mean that the State is committed to embodying it throughout its Constitution and in all its laws recognition, respect, protection and promotion of these fundamental rights, and purging from them anything that is violative of the dignity and worth of the human person. This rules out legalising abortion and requires the State to take the necessary steps to reverse the effects of the Supreme Court ruling in the *X* case, which purported to create a right to abortion in Irish law.

This follows because the fundamental human right is the right to life. It is the *fundamental* right because all the other rights can only be possessed and exercised on condition that one is alive, and abortion destroys an innocent human life. Again, what is done to the unborn child in the course of an abortion is plainly and grossly incompatible with his or her dignity and worth as a human

being. If the same things were done to a born human being, it would rightly be described as unlawful and lethal violence. That something so harmful, so hurtful, can lawfully be done to unborn children but not to those who are born shows that all the members of the human family are not being treated equally.

Again, as a signatory to the *Convention*, Ireland has determined to promote social progress. The mark of social progress is equal treatment, equal opportunity, the removal of violence and discrimination and its replacement by equality in just treatment. On each of these counts, abortion is ruled out – it treats unborn children unequally, subjects them to unjust treatment, denies them equal opportunity to live and enjoy the opportunities that go with life, it subjects them to violence, and discriminates against them detrimentally.

Again, as a signatory to the *Convention*, Ireland has determined to promote better standards of life in larger freedom. If this commitment is taken seriously, legalised abortion is once again ruled out. If unborn children are to enjoy any standard of life, then they must first be allowed to be born and to live. If they are to move from the smaller freedom of life in the security of the womb, into the larger freedom of life in the security of the family, the community and the wider society, then the State must ensure this security and freedom by the enactment of appropriate laws, by adequate material and professional resourcing, and by contributing to the generation and sustaining of a climate of opinion supportive of and welcoming to all unborn children.

> Recognising that the United Nations has, in the *Universal Declaration of Human Rights* and in the *International Covenants on Human Rights*, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

As a signatory the State is already committed to the view that *everyone* is entitled to all the rights and freedoms set forth in the *Convention, without distinction of any kind*, such as social origin or birth.

This precludes the legalisation of abortion. Legalised abortion introduces an invidious distinction according to which some are empowered by the law to bring about the death of others.

Instead of everyone being entitled to their right to life and to the law's protection for that life, distinctions are introduced. It means that those whose lives have begun but who are not yet born, and whose existence is not desired by others due to the social circumstances surrounding their origin, may lawfully have their lives taken.

> Recalling that, in the *Universal Declaration of Human Rights* the United Nations has proclaimed that childhood is entitled to special care and assistance.

As a signatory to the *Convention*, the State is bound also to respect the commitment given in the *Universal Declaration of Human Rights* to provide the special care and assistance that childhood is entitled to.

This means that the State has an obligation to put in place adequate special care and assistance so that children who are at risk of death because they are unborn and their mothers who need special supports throughout crisis pregnancy will have them put in place to enable them to continue with their pregnancies.

It also means that the State may not legalise abortion because by no reasonable stretch of the imagination could abortion be considered an honouring by the State of this commitment to provide the special care and assistance that these unborn children need.

If what is done to unborn children in abortion were done to born children, it would not and could not rightly be called the giving of the special care and assistance needed by childhood.

To make different, indeed opposite, provision for the unborn and the born is to discriminate, to treat unequally, to alienate the equal right to life, and to violate the equal dignity and worth of the unborn as compared with the born.

> Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community.

As a signatory to the *Convention*, Ireland is committed to the view that the family is the fundamental group of society, that it is the natural environment for the growth and well-being of all its members and particularly children, and that it should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community.

The courts in Ireland have found that a mother and child are a family entitled to support and protection. This should apply even before the child is born.

A pregnant woman is entitled to proper and adequate pre-natal care and social support. Where the pregnancy is a crisis one or the child is unwanted for some reason, the mother is at risk of feeling there is no way out other than abortion, which exposes the child to death and the mother to the violation of abortion and the consequent risk of emotional and physical harm and heartbreak.

The pregnant woman with an unwanted pregnancy and the unborn child are a family at risk – the State is committed as a signatory to the *Convention* to providing for this vulnerable family all the necessary protection and assistance so that they can fully assume their responsibilities within the community.

The legislation of abortion is an attack on the family as it purports to render lawful the violation of the most intimate human bond, the heart of the family, the relationship between mother and child, often at the behest of the father, or in the alleged interests of the already born children, as the provisions of the British abortion laws allow.

> Recognising that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding.

By ratifying the *Convention*, the State has committed itself to putting in place the social and legal conditions conducive to the full and harmonious development of the personality of all children, as far as possible in a family environment, in an atmosphere of happiness, love and understanding.

It also imposes a responsibility on the State to provide better alternatives than it does at present for those children whose mothers, for whatever reasons, feel unable to keep them after birth.

In particular, adoption needs to be made easier and emphatically encouraged in the social services and in public opinion.

Also the State must resource on a far greater scale than at present, voluntary groups who encourage women with unexpected pregnancies to go to term and either keep the children themselves or offer them for adoption.

But there is also an obvious duty implied also in this commitment, to protect and enhance the full and harmonious development of a child: the very least that has to be done is not to put in place laws that enable him or her to be killed before they are born.

> Considering that the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the *Charter of the United Nations*, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity.

By signing and ratifying the *Convention*, the State has undertaken to shape our society so that every child in it is fully prepared to live an individual life in society, brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity.

At the very least, therefore, this obliges the State by its laws not to legalise abortion, for in abortion unborn children are prevented from being fully prepared to live an individual life in society.

To abort an unborn child with the backing of the law is not an act of peace but an act of violence.

It is not an act respectful of his or her dignity, but one violative and destructive of it.

It is not an act of tolerance, but a lethal act of intolerance, a violent refusal to tolerate the existence of one whose life may be a disturbing reminder of terrible past violence, or as is more often the case, merely an embarrassment or an inconvenience.

It is not an act respectful of human freedom, but rather an abuse by one person of their freedom in bringing about the extinction of the opportunity for the exercise of his or her freedom by another as-yet-unborn human being.

It is not an acknowledgement of human equality, but a denial of it in which one person asserts their will at the expense of the life of another, without the other's consent.

It is not an act among two human beings who respect and treat one another as equals, but an act in which one human being denies and violates the equal humanity of the other.

And, finally, it is not an act expressive of respect for human solidarity, a compassionate siding with the weaker and more vulnerable and voiceless member of the human family, but rather an act of domination that denies the equal right to life of a defenceless fellow being and brings about their death.

> Bearing in mind that the need to extend particular care to the child has been stated in the Geneva *Declaration of the Rights of the Child* of 1924 and in the *Declaration of the Rights of the Child* adopted by the General Assembly on 20 November 1959 and recognised in the *Universal Declaration of Human Rights*, in the *International Covenant on Civil and Political Rights* (in particular in articles 23 and 24), in the *International Covenant on Economic, Social and Cultural Rights* (in particular in article 10) and in the statutes and relevant instruments of specified agencies and international organisations concerned with the welfare of children.

As a signatory, Ireland is committed to recognising and acting upon the need to extend particular care to the child.

This clearly once again precludes the legalisation of abortion. All children must be treated equally. If what is done to unborn Children in abortion were done to born children it could not be termed 'extending particular care' to them. It would rather be termed child abuse of the most deliberate and horrific type, the deliberate taking of a child's life. To mistreat some children on the basis of age, size, developmental level reached, bodily advancement, suspected presence of disabilities, or parental rejection, as legalised abortion does, is invidious discrimination and is prohibited by the terms of the *Convention*.

> Bearing in mind that, as indicated in the *Declaration of the Rights of the Child*, 'the child, by reason of his physical and mental immaturity, needs special safeguards and case, including appropriate legal protection before as well as after birth.

By signing the *Convention* the State is committed to recognising and respecting that, as indicated in the *Declaration of the Rights of the Child*, 'the child by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection before as well as after birth.'

Again, at the very least, appropriate legal protection before birth must mean not allowing the lawful killing of the unborn.

This places upon the Irish government a clear obligation to act without delay to put in place appropriate legal protection before birth. In the wake of the flawed *X* case ruling by the Supreme Court, the legal protection for unborn children is no longer adequate. The purported 'right to abortion' crafted by the Supreme Court in *X* has not time limit whatsoever, requires no medical or psychiatric evidence, and is triggered by a mere assertion of suicidal inclination. This cannot be restricted by Oireachtas legislation, but requires a referendum. Legislation cannot narrow the scope of this 'right'.

Appropriate legal protection before birth needs urgently to be restored and the only way to do this is to hold a referendum offering the people an unambiguous opportunity to reverse the effects of the *X* case ruling and restore to the right to life of the unborn the legal protection the people meant to give it when they voted to insert Article 40.3.3 into the Constitution in 1983.

> Recognising that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration.

By ratifying the *Convention* the State has committed itself to having special consideration for children living in exceptionally difficult conditions. The unborn children of women with crisis or unwanted pregnancies, especially those following sexual violence, are children living in exceptionally difficult conditions, they are children at risk of their lives.

The State has a responsibility under the *Convention*, to them and to their mothers, to do all that can be done to alleviate the women's distress and practical difficulties, to provide professional and practical help and to facilitate organisations that offer personal and other support, and to encourage and facilitate them in continuing to term with the pregnancies and either keeping the children or offering them for adoption.

> Taking due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child.

By signing the *Convention* Ireland was acting in accordance with its traditions and cultural values which favour the protection and harmonious development of the child. Irish people value family life and treasure children. There is a deep-seated aversion to abortion in Ireland. Abortion is the opposite of protection for a child and ends any possibility of his or her harmonious development in this life.

The least the State must do to protect the child and his or her harmonious development is not to put in place laws that allow for the killing of unborn children. That is not in accordance with the pro-family, pro-child, anti-abortion ethos which everyone admits is a feature of Irish traditions and cultural values.

> Recognising the importance of international co-operation for improving the living conditions of children in every country, in particular in the developing countries, they recognise and commit themselves to respect and defend certain rights of children, and to that end, to recognise and discharge certain responsibilities and duties as States signatory to the *Convention*.

By signing this international *Convention*, the State has recognised the importance of international co-operation for improving the living conditions of children in every country, in particular in the developing countries. Each country has its own traditions and cultural values to offer to enrich the world community. Ireland has a rich tradition of family life and sees an immense cultural value in welcoming and cherishing children.

By putting in place appropriate legal protection before birth, Ireland would be offering an important indication to the very many other nations who have similar traditional and cultural values of the way in which the equal dignity and worth of children should be recognised and respected, and their equal right to life protected.

Several Articles of the *Convention* set out rights of the child relevant to this submission, entailing also correlative duties and responsibilities of the State.

> ARTICLE 1
> For the purposes of the present *Convention*, a child means every human being below the age of eighteen years unless, under the law applicable to the child, a majority is attained earlier.

This defines as children 'every human being below eighteen years of age' and so includes the unborn.

> ARTICLE 2
> 1. States parties shall respect and ensure the rights set forth in the present *Convention* to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national or ethnic or social origin, property, disability, birth or other status.
>
> 2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 2.1 obliges the State, as a signatory, to respect and ensure the rights set forth in the present *Convention* to each child within their jurisdiction without discrimination of any kind. At present in the Republic as a result of the *X* judgement, the right to life of the unborn is not given appropriate legal protection before birth. This provision of the *Convention* requires the State to rectify this situation, which requires a referendum to ban abortion.

Article 2.2 obliges the State as a signatory, to take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment. Abortion is a form of fatal discrimination and vicious punishment. The State is thus committed to introduce the appropriate legal measures to see that unborn children are protected against abortion, and to bring forward the practical steps needed to encourage and empower women at risk of abortion to bring their pregnancies to term and either keep the children or place them for adoption.

> ARTICLE 3
> 1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be primary consideration.
>
> 2. States parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

Article 3.1 obliges the State, in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, to have the best interests of the child as a primary consideration. This definitely rules our legalised abortion because there is no way that abortion could conceivably be considered to be in the best interests of the unborn child.

Similarly, Article 3.2 requires the State to take all appropriate legislative and administrative measures needed to ensure the child such protection and care as is necessary for his or her well-being. Here again, this rules out legalised abortion as by no stretch of the imagination could abortion be regarded as providing an unborn child with the protection and care necessary to his or her well-being.

> ARTICLE 6
> 1. States parties recognise that every child has the inherent right to life.
>
> 2. States parties shall ensure to the maximum extent possible the survival and development of the child.

By signing and ratifying the *Convention*, Article 6.1 commits the State to recognising 'that every child has the inherent right to life'.

The word inherent is important. It means that the child's right to life is not bestowed on him or her by the State, the Constitution, the laws, the Oireachtas, the judiciary or even by his or her parents. He or she possesses that right to life by virtue of being a living human individual.

Article 6.2 binds the State to ensuring to the maximum extent possible the survival and development of the child. But abortion prevents the survival and development of the child. So this article again imposes a clear obligation on the State, at the very least, not to legalise abortion.

> ARTICLE 4
> States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognised in the present *Convention*.

Finally, the State is committed under Article 4 to undertaking 'all appropriate legislative, administrative, and other measures for the implementation of the rights recognised in the present *Convention'*.

Since the *Convention* explicitly recognises the right to life as inherent, and explicitly recognises the need for appropriate legal protection before birth, it follows from this that as a signatory to the *Convention*, Ireland is obliged to take an appropriate legislative measure to put in place adequate legal protection before birth of the inherent right to life of the unborn child. The simplest way to meet this obligation is to bring forward a bill without delay to hold a referendum on an amendment to Article 40.3.3 that would offer the people a clear opportunity to reverse the effects of the mistaken Supreme Court ruling in the *X* case.

11 The inconsistent and inconclusive discussion of abortion in the *Green Paper on Abortion*.

The discussion of abortion in the *Green Paper on Abortion* is marred by the conflicting political motives that governed the decision of the final text.

The dominant motive discernible throughout the entire test is the avoidance of any principled ethical position for or against abortion – the Cabinet Committee decided in the end to dodge the issue, to pass the parcel, to delay deciding what approach the Government is going to adopt in addressing the abortion issue. Nowhere is this clearer than in the discussion of abortion where there is an attempt to counter the strong evidence of studies showing that induced abortion is not needed to manage medical conditions in pregnancy with anecdotal reports in which induced abortion was carried out.

(i) Ireland's maternal mortality is better than Britain's without abortion, so abortion is not necessary The *Green Paper on Abortion* accepts that Ireland's maternal mortality rate is one of the lowest in the world, citing the Jenkins study showing our rate to be half that in England and Wales, achieved *without* legal induced abortion.

If our rate is safer by half than the British rate, without induced abortion, then abortion is not needed to save mother's lives. The *Green Paper on Abortion* tries to wriggle out of this conclusion by a convoluted reasoning that, since our figures are so good, they have to go to international data to see if abortion is needed. (1.01, p.11).

(ii) The range and depth of the differences between different developed countries make international comparisons technically so complex and problematic that the *Green Paper on Abortion* is not in a position sufficiently to support a reliable conclusion that abortion is needed to save mothers' lives They themselves have to concede, however, that the international data do not support a conclusion that induced abortion is necessary to save mother's lives. The interpretation of the literature in developed countries, they acknowledge, 'poses certain difficulties' because (i) countries' cultures differ, (ii) they use different medical criteria, (iii) evaluate different outcomes and, (iv) probably use different statistical techniques. (1.02, p. 11). If they are right in this, then it means that the *Green Paper on Abortion* was not in a position to carry out the refined comprehensive comparison needed to provide sufficient support for the conclusion that abortion is really needed to save mothers' lives.

(iii) The use of anecdotal reports of cases where abortion was used is highly problematical They cite two kinds of papers. The weaker kind are what they term 'anecdotal' – reports by doctors who carried out abortions when treating cases. The stronger evidence is of studies showing that mothers with different types of conditions could be successfully brought to term without recourse to induced abortion.

