



Doctors for Choice Ireland

Submission to the United Nations Human Rights Committee for Ireland's
Review under the International Covenant of Civil and Political Rights

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1. Doctors for Choice

Doctors for Choice (DFC) is an alliance of independent medical professionals that advocate for comprehensive reproductive health services in Ireland, including the provision of safe and legal abortion for women who choose it. DFC was established in 2002 and has been a leading voice in the abortion debate in Ireland since. We believe that women should be supported to make their own decision regarding their sexual and reproductive health and to manage their own fertility, with doctors and nurses providing expert advice and care without judgment, recourse to the law or fear of criminal sanction.

Doctors for Choice made representations regarding the development of the Protection of Life During Pregnancy Bill 2013 with formal presentations and submissions to the Irish Parliament. We expressed serious reservations with many

aspects of the Bill, but they were not addressed to any substantive degree when the Protection of Life During Pregnancy Act (PLDPA) was passed in July 2013. In June 2014, at the time of this submission, the Act still has not been implemented and there is no appropriate guidance for medical practitioners on the practical interpretation of the Act. More importantly, Irish women, whose lives or health is at risk, do not have access to abortion services in Ireland. DFC believes implementation and formalized guidance arising from the PLDPA is likely to remain inadequate for Irish women and doctors.

We welcome this opportunity to build on our public contributions to the debate on abortion care in Ireland. Together with many other civil society organisations, we offer this submission as evidence of the ways in which the Irish state party is not protecting women's civil and political rights to internationally acceptable standards.

2. Recommendations

1. That the Irish state party repeal laws restricting abortion and integrate abortion care into normal health care provision in order to protect and vindicate

- pregnant women's civil and political rights to life, freedom from cruel, inhuman and degrading treatment, freedom of conscience, privacy, non-discrimination and free expression as recognized persons before the law, and
- health care professionals' rights to conscience and free expression in their care for and of women

2. That legal and policy standards for abortion care adopt international standards of medical ethics and take a woman-centred perspective in a clinical context in order to reduce harm and to respect patient autonomy. Any legal test for abortion, from the current 'real and substantial risk to life' to a future possible 'indicated by the patient's circumstances', must take women's views seriously.

3. That legal processes respect and promote principles of equality and privacy by removing discriminatory and privacy-disrespecting measures and tackling discriminatory and privacy-disrespecting effects.
4. That abortion law and policy recognize the consciences of women and pro-choice health professionals, and limit any harms which may occur through the recognition of anti-choice conscience.
5. That abortion law and policy recognize women's, health professionals' and civil society's interests in the free exchange of information about abortion care.
6. That the state party be more pro-active in its fulfillment of women's fundamental rights, including the rights of women who are poor, pregnant, marginalized or mentally ill, particularly given the history of state abuse of women's rights.

3. The state party has failed to ensure women's access to life-saving abortion in non-discriminatory and privacy-respecting conditions (Articles 2, 6, 26 and 17)

Current abortion law and policy in the Republic of Ireland breaches Articles 2, 6, 26 and 17 by failing to ensure women's and girls' appropriate access to life-saving abortion. Firstly, Irish law still does not adopt a clear clinically relevant standard for assessing the 'real and substantial risk' that legally justifies a termination of pregnancy. Secondly, by maintaining a bright line distinction between health and life, Irish law fails to prevent the aggravation of serious risks to women's and girls' lives and compromises good clinical practice. Thirdly, Irish law discriminates against women and girls whose risk to life arises from their mental condition. Fourthly, Irish law permits infringements into the privacy of pregnant women and girls by subjecting them to a disproportionately high level of scrutiny when assessing whether they meet the legal grounds for a termination of pregnancy.

3. 1. There is no clinically appropriate guidance on the ‘real and substantial risk’ which justifies a lawful abortion

Since the Supreme Court decision in the *Attorney General v X* (1992), Irish law has permitted abortions where there is a ‘real and substantial risk’ to a woman’s life, a risk that manifested as a threat of suicide on the facts of that particular case. As the European Court of Human Rights ruled in *ABC v Ireland* (2010), there has been no clear procedure established since the 1992 whereby women could know whether they met that legal test. Women who are legally entitled to abortion at home in Ireland have travelled for abortion care elsewhere because of this legal failure. The *Protection of Life During Pregnancy Act 2013* (hereinafter the PLDPA) attempts to address this procedural deficit by establishing review panels at designated hospitals which will evaluate whether women meet this legal test. The PLDPA provides for lawful abortion in 3 different sets of circumstances where there is ‘real and substantial risk’ to a woman’s life. One year after the Act was passed in the Irish Parliament, **there is still no clinically relevant standard for assessing ‘real and substantial risk’**. As a result doctors and other health care providers continue to be unsure as to when life-saving abortion is legally justified.

Failure to specify an appropriate standard for ‘real and substantial risk’ obviously contributes to risk to women’s lives by leading to confusion and delay and by authorizing less than optimal standards of care for sick pregnant women and girls. Although this failure has been much criticized in official reports and policy submissions, including the investigations into the death of Ms Savita Halappanavar in October 2012, the 2013 Act has done nothing to address it. Healthcare professionals have been left with no national guidance on the appropriate means for assessing this risk, and know that they are liable to 14 years imprisonment if their professional assessment ends up falling outside of the legal definition.

Recommendation 4b of Professor Sabaratnam Arulkumaran’s report to the Health Services Executive (2013) on the death of Savita Halappanavar stated:

There is immediate and urgent requirement for a clear statement of the legal context in which clinical judgment can be exercised in the best medical welfare interests of patients... We recommend that the clinical professional community, health and social regulators and the Oireachtas [the Irish parliament] consider the law including any necessary constitutional change and related administrative, legal and clinical guidelines in relation to the management of inevitable miscarriage in the early second trimester.