> Many papers are anecdotal and describe particular interventions, including termination of pregnancy, which resulted in a successful outcome for the mother.
>
> Other studies, however, conclude that clinical conditions can be successfully treated by medical or surgical management without recourse to termination of pregnancy (1.02, p. 11)

Weighing up the evidential value of such anecdotal reports of individual cases in which abortion was used, the *Green Paper on Abortion* says:

> It is particularly difficult to evaluate the anecdotal reports which specify situations where termination was performed to save the life of the mother because of the difficulty in ascertaining whether or not the termination was responsible for avoiding a maternal death or whether this was attributable to the appropriate clinical treatment. (1.03, p. 11)
>
> Case reports which describe a successful outcome, however, do not provide sufficient evidence that the outcome would be different if therapeutic abortion was not performed. (1.14, p. 16)

In the summary of the first chapter, in a badly written sentence, the same point is made yet again:

> The further problem of anecdotal case reports where it was stated that elective termination of pregnancy was performed, cannot answer whether maternal morality was prevented solely on the basis of the termination. In general, the vast majority of conditions in pregnancy are managed successfully. However, scientific literature does note situations where elective termination was performed to protect the life of the mother. (1.28, p. 21).

This shows that anecdotal case reports of abortions having been performed do not suffice to prove that abortion is ever necessary to save mother's lives.

(iv) The *Green Paper on Abortion* fails to acknowledge the widespread routine rubber-stamping of abortions on medical grounds where they are really sought for social not medical grounds The *Green Paper on Abortion* virtually concedes the practical infeasibility for a range of technical reasons of grounding a claim that induced abortion is necessary to save the lives of mothers on comparisons of treatments in different developed countries. Similarly, it virtually concedes that anecdotal case reports comparisons cannot support such a conclusion either.

There is a further element, however, that needs to be considered in weighing up the evidential value of claims by doctors in jurisdictions where induced abortion is legal that induced abortion is appropriate medically to protect the mother.

According to the *Green Paper on Abortion*, in 1996, 180,000 induced abortions were carried out in England and Wales, and it concedes that '0.06% of abortions were performed on the sole ground that it was deemed that the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated.' That is, less than one in every thousand.

But every single one of these abortions was sanctioned by doctors on one of the 'medical' grounds specified in British law. In other words, doctors had no difficulty putting their name and authority to tens of thousands of demands for induced abortions every year which were really sought on social grounds but dressed up as 'medical' grounds by the abortion legislation.

Thus, for example, one of the grounds under which an abortion may lawfully be obtained in Britain is that the continuation of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) in the family of the pregnant women (Ground D under the *Human Fertilisation and Embryology Act 1990*, previously Ground 3 under the *Abortion Act 1967*).

For every one case that may have had some real medical aspect to it, there are, on their own admission, more than nine hundred and ninety nine that are not carried out on medical grounds at all but on social grounds, and the doctors allowed themselves to be put in the position of providing a fig-leaf of pseudo-medical legitimacy.

The widespread and routine involvement of so many doctors in the authorising and legitimising medically and socially of 180,000 abortions a year, more than 99.9% of which are sought for social grounds but given a medical gloss to salve public and individual consciences, is the social context in which the claims that certain conditions require 'therapeutic abortion' have to be evaluated.

In a society where doctors can persuade themselves that it is medically appropriate to authorise 180,000 abortions on social grounds in a year, claims that abortion was appropriate in this or that case have a serious credibility problem.

(v) The use of 'termination of pregnancy' The use throughout the *Green Paper on Abortion* of the phrase 'termination of pregnancy' is confusing.

It includes procedures that medically are ethically acceptable such as the delivery by normal birth of a living baby, the delivery of a baby that has already died, and the death of a baby as a side-effect of a medical treatment of the mother such as the removal of a cancerous womb, none of which are induced abortion, and included abortion itself which is not medically ethically acceptable.

(vi) Psychiatrists' evidence to the Rawlinson Inquiry said that although most abortions are on the grounds of supposed risks to mothers' mental health, in reality there is no psychiatric justification for abortion This is just a specific area illustrating the way in which the credibility of the medical claim that abortion is sometimes indicated is compromised by a context in which that claim is widely made in a manner that everyone knows is untrue.

The mental health ground is the main ground on which abortions are authorised in Britain but, as quoted in the *Green Paper on Abortion* (5.22, pp. 63-64) psychiatrists told the Rawlinson Inquiry that there were no psychiatric indications for abortion. In other words, psychiatry was allowing itself to be misused to confer a pretence of legitimacy on abortions sought on social grounds.

They made two points about this. Firstly, in falsely giving their medical authority to claims that an abortion was necessary on grounds of risk to the mental health when in truth they were sought on social grounds those who did so were breaking the law.

Secondly, women who may actually be inclined towards depression or suicide, instead of receiving the psychiatric treatment they really need, are likely to be put at greater risk by undergoing an abortion.

I would add that the lending of their names and authority of their profession to such a widespread deceit harms gravely the authority and credibility of the profession as a whole.

(vii) The *Green Paper on Abortion* and the Government have conceded that the *X* and *C* cases got it medically and psychiatrically wrong on suicide The threat of suicide was the ground on which abortion was declared to be lawful by the Supreme Court in the *X* and *C* cases.

This was a mistaken application by them of their own test, of the probability of 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 the pregnancy. In fact, the risk could have been avoided by treating the underlying causes of the suicidal inclinations and providing warm personal support and appropriate care during the pregnancy.

The *Green Paper on Abortion* accepts the points made by those who criticised the Supreme Court rulings' view of the way such conditions should be treated. It accepts that pregnancy protects hugely against suicide even with mental disorders. It does not list abortion as a 'treatment' for depression, rather underlying conditions are treated and social problems addressed.

The fact that the government in 1992 proposed to drop the suicide provision from the test shows that they believed it was wrong. The fact that the second option in the *Green Paper on Abortion* is a re-run of the 1992 substantive wording, excluding suicide as a ground, implicitly concedes that the Supreme Court got it wrong on suicide in *X* and confirms the pro-life critique of the Court's line of argument.

(viii) The *Green Paper on Abortion* failed to reject abortion on grounds of disability Ignobly, the *Green Paper on Abortion* discussed abortion on the grounds of foetal abnormality in the same non-committal language – shamefully failing to reject as unjust and discriminatory the taking of a human life on the grounds of disability.

(ix) The fact that a Civil Service Interdepartmental Working Group and a Cabinet Committee, including two Attornies General, could publish a *Green Paper on Abortion* that fails to say that taking innocent life is wrong shows that a constitutional ban is needed to prevent the legislature, the judiciary and the executive from legalising abortion in the same value-free manner The *Green Paper on Abortion*'s biggest flaw – its failure to take a clear stand on ethical and democratic grounds that abortion is wrong because it is an attack on the life and right to life of an innocent living human being persuades me that we need a referendum to ban abortion completely. The *Green Paper on Abortion* throughout uses studiously non-committal ethically cleansed language. This is unacceptable in a democracy based on equality under the law.

The language of the *Green Paper on Abortion* falls below the ethical criteria contained in the *Regulation of Information (Services outside the State for Termination of Pregnancies) Act, 1995* which, flawed and all as it is in policy terms, at least prohibited the referral, advocacy or promotion of abortion. This act embodied the social policy of the government on abortion, viewing it as something that ought not to be advocated or promoted. Why did the *Green Paper on Abortion* not adhere to even this minimal ethical level of social policy on abortion?

The fact that a Civil Service Interdepartmental Working Group and a Cabinet Committee, including two Attornies General, could publish a *Green Paper on Abortion* that fails to say that taking innocent life is wrong *itself* shows that a constitutional ban is needed to prevent the legislature, the judiciary and the executive from legalising abortion in the same value-free manner.

(x) *The Green Paper on Abortion* lists abortion itself as a cause of maternal death The whole approach in the *Green Paper on Abortion* is that they do not want to adopt any approach that could lead to women losing their lives even very rarely. But the *Green Paper on Abortion* itself admits that abortion itself is sometimes the cause of the death of the mother, though 'very uncommonly' (p. 12).

(xi) All the other options involve legalising some level of abortion The *Green Paper on Abortion* gives seven options. Six of them (ii-vii) would involve legalising some level of abortion. The All-Party Oireachtas Committee on the Constitution should reveal exactly how many people, if indeed there were any at all, called for each of these six options, ii to vii.

Those who advocate any of these options must be challenged and pushed hard to make clear:

* what level of abortion they propose to legalise, and,
* how they propose to prevent the limit they mean to set being swept aside as it has been in every jurisdiction where such limited legalising of abortion has been attempted.

Four of the options proposed, (i, ii, vi and vii) would require the holding of further referenda. Those who are advocating options ii, vi and vii should be subjected to the same hard questioning about their referendum options as those of us have who are proposing Option i, the referendum to ban abortion completely. Will their referenda be denounced as divisive, sectarian etc?

Conclusion

Only one of the seven options, the first, a constitutional amendment to ban abortion, would seek to ban legal abortion completely. Each of the others would have the effect of legalising some level of abortion. It is for this reason that I support the first option, and urge the All Party Oireachtas Committee on the Constitution to do likewise.

My reason is that the core value of Irish democracy is the dignity of the individual. What makes us a democratic people, a constitutional democracy, is respect, in our minds and hearts, but also in our laws and social policies, for the equal and inherent worth of every human life and for the equality of all before the law.

Without that respect we cannot be a democracy. With it we cannot legalise abortion.

What is needed is a balanced and even-handed approach that supports women in crisis pregnancy and restores to unborn children the protection of the law. These are the two sides of the coin of care. Restoring adequate protection to the unborn's right to life by a referendum offering the people a clear opportunity to ban abortion completely will consolidate, vivify and focus our commitment as a society to putting in place the full range of practical, professional and personal supports what women in crisis pregnancies need so that they have real alternatives to abortion.

I urge the All-Party Oireachtas Committee on the Constitution to consider and adopt these values and the two-sided approach of support for women in crisis pregnancy and legal protection for unborn children that follows from them, and to recommend the adoption by the Government of the first option, a referendum on a constitutional amendment to ban abortion completely.

EUGENE DOHERTY
21 NOVEMBER 1999
SUBMISSION TO THE ALL-PARTY OIREACHTAS COMMITTEE ON THE CONSTITUTION

I understand that the government has again asked for submissions concerning matters relating to abortion. The following set of anecdotes and explanations are presented which outline the array of deceptions used in desensitising minds towards accepting the vivisection of children.

A few years ago I presented a model/replica of a 14 week old foetus to my two-year old godson and as he held it I asked him the simple question – what is that? His reply was immediate and precise. He said that it was a little baby. Not alone that – he then proceeded to take the child to a bedroom and after putting the baby's head on a

pillow asked me to be quiet so that the baby could sleep. I had not previously observed that the baby had its eyes closed. We both left the room to allow the baby the peace and serenity that my godson considered it required.

In my student days, just before I obtained my Master's degree in Science, I regularly attended the Medical Society lectures in Galway. One evening Professor Ian Donald was the invited lecturer and being a world respected academic ensured that the lecture theatre was packed to capacity. It is Professor Donald who developed the ultrasound technique for monitoring the developing foetus. His medical texts are considered essential reading in obstetrics. During the lecture the now elderly Donald moved between lectern and projector screen with difficulty, requiring the use of a walking aid. However, once he reached the projector screen everything seemed to change. It became evident that Donald had developed a special relationship with the children he had studied. He referred to each foetus as 'little fellows' and we, like him, began to marvel at the series of exercises a developing child engages in to stimulate the strengthening of its musculoskeletal structures. Eventually Donald raised his cane into the air and asked of us **how anyone could kill that child**. He also pleaded with us not to allow the crime of abortion into our country. Cadres of feminists sitting in the front rows were unusually silent.

During our most recent episode in social engineering – the *C* case, a senior politician was interviewed on the radio. The politician, I am sure, was expecting an easy conversation on the subject by our normally compliant media. This ended when the interviewer asked the politician the simple question – **what is an unborn child?** The radio fell silent for about five seconds. The interviewer was breaking the rules! The politician eventually gasped that she didn't know. Even though her husband is a medical doctor and the debate had existed in Irish politics for over 15 years – this politician had just asked the nation to believe her when she said that she didn't know.

The question must arise as to why a two-year old child and a leading and respected academic can agree on a simple question but which a person elevated and privileged by the state could only remain silent. My godson using only natural reason had stated what the academic, using natural science, had affirmed. But through what process of thought did the politician attempt to convince us that such a simple question could not lead to a firm conclusion? This, of course, is assuming that the politician was genuine in the reply – something the interviewer did not give her credit for.

It seems inappropriate to outline the central philosophical errors that enable innocents to be casually murdered. Inappropriate in the sense that natural reason (my godson) is sufficient witness to clarify the matter. But I outline briefly the philosophical contradiction involved.

The abortion culture sells its agenda through a deception that aims to confuse *essence* (what a thing is) and the array of qualities that a thing may possess. Once the focus is on qualities, and those qualities are considered devoid of value, then the intrinsic rights that the thing (the baby) possesses become contingent on *how* each quality is perceived. Believing that men could be weighed up quantitatively was an error made by Nazi biologism. Native Americans, European Jews, Soviet enemies and even the Irish have, at different periods in history, been considered inferior and lacking in those *essential qualities* considered necessary for their now *contingent* rights to be affirmed. An acceptance by a ruling class that such a standard is acceptable quickly led to a course of action. Those considered unable to meet the arbitrary standard became victims of a holocaust. Since age, timing and convenience are today's standard – the 700 million babies not reaching this standard have been silently led to slaughter houses euphemistically referred to as clinics.

As in all holocausts consciences must be allayed and attempts to expose the outrage repressed. The evil, intrinsic to the act, bears fruits only in proportion to the inability, of the culture that nurtures it, to control its unrelenting acceleration. Countries with the freest availability of contraception show the highest abortion rates. The psychological phenomenon of **denial** enables the following to become a feature of the modern world:

- Over 700 million babies vivisected in officially sanctioned institutions
- Councils ordering abortion clinics to clear out their underlying sewers
- Remains of aborted children being used as commercial end products – even as health foods
- The world's richest country sanctioning infanticide – where the child is killed on the operating table outside the womb
- The cruelty of watching babies swim away from the oncoming scalpel – even after two or more limbs have been removed
- The whitened hands of aborted children showing the severity of pain of the foetus whose clenched fists provide the only evidence of its prolonged and silent agony
- Pseudo-religious people who remain silent and refuse to exercise their most basic and primary duty of fortitude
- Political and media people who complain of the explosion of crime against women and children in the western world but who simultaneously protect its most explicit expression
- The continued denigration of those few who attempt to keep alive any sense of sanity and pity for those who are too innocent and weak to protect themselves
- The stain of sharing a period of history whose insult to God and civilisation will be remembered and cursed for eternity by future generations

It is strange to consider that in a society where *essence* reports to *qualities associated with it* – that the ruling classes must sustain a hierarchy of values which continually exalts their own pseudo virtues. Exemplars of this generation could not survive even the most basic scrutiny of their purpose and intent. Power must however be ruthlessly maintained lest their values are considered worthless and the same outrage is perpetuated on them. Hence the acceleration of contradiction.

If my godson were a high court judge I am sure that by the end of May 1998, the month of Our Lady, a child, survivor of a holocaust, would have been born. Some shame!

I often wonder if a modernist at his judgement asked of Our Lord as to why Ireland was not given good and holy priests and a noblesse worthy of restoring our nation to a sense of grace once the envy of the world. God may well answer that HE indeed gave us good and holy priests,

and a noblesse, but we fed them to the rats in the sewers of London.

There will not be time for a second question!

FR KEVIN DORAN
LECTURER IN PHILOSOPHY, MATER DEI INSTITUTE OF EDUCATION
24 NOVEMBER 1999

1 Green Paper on Abortion

The Green Paper, which was published earlier this year, offers seven alternative approaches to dealing with the problems presented by the Supreme Court judgment in the *X* case. The only one of these alternatives which is acceptable to me is the one which offers the people the opportunity to express, by means of referendum, the public will for a total ban on abortion. I believe that this is the only one of the seven alternatives which offers the prospect of affording proper protection for the right to life of the unborn, **and** the **equal** right to life of the mother.

Once this referendum is held and the right to life of the unborn re-affirmed, it will also be necessary to indicate how the state proposes to defend and vindicate the right to life of the unborn (e.g., not simply by prohibiting abortion, but through honest education, and by ensuring that support services are made available to women during pregnancy, through both statutory and voluntary agencies).

2 Personhood as a ground for the right to life

In order to decide how it is appropriate to act in relation to any entity, the first pre-requisite is to establish what it *is*. Justice and morality, if they are not to be arbitrary or subjective, must be rooted in fact and meaning. 'Ought' derives from 'is'.

The appropriate treatment of persons depends to a large extent on being able to recognise them as such, and to distinguish between them and other entities which are not persons. A person may be defined as a *complete or distinct entity of an intellectual or rational nature* (Thomas Aquinas, relying on the Roman jurist Boethius).

When law seeks to intervene in the realm of healthcare, it must be with a view to upholding the respect due to all persons, in view of their fundamental equality of dignity. At what point should this respect begin? Biologically speaking, life is a continuum. Genetically speaking, however, and in terms of philosophy, each human life has a beginning, a point at which this distinct individual comes into being. Genetic science has contributed to our awareness that each human being has a unique identity, related to but distinct from either of his/her parents.

From the time that fertilisation has been completed, the organism that develops in the womb is organised as a dynamic unit and is, as one, oriented towards on-going development. It is

(a) genetically complete
(b) genetically distinct from either parent (though related to both)
(c) genetically human

and therefore has all the elements of the definition of a person. It is at this point, therefore, that the obligation of respect for human life begins. It is clearly in the interests of justice and the common good that this obligation should be reflected in civil law.

There are various theories which seek to re-define the beginning of personhood, away from fertilisation, on the grounds of biology, sociology, and psychology. None of these is satisfactory.

(a) To be *complete* simply means that all that is necessary for life and continuing development is present. The human entity is complete in this sense once fertilisation is complete. To be *complete* does not mean to be incapable of further development. Paradoxically, if this were so, none of us would ever be complete until our bodily existence had come to an end.
(b) Performance as a person *follows* from being a person. To *be*, by definition, always comes before to *act* (Agere sequiter esse). Although certain rational activity is an indicator that we are dealing with a person, the converse does not apply. The achievement of a certain *personal* level of performance is not necessary to prove personhood. If we were to admit this view, then all those who are regarded as falling short of a minimum level of performance (e.g., mentally handicapped and brain damaged children and adults) would equally be candidates for 'termination'.
(c) The philosophical tradition known as *emotivism* would argue that the question *what is a person?* is a nonsense. Emotivists suggest that decisions about how an embryo/foetus should be treated depend on feeling. Decisions based on how *I feel* about an embryo, or how the suffering of a patient *touches me*, are, however, purely subjective and cannot therefore be regarded as a sound basis for legislation.
(d) The *utilitarian* tradition, similarly, would consider the value of the unborn, or indeed of any human individual, in terms of perceived value to society. Decisions about treatment which are based on the *usefulness* of a human subject overlook the fact that the value of a person is not simply socio-economic.

Concern for the health/life of the mother

The spirit of Article 40.3.3 implies that every mother, irrespective of social class or economic circumstances is entitled to good quality obstetric and gynaecological care. While pregnancy is not, of course, an illness or a disease, there are certain medical conditions particularly associated with pregnancy. Added to this, pregnant women are not immune to the normal range of illnesses that affect the population at large. In the treatment of illness during pregnancy, care must be exercised to ensure that, in so far as is consistent with good medical treatment, the life and health of the unborn is taken into account. It is a tribute to the quality of healthcare in Ireland that *without recourse to procured abortion* the level of maternal mortality is extremely low.

Studies carried out in Ireland, notably a ten-year study done by Drs Kieran O'Driscoll and John Murphy at the National Maternity Hospital, demonstrate conclusively that, under the procedures and ethical principles which currently guide the management of pregnancy in the Republic of Ireland, there are no cases of maternal death

in which the mother's life could have been saved, had abortion been available. It is only in Ireland that studies such as this could be carried out, because in other jurisdictions decisions to abort are routinely made where complications occur during pregnancy.

There do exist some complex cases in which the treatment of one patient (the mother) may involve risk for the other patient (the baby). Currently these are treated in accordance with the *Principle of Double Effect.* The principle of double-effect states that if a course of action has two effects, one good and one bad, this course of action may be taken provided that:

– the bad effect is not directly intended
– the bad effect is not out of proportion with the good
– the good effect does not result directly from the bad.

Examples of situations in which this principle may be relevant include:

– the treatment of cervical cancer (possible hysterectomy)
– ecotopic or tubal pregnancy (tubal surgery)
– ecclampsia (early delivery by caesarean section – baby may not survive)
– pain, particularly in terminal illness (the use of anaelgesic drugs which may shorten life)

Note: In all cases the basic ethical principle remains that medical personnel seek to save any life that can be saved. There is no deliberate choice between one life and another, but there is an acceptance of the reality that all life is vulnerable, and that healthcare professionals are not God. Of fundamental importance is the *intention*. Intention is difficult to prove, but it can be inferred from the facts of the case.

The Supreme Court

The people of Ireland, in the 1983 pro-life amendment, acknowledged the right to life of the unborn, and the *equal right to life* of the mother. In its decision in the *X* case, the Supreme Court, in effect, argues that the right to life of the unborn child is not really equal to the right to life of the mother. Mr Justice Finlay found that the threat to the life of the mother, which was a matter of speculation or at best probability, carried greater weight than the threat to the life of the unborn, which was certain. Mr Justice McCarthy acknowledges that the magnitude of risk applying to the mother would always be less than that applying to the child to be aborted. He holds, nonetheless, that abortion is envisaged by the Eighth Amendment, and uses the expression *with due regard* as if it in some sense cancelled out the expression *equal right to life.*

Mr Justice Egan interprets the terms *with due regard for the equal right to life of the mother* and *as far as practicable* to mean that an abortion will not in every possible circumstance be unlawful. His conclusion does not follow logically from the premises. In reality, these phrases simply acknowledge that, despite the best efforts of the state to carry out its responsibility, the unborn will sometimes die, whether naturally, through medical complications, or through some human agency which is beyond the reasonable control of the state. To acknowledge that the unborn may die, and that the state may be helpless in the face of this death, is fundamentally different to suggesting that it may be lawful for the unborn to be killed. Once again, the key issue is that of *intention*.

The Supreme Court, instead of interpreting the Constitution, seems to have gone beyond it and changed its meaning, which it is not the competence of the Court to do. The Court should have respected the stated intention of the vast majority of the Irish people, and might usefully have made reference to the principle of double-effect, which allows for all necessary medical treatment for the mother.

The basis for the decisions in both the *X* Case, and more recently the *C* case, would seem to be the very strong public sympathy for the young women concerned who were pregnant. The ground-swell of compassion was perfectly valid and understandable in both cases, but what is not understandable is that judges of the Supreme Court should allow the emotionally charged atmosphere to obscure one of the essential facts, namely that the unborn child also has rights, both under natural law and under the Constitution.

Given that, in both cases, the state seemed disposed to believe that the mother was subject to grave pressure, and likely to commit suicide, the question arises as to how else the state might have carried out its responsibility of care, other than by consenting to and, in the *C* case, formally participating in an abortion. Two questions in particular arise:

(a) What resources were made available, and what specialist agencies were approached to provide on-going counselling and care for the mother.
(b) What consideration was given to the possibility that the abortion, in itself a violent act, may have added significantly to the trauma of the mother. What kind of post-abortion care has she received.

Organisations such as *Cura* and *LIFE Pregnancy Care* have the capacity and the competence to provide such care, in an ethos which respects both the well-being of the mother and that of her child.

One further difficulty, which is associated more particularly with the *C* case, is the total failure of the state to protect the young mother from the intrusion of the media, which arguably contributed to the emotional pressure which she experienced.

Future legislation

The *X* case has left Ireland in the position that, theoretically, abortion is lawful at any time during pregnancy, as long as it can be reasonably speculated that the mother might take her own life because of her pregnancy. This situation conflicts with the will of the people expressed in the Eighth Amendment, and so clearly stated that it was generally accepted at the time, even by those who had most vehemently opposed the amendment, as representing a total ban on abortion.

The State must respond to the judgment of the Supreme Court. Legislation may form part of such a response. Such legislation must respect the will of the people already expressed. This will only be the case if legislation

(a) is so framed as to specifically exclude directly procured abortion, from the time of fertilisation,
(b) responds to the fears, expressed by some, concerning the well-being of the mother, by endorsing the current procedures and ethical principles, under which women are provided during pregnancy with all necessary medical treatment,

(c) outlines the nature and level of care which must be provided to a woman, in the event that it is believed by a competent person that she is at risk of taking her own life, **and**
(d) is then presented for the endorsement of the people in a further referendum, in order that the damage done by the Supreme Court judgment in the *X* case may be undone.

Legislators who may be tempted to justify procured abortion on the grounds of serious risk to the life of the mother, would do well to consider that this is the sole basis on which the 1967 Abortion Act provided for abortion in Britain. Whatever intention there may have been in this legislation to limit the availability of abortion has been eroded by the courts over the intervening years.

DR BRENDAN PURCELL
DEPARTMENT OF PHILOSOPHY, UCD
28 NOVEMBER 1999

In the light of the seven options offered in the Green Paper, I wish to develop just one point, that law is not an autonomous sphere in itself. It's an important issue, since the Presidential referral to the Supreme Court on 12 May 1995 of the Regulation of Information (Services Outside the State for the Termination of Pregnancies) Bill, led to an explicit repudiation by that Court of a criterion or source of legal order outside the legal order itself.

There are various legal philosophies which uphold this rejection of an extra legal source for law, theories which rely on one or other version of a social contract, or simply on the legal fiat itself, as in Kelsen's legal positivism. This isn't the place to go into these varying English-language or European debates, other than to list some difficulties which I would expect Irish legal thinkers to face, particularly with regard to legalisation regarding abortion.

1 Law as an expression of an experience of order and the limits of legal positivism

The legal order in the sense of an aggregate of valid rules is part of a larger phenomenon that includes the efforts of human beings to establish order in a concrete society. Just order, since it originates in experiences of reality transcending the legal order, cannot be defined by substantive rules. No philosophy of law can be developed as a system of rules derived, as it were, from the highest substantive axioms. Hans Kelsen's attempt at formulating a rational hierarchy of legal rules culminates in a hypothetical basic norm that orders the members of society to behave in conformity with the norms deriving ultimately from the constitution. The power structure articulated in the Kelsenian constitution purports to be the origin of the legal order, surmounted by the hypothetical basic norm. This basic norm makes the highest ordering acts intelligible as acts in conformity with a norm, thereby closing the normative system.

But such a 'dogmatic' treatment of the law ignores the actual intertwining of the legal rules with the social process of their making, and conceals an explicit articulation of this interaction. For the legislative action required to produce the valid rules of the statute is itself neither a constitutional nor a statutory rule, but a series of actions of particular human beings. The same is true on the level of individual decisions of judges regarding the application of these legal rules. The notion of a hierarchy of valid rules, thus, must be expanded into a lawmaking process in which rules and rule-making acts alternate. This process, finally flows into the vast reality of the society that 'has' the law that is made in the process.

This brings us to the core of the issue, in terms of criminal law. Crime is primarily what is indicated as crime by the law and assigned a penalty. However, the presupposition of a legal order where a criminal law is in operation, is that the crimes which are committed are recognized as such and assigned a penalty. But what a crime is can never be inferred from the legal order, rather it derives from ethics in general. So, what is a crime in the ethical sense can also be classified as a crime under criminal law, but the criminal law is not the source for understanding what a crime is. For there are very many things which are crimes, but which cannot be included in criminal law. Thus the functioning of law depends on the society as a whole being intact, and not criminal. For, with the criminal law one can only include things under the presupposition that what a crime is, is ethically understood outside the criminal law and indeed correctly understood. This leads to the primary correlate of our basic point, that law is an expression of the society's experience of order.

2 Problem of corruption in lawmakers and in the public

So, at this highest place in the hierarchy of legal norms, the problem of the content of the norm is interfered with by the problem of the personalities, political and legal, who have to decide about this content of the norm and who have to apply it.

There is no law that is mysteriously enacted somewhere and which can be applied by some fine jurist. Rather, there only exists the law which is made by concrete human beings. If the politicians and legal people are corrupt, and not capable of law and justice or if they proffer some kind of ideology under the name of justice, then, of course, one cannot have any legal order.

Towards the end of the 19th century, the idea became accepted in jurisprudence that the law was identical with positive law and that what goes beyond positive law is not the business of the jurist. This was the context in which Kelsen developed his positivist jurisprudence. The situation developed where the jurist is only bound by positive law, where positive law is supposed to form the basis of the order of a society. But this functions only as long as the society is socially and morally intact. If it is not morally intact, then even a parliament or people's assembly – as occurred under the National Socialist or Soviet Communist regimes – can make laws which indeed are formally right in terms of positive law, but run counter to all principles of justice.

3 The limits of legal positivism exposed under National Socialism

This was a problem with underlay National Socialist legislation. Hans Welzel in 1935 argued for a view of law in

which 'concrete ways of ordering life [must] be seen as part of the great unity … in the community of the Volk, with the requirements demanded by the concrete historical situation, which in the legal field find their most visible outcome in the expression of the Führer's will – that is, in the law'. (cf. Ingo Müller, *Hitler's Justice: The Courts of the Third Reich*, Harvard, 1991, p. 221.)

One of the finest German jurists, Gustav Radbruch, in a 1947 article, 'Rechts Ingenieure?' wrote: 'The traditional notion of law, the positivism that reigned unchallenged for centuries, with its doctrine, "the law is the law," was defenseless and powerless against such [National Socialist] injustice in the form of laws. Legal science must remember again the millennial common wisdom of antiquity, the Christian middle ages, and the age of the Enlightenment, that there is a higher justice (Recht) than the law (Gesetz), a natural law, a divine law, a rational law, in short a justice which transcends law (ein übergestzliches Recht), in terms of which injustice remains injustice, even when it is cast in the form of law.'

This is the problematic of German jurisprudence, already in the Weimar period, then under the Third Reich, where a whole series of things which without a doubt were criminal, occurred. And the question now arises, how can they be dealt with in an order of public law which cannot classify these crimes as crimes, for the good reason that all criminal law always presupposes that the society on the whole is intact.

4 Relevance to abortion legislation

The relevance to abortion legislation in Ireland is this. If an extra-legal criterion and source for legal reflection is ruled out, as apparently has been done by the Supreme Court majority in the 1995 Presidential referral, then the Irish people are entering into an arena of legalized criminality. The issue of abortion cannot be settled at the legal level. In Germany, it was the political and legal elites who supported the National Socialist regime and its brand of legalized criminality.

At the very least, an unambiguous constitutional referendum should be put to the people, so that, on the basis of the morality that sustains the ethos both of the pre-1992 Constitution, and of Irish public life in general, they can decide the issue. By 'unambiguous ' I would mean a referendum which makes it possible to outlaw abortion, for example by a simple negative, as did, for example, the former constitutional prohibition of divorce. Only the Green Paper's first option, of the seven options offered, proposing an absolute constitutional ban on abortion, and clearly reversing of the Supreme Court's *X* case judgement would thus, in my opinion, suffice.

ROBERT FAIR
SUBMISSION ON ABORTION

I have read the Green Paper on Abortion and the Appendices.

The neutral tone of the paper strikes me very much. It's flavour is more that of an academic treatise, than that of a document concerning the most pressing social issue facing us. The tone could be described as pessimistic, even fatalistic. There is an over emphasis on difficulties. The complete absence of any indication of the government's own thinking on the matter is a major omission and a major flaw. One might have hoped for signs of goodwill towards a strong pro-life ethos in the State. Is it possible that there is Cabinet disunity here? It seems, incredible, given our Christian tradition, but are there one or two in the Cabinet who would be prepared to tolerate legalized abortion?

Ireland has the opportunity to act as a catalyst for a change of attitude in this matter throughout Europe. Given goodwill on the part of our politicians and the Judiciary, we can help to point the way towards a future where the culture of death, so insidiously pervasive in Europe nowadays, is replaced by a culture of life.

Whether as individuals, or as a people, we must uphold either a culture of life, or a culture of death. There is no middle course. The notion that one can be neutral with regard to the most fundamental right of all, the right to life, is ludicrous.

Where is the sense, or the logic in an Irish Government providing funds, as it does, to organisations such as the Irish Family Planning Association, and others, which, in practice, present numbers of our more vulnerable women as fodder for the abortion industry, constantly operating on the other side of the Irish Sea? This is the people's money and it should be used to promote, and to maintain, social action of a manifestly good character. It should not be used to promote evil.

No mature adult male or female fails to recognise the huge impact on a women of an unwanted pregnancy. One can visualise extreme anxiety, panic, shame perhaps, even terror. The truly compassionate response is to help the woman to carry the child to full term. It is false compassion to help her to destroy the child. The Irish Government could move from it's excessively neutral stance, and make a really large sum of money, the people's money, available to assist women with unwanted pregnancies. This would surely encourage more women to reject any notion of having an abortion. The provision of large scale Government funding in this way would be a good use of public money, and a positive pro-life signal to the community at large.

The UN and the EU both have very influential elements, which are extremely pro-abortion. Is the Government trying to discriminate with regard to these two organisations. It must prevent Irish taxpayer's money being used to promote abortion? The UNFPA, for instance, is an arm of the United Nations which we should certainly not be funding. Under the guise of helping women and children, it is in fact destroying them.

The calculated inactivity of our political leaders on the abortion issue has become what is behind it. Are they afraid of an adverse reaction within the EU, if they vigorously support pro-life policies? Are they too concerned with conformity? It does not follow that, because other European countries have abandoned respect for the sacred nature of human life, we should do the same. On the contrary, given the political will, we could help to reverse this trend.

Our political leaders seem unwilling to offer us a vision of the future which is firmly rooted in our Christian tradition.

The delaying tactics employed in relation to the abortion question illustrate this reluctance. They are too much taken up with managing an economy. This activity has it's importance, but the main focus should be on upholding the moral values which we, the people, cherish. The most basic of these values is the right to life. Instead of offering us false gods, such as materialism, imported from other cultures, our political leaders should be offering us a programme, which reflects our own distinctive Christian tradition.

We were once the teachers and the evangelisers of Europe. We can be so again, if our political leaders choose to honour our Christian tradition, and particularly our Catholic heritage, by firmly, and publicly, supporting the pro-life cause. Seeking to compromise with secularism, as these leaders seem to be doing, is the road to national ruin. Adopting the pro-life cause would be a path to glory.

In the 1990s the Judiciary has failed us miserably, as far as upholding the right to life is concerned. In 1992, we had the unjust ruling of the Supreme Court in the *X* case. At the end of 1997, we had another unjust decision in the *C* case. The clear will of the people, as expressed in the pro-life constitutional amendment of 1983, has been flouted by the judges. The Supreme Court has moved away from basing it's decisions on the natural law, and moved towards moral relativism.

In happy contrast to politicians and judges, the Medical Council has stood firm on the abortion issue. The 1998 guidelines unequivocally uphold the right to life of the unborn child. We may well thank God that our doctors, as a body, have maintained the national honour in this matter. The Medical Council's guidelines could serve as a starting point for the wording of a future pro-life amendment to the Constitution.

I doubt I am the only citizen, who, seven years after the *X* case, is thoroughly exasperated by the refusal of our politicians to arrange another referendum on the abortion issue.

There are people in this country, with first class minds and abundant goodwill, who could provide a wording with an emphatic pro-life bias. If a clear majority of the people voted for such a wording, hopefully our judges would be dissuaded from misinterpreting it.

I insist upon another referendum, before the middle of the year 2000. A statement to the world that we Irish, despite the violence which has disfigured our land, still regard human life as sacred, would be a fitting way to celebrate the Great Jubilee.

DR DEIRDRE MCNAMARA
25 NOVEMBER 1999

I have been a homeopathic practitioner in New York City, US, over a span of twenty-seven years.

In that period I have seen many cases of Post Abortion Syndrome in both men and women and can testify only to its profoundly destructive effects.

Abortion is the deliberate and elective destruction of a human life, by the cruellest means possible. Consenting to abortion requires a radical transformation of the deepest human ethos: the preservation of life, the protection of children.

In acquiescing to abortion or to its provenance we revert to primitive barbarianism, murder for expedience.

The 'first' murder, in the Book of Genesis, Cain v. Abel, is emotive: rage fuelled by jealousy. The enthusiasm for abortion of special interest groups in unreproductive relationships might smack of this. Esteemed members of the Oireachtas, you have no such excuse, rationalisation, motivation.

It is to Ireland's great credit that our nation has withstood the destructive forces of 'political correctness' battering the US from within and our shores from without.

In the same context we would be subject to the bite of ridicule echoing down the canyons of history were we to embrace this vile, cruel and inhuman practise at a time when advances in genetics prove Hippocrates, Hebrew sages and Christian teachers correct in the assertion that life begins at conception and is sacred! That each and every human life is unique from its first zygotic shimmerings; that nothing is added between conception and death but nutrition (thus far); that to deny the humanity of the pre-natal human is to question the humanity of infant vs child, child vs adolescent, adolescent vis-à-vis adult. That leads to doubt regarding the 'nobility' of the elderly and theses such as are presently being expanded in American liberal colleges: 'No child under the age of five, no animal, no elderly person, that is no one incapable of, for example, voting rationally has an automatic right to life …'.

To some, such spurious arguments could be used to justify the 'euthanasia' of Clinton voters, Minister O'Donnell voters, etc.

The Associate Professor of Religion and Philosophy blanched and stuttered when discreetly presented with dismembered babies.

Ireland may be the only nation yet unsullied by the severed limbs and blood of its infants. Ireland lost millions of her citizens in defence of religious freedom: to lose more in violation of the faith for which our ancestors died would not only be tragic, but an incredibly stupid mockery of their stand and sacrifice.

Disposal

How does Ireland propose to dispose of the bodies? Sell little arms and legs to cosmetic companies? Little hearts and livers to the embryo researchers in the Rotunda? Brain cells to neuro-researchers (still centuries behind the Homeopaths), or ship the whole lot off to China where 'battered' baby is considered a delicacy – one female Chinese *pediatrician* can't get enough. Jakob-Kneutzfeld may find her yet.

On the other hand, in Kansas, they just throw the little heads and bodies on to garbage dumps/rubbish heaps for consumption by dogs, cats and rats?

Is this the right of the developing Irish baby?

Is this the future of Irish children and women?

Post Abortion Syndrome

Do you have a support system for the brilliant career women who stop functioning for no apparent reason, or the housewife who suddenly can't use a vacuum cleaner or walks out on her husband and child?

Economic cost

Insurance providers in the US thought they'd save a bundle by backing the pro-death movement. After all it cost $400 to kill a child in utero vs $4,000 to see a pregnant mother to term.

Like the airlines who lost millions of passengers by serving peanuts instead of bagels, bagels instead of hot lunch etc, US Insurance providers ended up paying more to treat depression, alcoholism, suicide, infertility, PID, AIDs etc, as derivative, secondary to abortion.

'Aborted' women are 9 times as likely to attempt suicide.

'Aborted' men suffer deeply, and usually alone.

Since *Roe v. Wade* passed in 1972, 35 million citizens have been denied the right to: live, vote, contribute to their communities. 35 million citizens have not bought cars, computers, clothes, airline tickets, booked hotels.

Social consequences

The human gene pool has been devastated. Crimes of passion are down: crimes of sadistic calculation and premeditation are up. Law sanctions the murder of the innocent: Lex Nala, Lex Nulla; Lex Nulla! Amorality and Anarchy. Doctors kill children: parents kill children: children kill parents: children kill children. Infanticide and abuse is epidemic in the US today.

Freddy Kruger, Texas Chainsaw Massacre, etc. are expressions of the abortionist embedded in the human superconsciousness.

I do not condemn any woman who has undergone abortion. Pressures on a woman facing unexpected mother[hood] are intense. Most pro-aborts are completely ignorant of the means and method used to kill the human child in utero. Most mothers are pressured into abortion by parents, boyfriends, girlfriends, as often as not economic circumstances. By the third abortion it's a matter of routine.

Too often however, abortion is the 'choice' of a woman in a stable, affluent spousal relationship where 1.75 children complete the picture while a third child would mar it.

Children as young as 2 know when one parent is unfaithful (before the other spouse!) and when a sibling has been destroyed *in utero*. A child may not articulate their suffering in words! They will express it through aberrant behaviour and/or conduct.

My Godchild was aborted August 11 1995, (her) mother coerced for the fifth time by *her* mother in cohoots with a stupid psychiatrist who claimed having a child would damage her fragile mental health. My Godchild's mother has been permanently institutionalised since the fifth abortion.

Esteemed members of the Oireachtas, do not impart, support, condone or allow this cruelty to destabilize our nation.

DONAL NUNAN
26 NOVEMBER 1999
SUBMISSION TO THE OIREACHTAS COMMITTEE CONSIDERING A RESPONSE TO THE GREEN PAPER ON ABORTION

Having made a submission to the Green Paper, I feel obliged to make this further short submission to your Committee. This submission is a personal one; I am not a member of any organisation campaigning on this issue.

A Freudian theme of the Green Paper may be that a policy on abortion could be the outcome of a weighted amalgam of the various views expressed in submissions made to it. If true, this is to deny the important issue as to what are the fundamental and inalienable rights of man/woman/child/infant/foetus to life.

By using the term 'option' to include such as 'abortion on demand', the Green Paper might be interpreted as being engaged in a process of softening-up public opinion through its use of language.

The right to life is a fundamental human right, much abused in this past century. By cruel means, several national governments (particularly those of Germany and Russia) declared that certain people (notably Jews, handicapped, peasants (in Russia)) no longer had a right to life, with immense consequences in terms of human suffering. Even in this last year of this century, similar crimes against human rights have been committed in the Balkans.

But why should the right to life be confined to born people? As life is a continuum from conception to death, intervention to destroy that life at any stage is the assumption of a prerogative which is generally considered to be the preserve of God alone.

Commendably, most European countries have abolished capital punishment; yet they freely allow abortion to take place, often on trivial grounds. Clearly, there is one law for the born and another for the unborn. The differences from country to country in the conditions under which an abortion may be performed, is evidence of the arbitrariness and subjectiveness of such policies.

The only situation where there is a real dilemma in terms of human rights is when the life of the infant in the womb threatens the life or health of the mother. This is provided for in the amendment 40.3.3 to the Constitution. This provision was undermined by the decision of the Supreme Court in the *X* case, by allowing the threat of suicide to provide sufficient grounds for an abortion.

My suggestion is as follows:
That there should be two further amendments to Article 40.3.3:

1 to the effect that the threat of suicide be excluded as grounds for an abortion, as in the failed 1992 Referendum
2 that the Oireachtas be empowered to pass laws, as it sees fit, to *exclude* any new grounds for obtaining an abortion which may be allowed from time to time by the Courts.

I do not have enough legal knowledge to know if the latter is compatible with constitutional law. No. 2 above is intended to avoid the need for further referenda, while,

at the same time, it does not empower the Oireachtas to extend the grounds for an abortion.

One other significant piece of information in the Green Paper is that the vast majority of Irish abortions in Britain are for 'social' reasons, i.e. on grounds of expediency rather than in consideration of the mother's life or health. Clearly, if there is a strong social commitment to the 'right to life', the infant in the womb needs to be protected from his/her mother's distraught and perhaps irrational frame of mind due to her situation.

Many European countries are now under the influence of a post-christian – i.e. neo-pagan – philosophy of life. Materialism is a dominant influence on their (and our) lives which makes increasing wealth and welfare an important goal. Rearing of children may be felt to be in conflict with this aim. Consequently many people plan the number and timing of the births of their children. There is, therefore, a consumerist type need for abortion when such programming goes wrong.

In conclusion, the task of the Oireachtas Committee is not an easy one. However, its recommendations will help decide whether Ireland is to be no different from other European countries in its attitude to the right to life, or, alternatively, if it will uphold one of the fundamental qualities of our civilisation to-date – the human right to life from conception to the grave.

DR MARTIN B O'DONNELL
24 NOVEMBER 1999
SUBMISSION TO JOINT COMMITTEE OF THE OIREACHTAS ON THE CONSTITUTION

My name is Martin O'Donnell and I am a General Practitioner in Charleville, Co Cork, since 1962. During my first ten years in practice I did a lot of maternity cases, this included home deliveries, antenatal care and also attendance at a private hospital in Mallow, Mount Alvernia. I also have a special interest in the Mentally Handicapped and I am the Chairman of the Charleville and District Association for the handicapped since its foundation in 1968 and I also act as honorary medical officer. The mentally handicapped services consist of a pre-school, a school for the moderately handicapped children with one classroom for severely handicapped and a broad range of adult services including a sheltered workshop and residences for adults.

I believe abortion is wrong, the unborn child is a person from the very first moment of conception. I believe there is no doubt about this now especially since ultra sound was introduced and we can see the baby's heart beating at six to eight weeks. It was significant that in the recent *C* Case, the unborn child was allotted legal representation in court.

We have seen the spread of abortion across the world in fairly recent years and the legalisation of this in very many countries, in particular in the western world. The numbers of abortions carried out annually in countries like America and Britain are absolutely staggering. It is inconceivable that any civilised country could engage in this practice where persons, that is unborn children, are subjected to being killed indiscriminately for no good reason. Any of the reasons put forward do not stand up because the end never justifies the means.

I look on all unborn children as having equal rights and I make no distinction between the unborn child who is handicapped or who is conceived as a result of rape, they are persons in their own right and they deserve to be treated with the dignity that everybody else in the world enjoys.

As a doctor over the last thirty-five years I have never seen or heard of a case where the mother's life could be saved by deliberately killing the unborn child. The principle of the double effect was always the principle by which doctors practised. This allowed a woman to have treatment for a life threatening illness even if this caused harm to the baby as a secondary effect. What was considered wrong was the deliberate killing of the unborn child, if the child suffered or died as a result of treatment which the mother required during pregnancy then this was considered to be a secondary side effect to the woman's treatment. The present argument being put forward that an abortion could be carried out deliberately to save the life of the mother is a fallacy because there is no situation where this arises. With the good obstetric care which we have certainly in this country, the effort is always made to save both the mother and the child and there has never been any argument about this until the modern liberal agenda was put forward.

I have the utmost regard for girls who when becoming pregnant decide to keep their babies, to give them life. This is a very difficult decision for a young girl and yet an awful lot of them take this decision and rear their baby with love and kindness. While there have been cases where these girls did not get family back up, in my experience the vast majority of families will stand by a girl who becomes pregnant and stand by her decision to keep the baby and with the help of organisations like Cura and Life, an awful lot of help is available to girls who wish to carry on their pregnancy and rear their baby. Adoption is always an option as well, there are many couples anxious and willing to adopt babies.

I believe the pro-life referendum was a very worthwhile exercise as it wrote into the constitution for the first time the protection of the unborn child. Following that referendum successive governments have been remiss in not interpreting for the people what this meant and so when the *X* case came along the Supreme Court made a judgment on the basis that the woman was suicidal. Following on this Supreme Court judgment the government of the day could have rectified the situation by holding another referendum pretty soon. I have no doubt in my mind if this had been a judgment in the commercial world we would have had a referendum to rectify the loop-hole immediately. In the Pro-Life Referendum the people of Ireland voted massively to protect the unborn child. The loop-hole which the Supreme Court say was there does not take from the spirit of what the people decided in that Referendum, namely, that the Irish people wished to protect the unborn life in all circumstances, and as we know from the obstetricians there is no circumstance where the life of the mother can be saved by aborting her baby. That insertion in the constitution should have been honoured. A lot of medical opinion and indeed the opinion of a lot of the people in Ireland would say that the

treatment of a woman who is suicidal is not to abort her unborn baby, there would be other and better treatments. By saving her unborn child and treating the psychiatric problem as required I have no doubt that in the long term that woman would do far better to save her child and she would have no guilt afterwards about an abortion.

There is a lack in Ireland today of leadership which would foster a decent moral stance. The liberal agenda which is being pushed very hard by the media is confusing, in particular for the young people, they feel that the liberal way is the way to go, promiscuity, pre-marital sex, drugs, they feel that they have to avail of this freedom and of course it is too late when they discover their mistakes, they are not able to cope with the consequences and so we have large scale disillusionment amongst young people and a very high suicidal rate. This I believe is contributed to by the lack of belief in God and belief in a good moral stance that they can fall back on in times of trouble. We hear a lot of people condemning the pro-life movement for showing photographs and slides of babies being aborted, while I agree this would be a jolt to people's sensibilities nevertheless it is reality and research going on around the world is showing that the unborn child feels pain and particularly pain in the process of the abortion and people are advocating that the child needs to be anaesthetized in the womb before it is killed. If people stood back from party politics and three line whips and just thought about the awfulness of what abortion is, there would be no legalised abortion ever brought into this country. The people should be given a chance in another referendum which should be clearly worded as to whether they do or do not want legalised abortion and I have no doubt in the world, as they have in the past, they would vote massively to protect the unborn child in all cases.

I wish the Oireachtas Committee every good wish and blessing in their work on this very important issue and I hope that Ireland will continue to be known as a country where we honour and protect all our citizens, old and young, including those most vulnerable, the babies before birth.

DR VINCENT TWOMEY, LECTURER IN MORAL THEOLOGY
EDITOR, *IRISH THEOLOGICAL QUARTERLY*
30 NOVEMBER 1999
SUBMISSION ON ABORTION

I wish to respond to your invitation to make a submission on the seven options on, or approaches to, the question of abortion at the end of your Green Paper. In fact, there are only two basic options, either an 'absolute constitutional ban' on abortion or some form of restricted abortion. For this reason, your discussion of option (i) merits special attention.

The main objection would seem to be the distinction between direct and indirect abortion, as has been traditionally practiced by the medical profession in Ireland, a practice that has the lowest maternal mortality rate in the world, as the Green Paper points out.

In the first place, reliance on international scientific literature (7.18) has, over the past three decades, become rather shaky ground on which to base any change of legislation, since most countries where such research is undertaken already allow abortion for the most insubstantial of reasons due to the introduction of pro-choice (pro-abortion) legislation. Those studies that conclude 'that clinical conditions can be treated successfully by medical or surgical management' therefore need to be given special authority, since they are more likely to be critical and more credible. By inserting the adjective 'some' before these particular 'studies', the impression is unfortunately given that this is a minority opinion and thus not to be taken too seriously. Scientific evidence is not measured in quantitative terms but on the weight of the arguments produced, no matter how few hold them. The fact that respectable medical practitioners conclude that 'clinical conditions can be treated successfully by medical or surgical management' is very weighty indeed. The law, especially the Constitution, might be expected to support them.

The main objection raised by the Green Paper, then, would seem to be on the direct/indirect distinction as discussed in great detail in section 7.19-27. The direct/indirect distinction is one that *is* plainly applicable in law, as in the case of Dr. David Moor in the UK, who earlier this year was accused of murdering a terminally ill patient by a lethal drug overdose and was acquitted on the basis of the application of the direct/indirect distinction. The understanding of 'intention' here is not to be understood as 'motivation', neither is it adequately described as 'the state of mind of the person carrying out the procedure', as the Green Paper states (7.20). It refers, rather, to the precise purpose, or the intrinsic nature, of the particular procedure that is being carried out. In the case of Dr. Moor, the action or procedure was the administration of drugs to relieve the pain and distress of dying patients; this action also has the foreseen but unintended effect of hastening the actual process of dying. On the basis of this distinction he was acquitted, and the judge was applauded for his prudential, and therefore fair, judgement. The contention, that an absolute ban on abortion may have the effect of compromising current medical procedure (7.24) is therefore unfounded. The fact that there may be one or two extremely rare medical cases where the application of the distinction between direct and indirect abortion causes some difficulty (7.19) is insufficient ground to introduce direct abortion however limited. Once the principle of allowing direct killing of the innocent is introduced into the Constitution, and copper-fastened by the law of the land, then the application of this principle in effect knows no limit, as we know from experience in other countries.

The Green Paper (7.21) objects that: 'The manner in which the Courts might interpret such concepts in a constitutional context is an entirely open question'. At first sight, this seems to be an unintended vote of no confidence in our Courts. However, it may reveal something about the factual situation in contemporary jurisprudence, which seems to tend in the direction of being narrowly legalistic rather than based on some underlying sense of justice, prudence, or fairness. If so, then this is a dangerous situation for our country, since under such narrow legalism only what is expressly stated

as forbidden or allowed carries the force of law. The result would be, e.g., that wealthy criminals with the best barristers could escape the demands of justice. No law can comprehend the complexities of the human condition and so in many cases any hope of justice done can only be found in the fairness and prudential judgement of the judge (the principal of equity or natural justice).

A change in the Constitution involves more than a change in positive law. It is a change in the principles by which law is framed by the legislature and applied in particular cases by the Courts. It also produces a change in public attitudes with long term effects on the common good or well being of the country. To reject the distinction between direct and indirect killing of the innocent would introduce a paradigm shift in public consciousness. Among other things, it would pave the way for euthanasia, if, as stated publicly in the Green Paper, the direct/indirect distinction cannot be accepted as a legally significant distinction, since it is 'unsafe' (7.23). In the short term, it would undermine confidence in the present medical practice in Ireland (cf. 7.24). It would, indeed, eventually introduce a more 'liberal approach' to medical practice that a future Medical Council might wish to enshrine in its ethical guidelines (cf. 7.25).

If it were argued – following earlier debate leading up to the formulation of the 1983 amendment (7.26), and being concerned that the 'remote possibility' of an abortion being necessary to save the life of pregnant woman could not be ruled out' (7.22) – that an absolute constitutional ban on abortion should not be introduced, then one would have to question the wisdom of such an argument. In effect, it claims that the State should allow the *actual* and already foreseen direct killing of children in the womb, which any of the other options (ii – vi) would permit, in order to prevent the *possibility* 'however remote' (7.22) of endangering the life of a pregnant woman. A remote possibility is given more weight than the proximate and real destruction of many children that are foreseen in other options.

To conclude, it would seem that justice demands that an absolute ban on abortion be introduced by way of an amendment to the Constitution.

BRENDAN O'CONNOR
29 NOVEMBER 1999
SUBMISSION ON HUMAN RIGHTS, EQUALITY AND ABORTION

INTRODUCTION

The right to life and the principle of equality before the law are concepts which are at once familiar and profound. Familiar in that lawyers, political and lay people alike will readily identify situations which they believe to be contrary to one or other concept. Profound in that very few will be accustomed to offer a reasoned analysis of their conclusions. It is respectfully suggested in this submission that much of the present legal confusion concerning abortion stems from well-intentioned but ill-considered responses to the real human drama inherent in these situations.

Intuitive assumptions are a poor response to the conceptual challenges now facing the All-Party Committee. This submission calls on the Committee to conduct a careful and dispassionate analysis of the important human rights, equality and other constitutional and legal issues at stake.

A critique of the *X* case is necessary and instructive in this process. The present analysis examines the components of the right to life and the requirements of equality. It identifies the conceptual errors at the heart of the majority decision. It suggests a framework within which a solution can be devised, building on principles already correctly articulated in the Constitution.

The constitutional principle of equality

The principle of equality prohibits not only unreasonable preferment but, more fundamentally, the taking away of the rights of some as a means to advance those same rights in others. This *means* chosen to achieve a 'good' in a particular case must always be *consistent with a respect for the right of all* to enjoy the same 'good'.

This test does not require a strict equality of treatment between all persons in all circumstances. It permits a rational preferment of classes of persons for specific purposes by the State based on differences of physical and moral capacity and social function.[1] Such rational preferment is conceptually different to a denial of the rights of some as a means to advance the rights of others. An action or legal rule which pursues the good of some by means which involve the destruction of the *same* good (or right) in others is inherently discriminatory. Any such discrimination must fail the equality test, as it is incompatible with the equal *respect* due to the same rights in every person.[2]

The majority Supreme Court decision in 'X' did not in terms deny the equality of the right to life of the mother and of her unborn child expressly acknowledged in the Constitution.[3] The mother is unquestionably a 'human person' within the compass of Article 40.1. The unborn child is acknowledged in Article 40.3.3. to have a right to life equal to that of a human person, i.e. its mother. It follows a logical necessity that the Court was confronted in the *X* case with two subjects entitled to be held equal before the law in regard to the most basic of all the human rights acknowledged in the Constitution. The Court, nevertheless, authorised the deliberate termination of the life of subject A as a means to reduce the risk to the life of subject B.

It may be of assistance in assessing this decision to apply its principles to a less common but analogous human relationship – that of conjoined twins. Such cases can permanently interlink the lives of two born persons in a manner which is in some respects even more intimate that that of mother and child. Many difficult questions can arise concerning the medical treatment of one or other twin. The risks inherent in any attempt to separate them also pose difficulties every bit as complex in their own way as the problems that can arise in emergency pregnancies.

In the case of conjoined twins, however, the demands of equality are perhaps more intuitively obvious. A legal authorisation to kill one twin as a means to enhance the life prospects of the other would be self-evidently unjust. It would be utterly incompatible with the equal *respect*

for the rights of each person guaranteed *unconditionally* by the Constitution. There can be little doubt that the Supreme Court would wish to refuse an application for any such aurhorisation. On the precedent of the *X* case, however, they would have no logical reason to refuse the application.

Equally, it can readily be seen that the protection of the life of either conjoined twin may require the administration of medical treatments which substantially increase the risk to the life of the other twin. Provided that the death of the other twin forms no part of the object of the treatment, it would not offend against the equal right to life of each to tolerate a risk to the life of one as an unsought side-effect of a necessary medical treatment of the other. In fact it would be contrary to the equality of rights to deny a necessary medical treatment to one twin on the grounds that it might cause a detriment to the other twin. This would imply that the preservation of one life was a higher priority than the other. In reversed circumstances the other twin would be entitled to exactly the same protection.

These principles are directly applicable to the protection of the life of a mother who is carrying an unborn child and of course to the unborn child itself. They illustrate that the equality principle is a vital component in any formulation designed to restore a just protection of the right to life in the Constitution.

Exceptionless rights and rights limited by practicability

Human life is a basic good and the corresponding right to life is enjoyed equally by all human persons. The right to life has two essentially distinct but related components – a negative or passive component and a positive or mandatory component. The negative right prohibits any *unjust attack* on one's life by another and entitles one to defend one's life *against unjust attack* (self defence). The positive right entitles one to protect one's life as far as practicable (including a proportionate share in any available means) when it is in danger for any reason other than an unjust attack.

The negative or passive right cannot come into conflict with the same right in others, because it simply requires others to refrain from acting unjustly. It arises from a strict duty to respect the lives of others and, in particular, a duty *not to choose* the death of another as an intermediate or final goal of any deliberate act. Such a choice is the essence of the crime of murder.

This basic right is exceptionless. Every human person has an absolutely equal right in this regard. No person can ever have a duty to choose the death of an innocent person, even to save the life of another. No superior human right can therefore be invoked to justify a deliberate act in breach of this right.

The positive right to protect one's life (e.g. from illness) may impinge on similar rights of others. It includes a right to available assistance when in need. The duty to protect or defend any one person may be mitigated by like competing claims from other persons. In other words, this right is not an exceptionless right. It is necessarily subject to limits of practicability.

The constitutional expression of the right to life

The following analysis will show that the constitutional principles applicable to the mother-child relationship are the same as those which apply to other instances of the right to life. The distinction between the positive and negative components of the right to life in each case is reflected in the text of the constitutional guarantees. These provisions, properly understood and applied, already contain the principles necessary to ensure a just and equitable protection of the right to life of a mother and her unborn child.

An analysis of the text of Article 40 shows that the State guarantees –

- *in* its laws to *respect* personal rights (including the right to life[4]) unreservedly, and
- *by* its laws to *defend* and *vindicate* those rights, but only *so far as practicable.*[5]

The guarantee *by* its laws to *defend* and *vindicate* personal rights, *so far as practicable*, means that the State will –

- *protect* a person *as best it may from unjust attack*, and
- *in the case of injustice done, vindicate the life* and other rights of the person.[6]

The positive commitment '*by* its laws' to vindicate personal rights is of its nature limited by considerations of practicability. That limitation does not apply to the *unqualified* commitment to *respect* personal rights *in* its laws, because that is simply a commitment to refrain from *destroying* those rights. That commitment can always be observed without the limitation of practicability.[7]

It follows that the right to life of a mother (as a human person) has two distinct components:

a) an exceptionless guarantee by the State to respect her right to life, i.e. not to act contrary to that right, and
b) a qualified guarantee by the State to defend and vindicate her right to life, so far as practicable, having due regard to her physical and moral capacity and social function, and in particular to defend her right to life against unjust attack and in the case of injustice done, to vindicate that right.

In Article 40.3.3, the right to life of the unborn is acknowledged and recognised as being equal to that of its mother. The equality of the right to life of the unborn with a born person is emphasised by the fact that it is expressed in essentially the same terms, and with the same duality, as that of a born person.

The statement of the right comprises –

a) a specific acknowledgement of the right to life of the unborn, and
b) '*with due regard to*' the equal right to life of the mother–
c) an exceptionless guarantee by the State to respect the right to life of the unborn, i.e. not to act contrary to that right, and
d) a qualified guarantee by the State to *defend* and *vindicate* the right to life, *so far as practicable.*

Article 40.3.3 does not alter the protection of the right to life of the mother. Her right is already fully protected in the preceding sub-sections. The article recognises two equal rights, each one having the two components identified above. The phrase '*with due regard to the equal right to life of a mother*' establishes an equality of rights, not a

derogation. The two components of each right to life must therefore be understood as equal, each in its own terms.

The first of these components in each case is an exceptionless guarantee by the State to *respect* the right to life. This right is not qualified, in either case, by the phrase '*as far as practicable*'. It requires the State to *refrain* in all circumstances from acting, or authorising others to act, contrary to the right in question. Since it is always possible for the State to refrain equally from acting against either right, the negative component of the right to life of the unborn and of its mother is strictly equal. No direct conflict can logically arise between such rights and accordingly there can be no question of an exceptional circumstance in which the State lawfully fails to respect, or pro-actively takes away, either right to life.[8]

To argue that the first component, in the case of the unborn, is qualified or limited by the phrase '*with due regard to the equal right to life of a mother*' (and therefore open to exceptions in favour of the mother) is to ignore the fundamental point that the phrase establishes an *equal* right to life. If the mother's right to life has an exceptionless component, so also does that of the unborn. This is one of the crucial points of analysis overlooked by the Supreme Court in the *X* case.

The phrase '*with due regard to*' the equal right to life of a mother must therefore be understood as referring to the second component of each right to life, namely the guarantee to *defend* and *vindicate* the right to life, *so far as practicable*. This guarantee refers to the positive actions of the State in favour of a right to life, and *in particular* to the commitment to defend the right to life against an unjust attack and *in the case of injustice done*, to *vindicate* that right.

The qualified terms of the second component of each guarantee mean that the second component can never justify an action by the State the object of which is to deny the first component of either right. The State cannot, in other words, elect or authorise others to choose to defend and vindicate one right to life by means of an attack on the other right to life, even if the motive for the vindication is some '*injustice done*'.

In the case of a mother and her unborn child, there can be no question (even in the case of rape) of any injustice done *by the unborn* which could justify a vindication of any of the rights of the mother *by means of* a denial of the first component of the right to life of the unborn, i.e. an attack on the life of the unborn by means of abortion. An injustice done by a third party (the father of the child, in a case of rape), no matter how serious, cannot be constitutionally vindicated by means of an attack on the right to life of the innocent unborn child.

The words '*due regard*' also mean, however, that the positive component of the right to life of the unborn is qualified, not only by the inherent limits of practicability, but also by the equal obligation on the State to defend and vindicate the right to life of the mother '*as far as practicable*'. The constitutional provision requires that the negative component of each right be absolutely respected and that neither can ever be set aside. The resolution of conflict situations would therefore depend on the application of the positive component of each right, in accordance with the circumstances. It has already been shown that this does not otherwise limit the right of either life to the medical treatment necessary to protect it as far as practicable, even at a proportionately grave risk to the other life.

A human rights analysis of the *X* case

The majority decision of the Supreme Court in the *X* case was to the effect that it is permissible to terminate the life of an unborn child *as a means of avoiding a risk to the life of the mother of the child*, if it is established as a matter of probability that there is a real and substantial risk to the life of the mother which can only be avoided by the termination of her pregnancy.

It is clear from the terms in which the majority judges expressed their decisions that they considered the circumstances of 'X' to be directly analogous to those of a mother faced with a medical emergency, such as an ectopic pregnancy. It appears that they intended to apply what they understood to be established medical practice to the unusual and difficult circumstance of a threat of suicide by the young mother. No evidence was adduced as to the actual ethical basis on which such medical emergencies are resolved. The Court also failed to consider the wider implications of the proposed 'preventative' abortion.

The relevant constitutional principles would have suggested the following parameters:

a) Every human person has a fundamental *right* to protect his or her own life and to have it respected and protected by others,
b) That right involves a duty on each person to respect and protect his or her own life and to respect and protect the lives of others,
c) A person who fails in his or her duty to respect and protect his or her own life or the life of another by attacking that life is an unjust aggressor,
d) The right to protect one's own life includes a right to repel an unjust aggressor with the violence objectively necessary to neutralise the unjust attack, even to the extent of taking the life of the aggressor as a foreseen but unsought result of a proportionate act of self-defence,
e) The right to life of an unjust aggressor in the circumstances of an attack on another is limited to the right not to have unnecessary or disproportionate violence used against him or her by the victim of the attack.

The Court did not address the basis of its jurisdiction to act in respect of each right to life or identify any injustice or unjust attack it purported to remedy or repel.[9] It should have considered the implications of the threat of suicide for the rights of the persons affected. The claim to a legal entitlement to abortion was premised on this threat to the life of the mother and her unborn child. Unless a consideration of the suicide threat somehow disclosed an unjust attack by the unborn child on the mother, there could be no legal excuse for a violent act by the mother against her child.

On the one hand, the young mother ('X') was simultaneously the potential victim and aggressor in her suicide threat. In the words of Costello J. in the High Court proceedings, the court had *'a duty to protect her life not just from the actions of others but from actions she may herself perform'*. The threat to her life was not imputable in any objective sense to her unborn child. The fact that she apparently believed that it was necessary for her to

kill her unborn child in order to make the continuance of her own life tolerable, did not constitute a valid plea of self defence. The threat to her life in fact arose, not from an unjust attack by another, but from her own psychological condition. As with a physical illness, she had a positive (second component) right to protect herself and to be protected from this risk, so far as practicable. In the absence of an unjust attack, however, she had no self-defence justification for taking the life of another as a means to achieve this.

Due regard to the *equal* right to life of the mother in accordance with Article 40.3.3 required *that each component* (negative and positive) in the right to life of the unborn be defended and vindicated having regard to the same *component* in the right of the mother. The negative right of the unborn child not to be unjustly attacked was perfectly compatible with due regard for the mother's *equal negative right* (i.e. her right not to be unjustly attacked). It should not have been balanced against the positive limited right of the mother to protection against other threats to her life.

The mother's limited positive right was subject to the exceptionalness negative right of the unborn child not to be killed as a means to avoid the risk of suicide. The unborn was entitled to the unqualified respect of the Court for that guaranteed right. 'Respect' for an absolute right requires, at a minimum, that the right is not set aside in favour of a lesser or limited right. The unborn was also entitled to the *protection* of the Court against the alternative threats to its life by reason of the suicide of its mother or by abortion. That entitlement was also part of the negative (first component) right and hence was not subject to the limitation of practicability. The Court clearly failed to respect or defend this exceptionless (first component) right when the majority declined to protect the right and in fact decided to render it lawful to set aside that right under certain conditions.

The Court read Article 40.3.3. as subjecting to a limit of practicability the right of the unborn not to have its life unjustly attacked.[10] That was a logical fallacy. There is no practicable limit, for example, to a right not to be tortured any more than there is to the right not to be unjustly attacked. A negative or restraining right simply requires others to refrain from choosing to act in certain inherently unjust ways. The Court for its part should at least have declined to authorise an unjust attack on the life of the unborn child. Is it conceivable that the Court would have treated a born child in this manner? The failure to identify and differentiate the absolute and limited components of the right to life led to the cardinal errors in the decision of the majority in the *X* case.

The duty of the Court was to defend as far as practicable the lives of the two potential victims (mother and child) from the intended attack (the suicide threat) and at the same time to reject the claim that the deliberate killing of the unborn child would be lawful. They could have required the parents of 'X' (a minor) to take whatever reasonable steps were open to them to limit the risk of suicide. It was not relevant that such steps might not necessarily be effective. There was no other course open to the Court under that heading to vindicate the two lives at risk.

The Court formulated a test which, if satisfied, would render any such abortion a lawful act in the jurisdiction. In so doing, they created by precedent and alarming defense of *necessity* [11] to the charge of unlawful killing – a subjective belief in the aggressor that it was necessary for him to kill his victim in order that he could tolerate the continuance of his own life. Such a defense could not be applied in other cases without permitting the gravest mischief in society, for young and old alike. It is clearly unsound.

It does not follow from the above analysis that the Supreme Court was obliged to uphold the injunction restraining 'X' from leaving the State. That was a complex issue involving jurisdiction and the anticipation of events that might happen outside the State. What is clear from the above is that the majority of the Court was not entitled on the facts of the case to declare that the killing of the unborn child was lawful.

The conclusion is inescapable that the X *case was wrongly decided. The All-Party Oireachtas Committee should now formulate a constitutional amendment to redress the grave constitutional errors flowing from the Court's mistaken interpretation.*

Towards a further clarification of the constitutional right to life

Regrettably, the Supreme Court did not engage in the necessary scrutiny of the issues involved before arriving at its decision in the *X* case. The problem is compounded by the application of this decision in subsequent cases. The Supreme Court has also reaffirmed its erroneous conclusions in the referral of the *Abortion Information Bill* and further complicated the larger question by its treatment of the right to life in the *Ward* case.

These considerations lead to the conclusion that the Committee should now approach its task in either of two ways:

i) propose a full re-statement of the general principles to be applied in respect of the right to life and include the right of the unborn in these general principles, or
ii) propose an amendment to Article 40.3.3 dealing specifically with the relationship between mothers and their unborn children and leave the remaining issues to be addressed by Committee on another occasion.

A general re-statement of the right to life could usefully be developed on the basis of the principles discussed above.

In the alternative, an addition to the existing text of Article 40.3.3 to remedy the errors of the *X* case and to reflect the current Medical Council guidelines could be devised by the Committee in accordance with the following structure and brief:

i) Insert a new sentence in Article 40.3.3, immediately after the first sentence, in order to state 'in particular' two specific requirements of the general principle set out in the first sentence. This would be analogous to the relationship between Art 40.3.1 and Art. 40.3.2.
ii) The second sentence should specify two particular classes of action which would be unlawful:-
    - A failure to provide proportionate medical treatment (not including an abortion) to a mother, which is necessary to protect her life, on the grounds that the treatment may harm an unborn life,
    - Procuring an abortion

iii) The phrasing of the second part of the sentence could be based on the terms used in the Medical Council guidelines. Alternatively, it could define the unlawful activity in terms of the direct destruction of an unborn life as an end in itself or as a means to achieve any purpose.

It is submitted that a dual statement of this type would assure medical practitioners, the public and the Courts that the amendment endorses current medical practice and nothing more or less. The use of a form which clarifies and declares the meaning implicit in the general principles for the first sentence, without altering them, should ensure that the amended provision continues to enjoy the protection of Protocol 17. This approach is also the most appropriate way for the People to exercise their right to explicitly correct the errors of interpretation which arose when the first sentence was tested in the courts.

Notes

[1] Art. 40.1 of the Constitution. Conferring of benefits on some but not on others does not necessarily imply a lack of respect for the right of others to the same goods. It may simply reflect a limitation in the available resources and a rational and prudent decision as to their allocation.

[2] The distinction may be illustrated as follows. Three sailors A, B and C find themselves alone on an island without food. A is in charge. As a matter of probability, some or all will die of starvation before they can be rescued. A decides to kill C in order that A and B can eat his flesh and survive until they are rescued. A is clearly guilty of a fundamental breach of the right to life of C, because the means he chose to protect his own life and that of B are incompatible with the respect due to the equal right of C. It matters not that A and B might be socially important or persons upon whom others depend or that C might be weak, ill, orphaned and of no social value whatever. It is not permissible to vindicate one human life by means of the destruction of the life of another innocent person. See the judgement of Lord Coleridge in *R. v. Dudley & Stevens* (1884-5) LR 14 QBD 273. Suppose on the other hand that A decides against killing C and discovers some water on the island. If he decides that C (who is ill) should have a greater share of the water than B, he would be practising a legitimate and rational preferment such as is countenanced by Article 40.1. Provided that his decision is not based on self-interest or irrational prejudice, a person in authority is entitled to allocate scarce resources in accordance with his reasonable judgement as to the optimum use of those resources for the benefit of those under his authority.

[3] The Chief Justice took into account a range of personal rights and duties of 'X' and even of other members of her family, to justify the preference accorded to her. This attaches a subjective 'value' to human life and accords preference to lives with a higher 'value'. Article 40.1 does not authorise the invidious discrimination inherent in this approach. If anything, it requires that weaker, more vulnerable lives be given greater protection.

[4] Article 40.1 and 40.3.1 are expressed in general terms and do not expressly refer to the right to life, but this right is the first of the list of specific rights expressly recognised and protected in Article 40.3.2.

[5] Article 40.3.1 and Article 40.3.3 each make the same *unqualified* commitment to *respect* personal rights, while making a commitment '*as far as practicable*' to *defend* and *vindicate* those rights.

[6] Article 40.3.2 explains 'in particular' the pro-active commitment given in Article 40.3.1 to defend and vindicate personal rights *by* its law.

[7] For example, the State gives an absolute guarantee in Article 43.1.2 '*to pass no law attempting to abolish the right of private ownership*'. That guarantee is not qualified by the phrase '*as far as practicable*', although the Article does go on to provide for a degree of control over the exercise of that right, in the interests of the common good.

[8] As between born persons it may be argued that capital punishment for the crime of murder would involve an exception to the first component of the guarantee. On one view at least, capital punishment is a form of collective self-defence which does not of itself necesssarily violate a person's right to life and so does not establish an exception to the principle argued here. It is outside the scope of this submission to discuss whether or not capital punishment in modern society could still be a proportionate response to any crime. The writer is of the view that it is not a proportionate response.

[9] The majority of the Court construed their task as one of 'vindicating and defending as far as practicable the right of the unborn to life but at the same time giving due regard to the right of the mother to life'. One of the judgements (McCarthy J) identified Art. 40.3.2 as the source of the obligation to defend and vindicate the life of the mother as far as practicable. The other three of the majority relied on Art. 40.3.3 alone and made no reference to any limitation of practicability in the obligation to defend the life of the mother.

[10] The majority reasoned that the words 'as far as practicable' in subsection 40.3.3 implied that the Constitution contemplated circumstances in which it might not be practicable to vindicate the right to life of the unborn. They adopted the submission of the Attorney General that the Constitution permitted abortion in certain unspecified circumstances and that the task of the Court was to establish a test by which those circumstances might be ascertained.

[11] See *Regina v. Dudley & Stevens* (1884-5) LR 14 QBD 273 where this defence was roundly rejected.

BRIAN FLANAGAN

19 NOVEMBER 1999

SUBMISSION TO THE OIREACHTAS COMMITTEE ON THE CONSTITUTION RE ABORTION

It seems extraordinarily appropriate in the last quarter of the last year of the present millennium to meditate upon appropriate changes to our constitution. So thank you for the invitation.

Abortion and the shape of things to come

The pressure to homogenise Irish society with that of Sweden, England and the US is, it seems to me, entirely of a part with the contemporary demand for abortion rights. This drive for homogenisation is caused by the emergence of a substantially diminished view of the value of personhood, matched by corresponding totalitarian developments. This lowering of esteem is caused in turn by an annihilation of the real foundation upon which centuries old esteem for personhood was painstakingly built up and was maintained.

The PC secular ('of the here-and-now') view of the universe and of mankind within it, affords *no real foundation for valuing the diversity* to which we all declare loyalty. The heretical empiricism of the last century has become the orthodoxy of the twentieth century. Physicists currently speculate (recently on 'Tomorrow's World') about the possibility of being able to transmute anything into anything else. It is not just sand into glass or lead into gold, or the cloning of human beings, but sand directly into a mouse or even a human being!

Current scientific contempt for the most accessible considerations of philosophy is well-known. As a result even common sense seems to be in danger of being trampled under foot. The Dr Strangeloves of this world are now in the ascendant. If everything is capable of being transmuted into everything else – or considered to be so at conceptual level – then what basis is there for valuing diversity? At all times it can be but an apparent diversity. Everything is now in danger – if not in fact of becoming plastic – of being so viewed, including human beings.

The only criterion for choice is desire. If I want it there should be nothing to stop me having it except an equal – or stronger – opposite desire from somebody else. If people want something – say an abortion – they should be allowed to have it, especially if it is allowed elsewhere in neighbouring countries. In the logic of strict materialism we would be expected to behave rather like shoals of fish in the sea, starting now one way then another. To change the analogy, ants in anthills behave just like ants. People are quite different. Ants like Woody Allen (in his recent animation movie) just don't turn up. My argument is that free beings such as we are choose to be different – and are quite incorrigible in so doing. Materialism would have it otherwise. Ireland must choose its view of things. An ever widening homogeneity as illustrated by world airports: or a world of ongoing surprises as in Mohammed Ali, Ghandi, Von Braun; Joan of Arc, a 17 year old illiterate shepherdess who after 100 years of French failure, managed to drive the English out of France in 18 months; the Australian who discovered the cure for ulcers, the person who is still to come who will find the cure for cancer and AIDS, in short the kind of thing that happens in 'A Hitchhiker's Guide to the Galaxy' or Mozart's 'The Magic Flute'.

It is in fact a strange paradox that only a firm commitment to the transcendent preserves the secular. The drive to homogenise everything is based upon the deep-seated belief that in the final analysis everything is the same as everything else anyway.

Indeed the next world war may well be fought between Muslims committed to the transcendent and the Post-Christian secular West who have forgotten so much in one generation. Muslim contempt for all things Western is well evidenced in recent years. Their alliance with the Pope at Cairo and Beijing against the efforts of the US and the UN in the field of population control was as predictable as a copper sulphate crystal out of a copper sulphate solution.

The secular view of Man is that each individual is distinguished from his fellows, by shape, size, colour, fingerprints, DNA, and the space which he physically occupies. These are the sort of things which one might expect to hear being presented in a court of law about inheritance, criminal responsibility, etc. These evidences are taken to be unique to individual living creatures, and so they are. But they are not sufficient evidences of the existence of persons. The reality of personhood is not amenable to scientific proof of the physical kind. Indeed the word 'person' only came into existence as a technical term in theologians' deliberations about the Trinity in the early part of the first millennium.

Before that the word 'person' did not exist. One had the word 'persona' which referred to 'personality'. Our strong self-awareness of ourselves as persons, seats of so many important freedoms, feelings, etc, is principally rooted in and sustained by theistic religion, and was unknown, or little adverted to by the Ancients. And as in 'The Lion King' the wheel seems to be turning.

Even Abraham was of his time in believing in child sacrifice. It took many centuries of much turmoil, before the value – to which we still pay lipservice – of the person became accepted. It is based largely on the Christian creed's anthropocentric – man-centered – view of the universe. In the Christian view of things God put the entire universe together for Man and placed it under Mankind's dominion. God himself became Man to help Man sort out his messes. He obviously figured Man was worth it. In fact he invited each member of the Human Race to mix it with his divine family.

The importance the individual still places upon himself in our culture is contrasted with the totalitarian culture of the Asians in say the Vietnam war. They sacrificed themselves in endless hordes while the Americans were accused of shooting their own leaders in the back to avoid advancing into danger. Indeed 'The Deerhunter' amounted essentially to a romantic lament over the loss of place for persons in this world. So too the anti-war poems of the First World War. Personhood's lease is up and hardly anyone is doing anything about its imminent departure.

What I am suggesting therefore is that our concept of the person as 'sui generis', very like the disappearing species of flora and fauna of the Rainforest, each incapable of being repeated, is now under heavy threat. It is in fact a new kind of threat in that it is a root and branch kind of threat which gets at even nearly every theory constitutive of civilisation.

Like the characters out of Aldous Huxley's *Brave New World* each person – or should we say personality – (names are just the same as numbers to an alpha-numeric computer!) – at a certain predetermined age will be expected to 'go down the tubes', i.e., to be recycled.

Now if slavery, private property, fascism/democracy, religion, etc. were worth going to war about surely so too is this nonsense. Do the Muslims not in fact give every indication of already preparing for it? I felt like a 2nd Dr Zhivago writing this! Wasn't it 'the personal' in Zhivago's poetry that the Communists objected to?

Belief in gods and after-lives has long been unfashionable. It was until recently however PC to express admiration for things Eastern. Now belief even in Eastern religions seems to be becoming untenable. Marian Finnucane in a recent radio programme about Y6B observed with uncharacteristic logic that since there were now more people alive than ever had lived in totality since the world was formed, it followed that belief in re-incarnation from an earlier existence would now have to be abandoned. Nobody's sacred anything, it would seem, is safe to the secularist.

We are left with personhood being viewed as no more than at best being an 'epiphenomenon' of highly organised and presumably highly agitated atoms. (Gilbert Ryle – *The Phenomenon of Mind*?)

Still we have to observe and it goes without saying that those who promote abortion as a right want their own lives treated as legally sacrosanct. They would, however, at the same time like to have all protection removed from their children's lives – at least until they are old enough to have exhibited genetic imperfection

and to have been dealt with. Under ancient Roman law the Paterfamilias held the right of life and death over his offspring up to the age of 12. That early lack of community care for the young was addressed uncompromisingly by Christianity. (Every one of the first 29 popes was martyred.) But now the influence of Christianity is faltering noticeably. It is not strong enough, it would seem, to sustain the effort to extend legal protection of children into the womb. In fact in many parts of the world the battle seems to be going the other way. Euthanasia has made significant inroads in Holland. And it was only recently driven back in Australia.

Where are we headed in the present phase? Let us withdraw an ice-core from the permafrost zeitgeist and look at what it reveals of the changes which have taken place in our culture over the last two millenia.

Back under Roman law the father of the household held the absolute power of life and death over all his children up to the age of 12. When Christianity came into the ascendant it was one of its distinguishing features that it did not permit 'the exposure of infants to the wild beasts on the hillside' of new born children. And so it continued for 1500 years. Now in the western world abortion is liberally administered to women usually though not always at their own request. (The average Russian woman has had seven abortions.) And once again children are dismembered by law without anaesthetic.

(Incidentally it is a little known fact but abortion is *never* administered to thoroughbred horses because of the danger it involves. Yet we allow and sometimes even insist upon women having it.)

We are moving into a culture which works off the principle that 'might is right'. Look around. Violence is escalating at every level. Normally law-abiding people are now talking about the Provos and vigilantes as the only ones capable of keeping neighbourhoods safe.

The core drilled from the permafrost looks decidedly murky at both ends.

My thesis in summary is that as affluence has increased our value upon life has diminished. Like figures in an ever more dense forest landscape we have become more and more invisible amidst our possessions: skyscrapers, concords, internets, interplanetary travel, space-stations, heart-transplants, cloning, genomes, motorways, Kray computers. The evanescent person somehow seems swamped into insignificance. The world itself seems ever so much more important that the little persons inhabiting it. Is this the direction in which we want to continue moving? Of course not.

The real move forward now must be towards rebuilding the value of the person. This cannot be done without recognising the admissibility of evidence for the existence of at least some ineluctably transcendent aspects in our being. But the biggest affront to belief in the transcendent is – you've guessed it – legalised abortion. It must not only be rejected, we must, with the greatest expedition possible, reverse recent trends towards the extinction of the sense of personhood. We must go on to build our sense of the dignity of personhood to heights as yet undreamed of. Let us consult what – if trends continue unchecked – may yet be banned – poetry:

'Fol dol de dido,
He was a quare one I tell you.
He had the knack of making men feel
How small they really were
Which was as great as God had made them.'
(Ptk Kavanagh)

The alternative view I first heard enunciated in 1970 in the States – 'The human race is like an over-fed fungus on the face of the Earth'. Surely it's time for right thinking people to call a halt to this 'Dr Strangelove' madness.

I wish to state plainly that I am opposed to the legalisation of any degree of abortion in Ireland.

1 I therefore urge the Oireachtas to pursue Option 1: AN ABSOLUTE CONSTITUTIONAL BAN ON ABORTION.
2 I have kept myself informed on the question and have considered all the options in some depth. Ireland's unique and marvellous record in protecting the life of mothers in pregnancy convinces me that all arguments in favour of legalising abortion, for the sake of the mother, are false.
3 Furthermore, I am disappointed that such world-class achievement by Irish nurses and doctors appears to have received so little recognition at a public level within Ireland. I would therefore request that this achievement be properly highlighted by the Oireachtas Committee in its recommendations to the Government.
4 Under present Irish Medical practice – which bans abortion – Irish mothers are given all necessary medical treatment, even where the life of the unborn baby is put at a serious risk. Irish doctors have had no difficulty in recognising a clear distinction between such procedures and the planned, deliberate and intentional destruction of the unborn.

   This legal/medical definition of 'abortion' is traditional in Irish medicine and has served the nation well; again I refer to points 2 and 3. It merits the highest respect and must not be disregarded.
5 Where the total ban on abortion has been altered in other countries to introduce so-called 'Limited Abortion in hard cases' the record shows that once the baby is de-personalised the limits rapidly disappear. In this regard I wish to record my objection to the non-committal language used throughout the Green Paper. Its biggest flaw was its failure to take a clear ethical stand on abortion. I find it unacceptable in discussions about foetal abnormality, for instance, to speak of defenceless babies in such a value-free manner. I would therefore earnestly request that the humanity/personhood of the developing child be at all times respected in the language used in the White Paper.
6 Opinion polls have consistently shown that over 50% of Irish people are opposed to legislation for any form of abortion. I further understand from reports in the media that a much higher percentage of the submissions received for the Green Paper were also against abortion of any kind. One must conclude therefore that most people are satisfied with current Irish medical practice. The number of citizens *sufficiently dissatisfied* to put pen to paper is tiny. It would be undemocratic therefore to foist the opinions of this infinitesimal minority on the nation by affording their views a completely unbalanced constitutional privilege.
7 Many people have expressed shock and dismay at the recent compromising of Irish neutrality. I wish to place on record that there are widespread similar fears that

the Protocol and Solemn Declaration (of non-EU intereference in this issue) may similarly be ignored with regard to the abortion issue. The Irish people should therefore be reminded of their ownership of this protocol and its proper significance in safeguarding their traditional values. I request that the importance of the Protocol be clearly set out in the White Paper.

8 Legalised abortion is fundamentally incompatible with a society wishing to cherish all of its children equally, as it fails to acknowledge the inherent value of each and every human life.

My own town has suffered in recent years from an upsurge of violence among youth. The causes are legion but must be associated with a general rise in hedonism. Only a strong revival of attention to the transcendant in our culture can reverse this worrying trend. Legalised abortion is the equivalent of a bullet to the head to concerns with the transcendant.

9 Ireland is acknowledged for its innovativeness and creativity amongst its European counterparts in rural and community development. In addition to this success other countries envy and applaud our economic progress. Can the Irish nation harness a similar creativity for the two-fold task of (a) restoring legal protection for mothers and their unborn babies and (b) devising a Government strategy which provides alternatives to abortion. Such a comprehensive approach would, in my opinion, both heal divisions on this issue and attract widespread support. Many of our separated brethren in Northern Ireland are strongly anti-abortion and would admire a resolute interdict against abortion. It could only help the peace process, therefore, and might serve as a model for other countries.

10 I cannot reconcile myself to the double standards being presented by the Irish government in working to take the killing from the streets of Northern Ireland while at the same time engaging in a detached discussion as to when and how often we should permit the killing of innocent children. We must speak the language of non-violence *all* of the time.

11 In the light of current analysis of the Green Paper and the above considerations we urge the Oireachtas All-Party Committee to call for a clearly worded referendum to allow Irish people to rule out abortion in all circumstances.

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SUBMISSION TO THE ALL-PARTY COMMITTEE ON THE CONSTITUTION

1 Introduction

The Green Paper mentions abortion in the context of foetal abnormality. It is possible that in this regard the All-Party Committee would consider drawing from the vast experience gathered by Medical Genetics services in the UK. I would like to summarise some facts and figures from this experience for the information of the Committee.

2 Preliminary to a medical abortion programme

To institute abortion as a possible medical procedure in cases of foetal abnormality requires the prior establishment of a nation-wide network of medical services for the detection of abnormal pregnancies. This in turn will entail making new medical and technical appointments and new hospital and laboratory facilities, that should be calculated to serve the 60,000 yearly pregnancies if the services are to be seen to be provided on an equitable basis. Even if the number of abortions on medical grounds is small relative to the total number of pregnancies, the pressure will be to screen ALL pregnancies for defects. This has been the trend in most Western countries. Current genetic services in Ireland would not be able to cope with such increase in workload. Providing abortion on medical grounds will entail considerable hidden costs.

3 Abortion on abnormal pregnancies would require a prior 'screening service' which will most likely be based on the so called 'triple test' that is carried out on maternal serum in nearly all pregnancies in the UK and other countries. This test is centered on the detection of pregnancies at risk of Down's Syndrome. In the UK, 80% of prenatal diagnosis referrals for laboratory studies come from this source alone. The performance of such screening test has been the subject of heated debate on both sides of the Atlantic (a MEDLINE search on 'Down's Syndrome' from the late 1980's onwards throws up more than 1,500 references many of which refer to this test or other aspects of pre-natal diagnosis, including a considerable number dealing with ethical issues).

4 The 'Triple Test'

In its current form, the triple test detects as 'at risk' 69% of aneuploid pregnancies (mostly Down's Syndrome). Many of the remaining 31% come to term as Down's Syndrome. 5% of the unaffected pregnancies would be classified by the current test as 'screen positive' (i.e., they are false positives). Two points should be mentioned here. (1) the 'screening test' should only be offered after obtaining informed consent. Many surveys in the UK find that proper information on this type of test and its possible results is very difficult to convey. Information on the test should include the fact that an abnormality could be found and that (see later) the economic efficiency of the test program hinges on maximising the number of abnormal pregnancies aborted. (2) 5% of mothers carrying a normal pregnancy (much more numerous than those at risk) are put on a state of very high anxiety on receiving a 'screen positive' result.

5 Amniocentesis and its costs

All the screen positive pregnancies are then offered a 'diagnostic test' such as amniocentesis at week 16 or later, or chorionic villus sampling (CVS) at week 12. Amniocentesis carries a small risk of provoking foetal loss, about 0.9%. This figure is higher for CVS. Although the risk appears small on paper, it should be borne in

mind that these were normal, presumably wanted, pregnancies. Out of 60,000 pregnancies screened, a false positive rate of 5% means 3,000 amniocentesis done on women with normal pregnancies. If 80% took the option of amniocentesis (2,400), 0.9% or 21 normal wanted pregnancies will be destroyed by the system every year as a result of the procedure. It may not be possible to point them out individually in every case, but the fact remains. The grief brought to these families is beyond calculation.

6 A directive culture in the health services

The providers of the service, or ultimately the Department of Health, would be interested in maximising the efficiency of the scheme. This hinges on maximising the acceptance of screening, amniocentesis, and ultimately, abortion of abnormal pregnancies. Very clearly, this imposes a limitation to pregnant women's choice rather than an enhancement. It would create among health service providers a culture and an attitude of 'directive counselling' towards abortion, so that women wanting to keep their pregnancy would be looked on as irresponsible. External observers, as well as Irish women who became pregnant while working in England, attest to the widespread prevalence of this culture in the UK Health Services. See for instance Judy Brown's 1989 article 'The Choice'.

7 Poor understanding of Down's Syndrome

One hundred years ago, the life expectancy of a Down Syndrome patient was 2 years. Down's Syndrome patients born today can expect to live well into their 60s. Although the clinical expression of the syndrome is very variable, the recent pictures on Irish TV of Down's Syndrome youngsters returning from the Special Olympics with their load of medals attest to the quality of life that can be achieved in many cases. It is the life of people like these that would be most immediately devalued and put at risk by the introduction of abortion on medical grounds. Some ideas of the problems and potentials of Down's Syndrome people can be read in the internet article 'Welcoming babies with Down Syndrome', downloaded from the National Down Syndrome Congress US.

8 Anencephaly and spina bifida

A pregnancy screening procedure that overlaps the triple test detects Neural Tube Defects (NTDs). Again, NTDs vary greatly in their clinical expression; some spina bifida patients function nearly normally and are of standard intelligence. On the other extreme, some die early due to lack of brain development. It is not obvious that even in these most severe cases abortion alleviates the situation for the mother. As a paper from Daphne Wilkins indicates, the decision to terminate such pregnancies may be more traumatic for some women and their partners than allowing nature to take its course.

9 The issue of efficiency in genetic services

Some professionals involved in the recent debates in the UK and US on the issue of population screening using the triple test and associated abortion of Down's Syndrome pregnancies concluded that seeking maximum efficiency of the scheme in economic terms implied ignoring values that escape economic quantification; (1) the acute parental anxiety created by the test, completely unnecessary in the false positives, (2) the subtle imposition of a test without obtaining proper consent due to intrinsic difficulties in communicating the message, (3) the value of the normal pregnancies lost to the procedure every year, (4) the contribution that Down's Syndrome and other handicapped people make to their family and the State. Further details could be found in Elkins and Brown (1995).

10 Conclusion

In view of the experiences recorded above, it would appear to me that a better service would be provided to the Down's Syndrome community, to Irish pregnant women, and to the medical community, if the money that would be required to fund all the hidden expenses of the 'medical' abortion scheme was spent in improving our Mental Handicap services, and in helping to change the attitude of that sector of society which sees inherited abnormalities in general, and Down's Syndrome in particular, as an intolerable burden on the State. As an example of what could be done, please see the brochure from the University of Southampton, where Prof. Buckley has developed a system to teach Down's Syndrome children reading and writing skills using their specific and distinctive strengths. See article by Buckley S (1999).

11 For these reasons, I think introducing abortion on medical grounds will lead to the destruction of many Down Syndrome pregnancies that would be quite capable of being cherished by their parents and by society, and of a considerable number of normal pregnancies; that this would seem impossible to justify, and that therefore an absolute constitutional ban on abortion, together with the necessary enhancement of clinical and educational care of the mentally and physically handicapped and their families is the only option that recommends itself as fair to all.

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Appendix VI

EXTRACT FROM *REPORT OF THE CONSTITUTION REVIEW GROUP*

Appendix VI

EXTRACT FROM *REPORT OF THE CONSTITUTION REVIEW GROUP*

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.

This subsection shall not limit freedom to travel between the State and another state.

This subsection shall not limit freedom to obtain or make available, in the State, subject to such conditions as may be laid down by law, information relating to services lawfully available in another state.

RIGHTS TO LIFE ('Unborn' and Mother)

Background

The immediately preceding subsection (Article 40.3.2°) was in the original text of the Constitution and commits the State 'by its laws to protect as best it may from unjust attack and, in the case of injustice done, vindicate the life ... of every citizen'. Abortion, the unlawful procurement of a miscarriage, was prohibited by the Offences Against the Person Act 1861 (sections 58 and 59), a statute which is still in force. The right to life of the 'unborn' was recognised in the course of Supreme Court judgments (for example Walsh J in *McGee v The Attorney General* [1974] IR 284, Walsh J in *G v An Bord Uchtála* [1980] IR 36). However, the Supreme Court judgment in the *McGee* case, in which a right to marital privacy in the use of contraceptives was recognised, aroused concern that judicial extension of this principle of privacy might lead to abortion becoming lawful here, just as in the US the Supreme Court's decision in *Roe v Wade* 410 US 113 (1973) led to its being lawful there. The two largest political parties undertook, in the context of general elections in 1981 and 1982, that a constitutional amendment would be introduced to block such a development, which they considered would be generally unacceptable**,** whether resulting from judge-made law or from legislation. The formula which is now part of Article 40.3.3°, guaranteeing explicitly the right to life of the 'unborn' with due regard to the equal right to life of the mother, was put to the people by referendum in September 1983, and adopted by a large majority.

Developments since 1983

Various Supreme Court judgments between 1983 and 1989 were negative towards the operation in Ireland of abortion referral services. However, a ruling of the European Court of Justice in 1991 undermined this stance by suggesting that agencies here of foreign abortion clinics, and these clinics themselves, might be entitled, under EC law, to disseminate information in Ireland about the services they lawfully provided elsewhere in the Community.

Efforts to preserve the existing Irish prohibition on abortion and on dissemination of relevant information gave rise to Protocol No 17 to the Maastricht Treaty on European Union signed in February 1992. Later (following the *X* case described below), a Solemn Declaration on that Protocol stated, in effect, that the Protocol was not intended to prevent travel abroad to obtain an abortion where it was legally available, or the availability in Ireland of information about abortion services on conditions to be laid down by law. While the Protocol was intended to prevent any EU law permitting abortion from overriding the application in Ireland of Article 40.3.3° before it was amended by the travel and information referendums of 1992, there is doubt whether it is still effective in the light of these amendments.

There is also a question as to the legal significance of the Solemn Declaration which provides that 'at the same time the High Contracting Parties solemnly declare that in the event of a future constitutional amendment in Ireland which concerns the subject-matter of Article 40.3.3° of the Constitution of Ireland and which does not conflict with the intention of the High Contracting Parties hereinbefore expressed, they will, following the entry into force of the Treaty on European Union, be favourably disposed to amending the said Protocol so as to extend its application to such constitutional amendment if Ireland so requests'. The effectiveness of this Declaration may be in doubt, since the European Court of Justice has generally refused to admit contemporary declarations of this kind as an aid to construing the EC treaties and legislation: *see R v Home Secretary ex p Antonissen* (Case C-292/89) [1991] ECR 1-745.

In 1992, in *The Attorney General v X* [1992] 1 IR 1, which became known as the *X* case, where a sexually-abused young teenager had become pregnant, was considered suicidal, and had been restrained by the High Court from travelling to England for an abortion, the Supreme Court, by a majority, held that the injunction restraining the girl from leaving the jurisdiction should be lifted. The Supreme Court held that the right to life of the unborn had to be balanced against the mother's right to life and that Article 40.3.3° permitted termination of a pregnancy in the State where there was a real and substantial threat to the mother's life, as distinct from her

health. It also held that the threat of suicide constituted a threat to the mother's life for this purpose. Some statements of the majority of the court (in comments which were not part of the binding *ratio* of the decision) indicated that the constitutional right to travel under domestic law could be restrained so as to prevent an abortion taking place abroad where there was no threat to the mother's life.

This judgment, although it eased the widespread concern for the girl and her family, caused misgivings of principle both for those concerned about the admission of a suicidal disposition as a ground for abortion and for those opposed to permitting abortion at all in the State. There was also much concern about *any* restriction on freedom to travel and *any* curtailment of access to information. In a desire to ease some of these concerns and, at the same time, to augment support for the Maastricht Treaty, new referendums were undertaken to confirm freedom to travel to use an abortion service lawfully operating elsewhere and freedom to obtain or make available information relating to such services, subject to conditions to be laid down by law; and the third referendum proposed to amend the 1983 wording by adding the following:

> It shall be unlawful to terminate the life of an unborn unless such termination is necessary to save the life, as distinct from the health, of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life, not being a risk of self-destruction.

While the travel and information referendums were passed, the referendum providing for the foregoing change of wording was defeated by a two-to-one majority (1,079,297 versus 572,177). It was rejected, apparently, by those who disliked its restrictiveness as well as by those opposed to abortion being legalised here on any ground.

Incidence of abortion

Numbers of Irish women travel abroad annually to avail themselves of legalised abortion services in other jurisdictions, mostly Britain. Official British statistics (Office of Population Censuses and Surveys, London) show that over 80,000 abortions have been performed on Irish women in England and Wales since 1970. In 1994, the latest year for which full figures are available, 4,590 women normally resident in the Republic of Ireland had legal abortions in England and Wales. The ratio of such abortions to live births in the State is almost 1 to 10. (See the paper submitted by Women and Pregnancy Study Centre, Trinity College, Dublin, Appendix 21.)

While opposite standpoints - 'pro-life' or 'pro-choice' - have tended to dominate the public discussion of the abortion issue, there is much private sympathy and concern for the personal, social and moral anxieties of those facing crisis pregnancies, particularly where rape, incest or other grave circumstances are involved. It may be doubted whether enough attention is being given to such basic matters as education on sexuality, human reproduction and relationships as a way of reducing the incidence of abortion, counselling in relation to crisis pregnancies, and the promotion of women's and men's sense of parenthood as a valuable contribution to society. The Review Group appreciates that there are much wider considerations involved than constitutional or legal provisions but it is on these that the Review Group must necessarily focus.

Difficulties

The state of the law, both before and after the *X* case decision, gives rise to much dissatisfaction.

There is no definition of 'unborn' which, used as a noun, is at least odd. One would expect 'unborn human' or 'unborn human being'. Presumably, the term 'unborn child' was not chosen because of uncertainty as to when a foetus might properly be so described.

Definition is needed as to when the 'unborn' acquires the protection of the law. Philosophers and scientists may continue to debate when human life begins but the law must define what it intends to protect.

'Unborn' seems to imply 'on the way to being born' or 'capable of being born'. Whether this condition obtains as from fertilisation of the ovum, implantation of the fertilised ovum in the womb, or some other point, has not been defined.

In the context of abortion law, which deals with the termination of pregnancy, a definition is essential as to when pregnancy is considered to begin; the law should also specify in what circumstances a pregnancy may legitimately be terminated and by whom.

If the definition of 'pregnancy' did not fully cover what is envisaged by 'unborn', the deficiency would need to be remedied by separate legal provisions which could deal also with other complex issues, such as those associated with the treatment of infertility and *in vitro* fertilisation.

At present, all these difficulties are left to the Supreme Court to resolve without explicit guidance.

The impossibility of reconciling the 'equal' rights to life of the 'unborn' and the mother, when the two rights come into conflict, was manifested in the *X* case.

Following the *X* case judgment, the scope of admissibility of a suicidal disposition as a ground for allowing an abortion and the absence of any statutory time-restriction on intervention to terminate a pregnancy remain causes of disquiet.

Possible approaches

The definitional difficulties are open to four different approaches:

i) to leave things as they are, relying on the Supreme Court to determine the meaning of 'unborn'
ii) to write a definition of 'unborn' into the Constitution itself
iii) to authorise expressly by a constitutional provision the making of all necessary definitions by legislation
iv) to make definitions by legislation in the expectation that, if challenged, they may be held by the Supreme Court to be in conformity with the Constitution as it is.

The Review Group considers that definition is required. Approaches ii) and iii) would require approval by a referendum.

Apart from the definitional problems, there are various possible approaches to clarifying the state of the law. Equally, however, there is a great divergence of public opinion as to what issues should be addressed, and how; value judgments are involved in every case. The Review Group has considered five options which are discussed in turn:

a) introduce an absolute constitutional ban on abortion
b) redraft the constitutional provisions to restrict the application of the *X* case decision
c) amend Article 40.3.3° so as to legalise abortion in constitutionally defined circumstances
d) revert, if possible, to the pre-1983 situation
e) regulate by legislation the application of Article 40.3.3°.

a introduce an absolute constitutional ban on abortion This must rest on a clear understanding of the meaning of 'abortion'. The 1861 Act prohibits 'unlawfully procuring a miscarriage' which might nowadays be rendered as 'illegal termination of pregnancy' but, in either case, the words 'unlawful' and 'illegal' are significant. If an abortion can be either lawful or unlawful, the word on its own must be understood to refer neutrally to the termination of a pregnancy or procurement of a miscarriage. To ban abortion *simpliciter* could thus criminalise medical intervention or treatment necessary to protect the life of the mother if such intervention or treatment required or occasioned the termination of her pregnancy.

According to a press report (*The Irish Times*, 10 September 1992), the Pro-Life Campaign considers 'a complete prohibition on abortion is legally and medically practicable and poses no threat to the lives of mothers'. Reference is made to 'the success of medical practice in protecting the lives of mothers and their babies', and it is claimed that 'a law forbidding abortion protects the unborn child against intentional attack but does not prevent the mother being fully and properly treated for any condition which may arise while she is pregnant'. Either of two hypotheses seems to be involved here - that the termination of a pregnancy is never necessary to protect the life of the mother or that, if it is, such medical intervention is already protected by law and that this protection would not be disturbed or dislodged by a constitutional ban on abortion. It would not be safe to rely on such understandings. Indeed, as explained later, if a constitutional ban were imposed on abortion, a doctor would not appear to have any legal protection for intervention or treatment to save the life of the mother if it occasioned or resulted in termination of her pregnancy.

It would not, therefore, be reasonable to propose a prohibition of abortion (understood as termination of pregnancy) which did not expressly authorise medical intervention to save the life of the mother.

b redraft the constitutional provisions to restrict the application of the *X* case decision The attempt to do this by referendum as recently as 1992, by ruling out the mother's suicidal disposition and mere risk to her health as justifications, failed conspicuously. There would obviously be extreme reluctance to go this route again, given the uncertainty as to what precise amendment of the 1983 subsection would be likely to command the majority support of the electorate.

c amend Article 40.3.3° so as to legalise abortion in constitutionally defined circumstances Although thousands of women go abroad annually for abortions without breach of domestic law, there appears to be strong opposition to any extensive legalisation of abortion in the State. There might be some disposition to concede limited permissibility in extreme cases, such, perhaps, as those of rape, incest or other grave circumstances. On the other hand, particularly difficult problems would be posed for those committed in principle to the preservation of life from its earliest stage.

d revert, if possible, to the pre-1983 position This presents itself as a reaction to the unsatisfactory position created by the equal rights provision of the 1983 Amendment. There is a view that experience since 1983 is a lesson in the wisdom of leaving well enough alone, of being content to rely on the judgment of a majority of legislators, and of recognising the superior capacity of legislation to provide, for example, necessary clarification as to when medical intervention is permissible to terminate a pregnancy.

It does not appear, however, that it would now be feasible or safe to revert simply to the pre-1983 situation, which was governed basically by the 1861 Act.

That Act prohibited the *unlawful* procurement of a miscarriage, leaving it to be understood that miscarriages procured consistently with ethical medical practice were not unlawful. So, before 1983, the position was that unlawful procurement of a miscarriage was prohibited by legislation, ethical medical intervention to protect the life of the mother, even if it occasioned or resulted in termination of her pregnancy, might well have been regarded under the 1861 Act as not being unlawful, and a number of comments of individual Supreme Court judges had affirmed the right to life of the unborn human being. However, the extent of the doctor's protection under the 1861 Act was never tested in an Irish court and carried no certainty.

Reverting to the pre-1983 situation would, therefore, be unsafe unless there were an express assurance of the protection afforded to doctors.

It is essential to have specific legislative protection for appropriate medical intervention because it cannot safely be said how far, if at all, the presumed 1861 Act protection is now effective in Ireland. Moreover, the protection could not be allowed rest on such an uncertain base as ethical medical standards. These are not uniform even amongst doctors in one country and medical ethics may change over time. Even prior to the 1967 Abortion Act in England, it would seem (in *R v Bourne* [1939] 1 KB 687) that abortion was permissible if the pregnancy threatened to make the mother a 'physical or mental wreck'. In any case, in this litigious age, doctors could not safely rely on any convention not clearly specified and confirmed by law.

Reverting to the pre-1983 situation would involve:

i) removing the abortion issue from the Constitution by deleting, without prejudice to particular decisions taken under it, the 1983 insertion (the Eighth Amendment) and
ii) placing renewed trust in the legislature by relying henceforth on the prohibition in the 1861 Act, reinforced, however, by specific legislative protection for medical intervention to save the life of the mother.

As shown by the 1992 referendums, however, there would be public insistence on retaining the travel and information provisions as independent entitlements.

Moreover, it would appear that recourse could still be had to the provisions which would remain in the

Constitution protecting life and other rights (for example Article 40.3.1° and 2°).

There could, in any case, be no assurance that a referendum proposal as outlined at i) and ii) above would commend itself to a majority of the electorate.

e regulate by legislation the application of Article 40.3.3° Relying on legislation alone would avoid the uncertainties surrounding a referendum but the legislation would have to conform to the principles of the *X* case decision and be within the ambit of Article 40.3.3° generally.

In brief, legislation could:

i) include a definition of 'unborn' (preferably 'unborn human') or, in the context solely of abortion law, a definition of 'pregnancy', even if 'unborn' were not thereby fully covered. Any legislative definition of 'unborn' would, of course, be open to constitutional challenge but could be an advance towards clarifying the law
ii) afford express protection for appropriate medical intervention
iii) require written certification by appropriate medical specialists of 'real and substantial risk to the life of the mother'
iv) in preference to leaving the matter to medical discretion, and again subject to possible constitutional challenge, impose a time-limitation to prevent a viable foetus being aborted in circumstances permitted by the *X* case decision.

Conclusion

While in principle the major issues discussed above should be tackled by constitutional amendment, there is no consensus as to what that amendment should be and no certainty of success for any referendum proposal for substantive constitutional change in relation to this subsection.

The Review Group, therefore, favours, as the only practical possibility at present, the introduction of legislation covering such matters as definitions, protection for appropriate medical intervention, certification of 'real and substantial risk to the life of the mother' and a time-limit on lawful termination of pregnancy.