Similarly, Professor Peter Boylan, a former Master of the National Maternity Hospital, Holles Street, who was an expert witness at the coroner's inquiry into Savita Halappanavar's death, claimed that it was restrictive abortion laws that led to Ms. Halappanavar losing her life. Over twenty GPs, in a published survey, stated they had managed a woman who underwent a termination specifically indicated because of a "real or substantial risk to their lives" (Murphy et al. 2012). The main indications were maternal cancer on chemotherapy, severe cardiovascular disease and severe psychiatric risk post-rape. All but one of these abortions took place in another state, despite the 1992 Supreme Court decision. Although general practitioners delivering primary care to pregnant women believed that 20 of their patients met the legal grounds for abortion, 19 of those women did not receive abortion care in Ireland.

3.2 The legal distinction between life and health in the test for abortion has life-threatening consequences

As health care providers we are particularly concerned by the bright line distinction which Irish abortion law draws between risks to health and risks to life. This is a meaningless and dangerous distinction in our view. In clinical practice there is a spectrum of risk, not a legally definable line to be crossed. Many different factors can combine to produce risk in different ways. Clinical judgment should be permitted to evaluate these factors in particular concrete circumstances. Medicine requires the exercise of skilled subjective judgment. Severe haemorrhage or preeclampsia may necessitate the delivery of the fetus to save a mother's life. But there is no one clear, exact moment in time when all doctors will agree that a

threshold has been crossed and a termination is necessary. Being legally required to make sharp distinctions between life and health is unwelcome from a clinical perspective as the two are intimately connected. A risk to life has to be evaluated using health indicators.

Moreover this distinction currently legitimates poor clinical practice in our view. The only way to give the distinction meaning is to suggest that doctors effectively have to wait for an already substantial risk to a woman's health to turn into a clear risk to her life before they can intervene. Mandating non-intervention, until a woman's life-related health deteriorates to the extent that her life is at risk, is dangerous. It risks contravention of a basic requirement of medical ethics that doctors should 'do no harm'. But given that the consequences are criminal prosecution, current law supports this kind of poor and unethical clinical practice in our view. For example, if a pregnant woman is unwell with a second trimester inevitable miscarriage, her clinical situation could theoretically deteriorate further over the course of hours or days. If the patient's clinical state does deteriorate, and the foetus is still alive, doctors can only lawfully terminate this pregnancy if they deem "a real and substantial risk" to the life of the pregnant woman to be present. In other words, there is nothing in Irish law or policy, which clearly *prevents* a tragedy like Ms. Halappanavar's death happening again (HSE, 2013).

Members of Doctors for Choice and other leading medical professionals have repeatedly criticised this failure in the Irish media and in formal submissions to the Irish Parliament. The Joint Oireachtas Committee for Health heard submissions from Dr. Rhona O'Mahony (Master of the National Maternity Hospital), Dr. Peadar O'Grady (Consultant Child and Adolescent Psychiatrist, Portlaoise) and Professor Veronica O'Keane (Consultant Psychiatrist, Adelaide and Meath Hospital, Tallaght), among others stating that the Irish law on abortion was overly restrictive and led to a chilling effect on doctors, causing uncertain as to when they could 'intervene' and perform an abortion under the 1992 common law interpretation of a 'real and substantial risk'. Dr. O'Mahony in particular at the Joint Oireachtas hearings stated that obstetricians hands were tied, uncertain as to when they could terminate a

pregnancy if there was severe maternal ill health requiring an abortion as part of her management.

3.3. Current abortion law and policy discriminates against pregnant women whose risk to life arises from their mental health status or condition.

Since a risk of suicide was established by the Supreme Court as a legal ground for abortion in 1992, the Irish legislature has tried twice to have this ground removed by constitutional referendum, and failed on both occasions. In 1992 and in 2002 the Irish electorate refused to remove the risk to suicide from the constitutionally recognised grounds for abortion. Section 9 of the 2013 Act implements the 1992 Supreme Court ruling and permits an abortion when there is a risk of loss of life from suicide. It provides that this group of women need to have their abortion approved by 3 medical professionals, an obstetrician and 2 psychiatrists, 1 of whom has experience and training in perinatal psychiatry.

This provision unjustifiably discriminates against vulnerable women and women with mental health issues for 3 reasons. Firstly, it requires them to meet a significantly higher approval threshold than women who need access to life-saving abortion due to physical ill health. In conditions of emergency, the latter require the approval of 1 medical professional. In non-emergency circumstances, they require the approval of 2 medical professionals including an obstetrician. Secondly, in requiring an obstetrician's approval, section 9 imposes an unnecessary barrier to access, because an obstetrician does not have medical expertise that is relevant for assessments of suicide risk. Thirdly, as was pointed out during the hearings, the relatively low number of psychiatrists with the appropriate expertise means that timely access is likely to be a problem when time is of utmost importance. The PLDPA has actually introduced a test which discriminates against women with mental health problems, where none existed in abortion law before.

Members of Doctors for Choice and other leading medical professional have consistently pointed this injustice out during the hearings, in policy submissions and in public media (Hunter 2013, DfC 2013a, 2013b, 2009). They have argued that only one psychiatrist or GP should be required to certify eligibility for an abortion (e.g. O’Grady, 2013). The legal process for approving life-saving abortion has adopted another unnecessary barrier to care by failing to address the clinical reality that pregnancy, including pregnancy which poses threats to the life of the woman, is managed by general practitioners in a primary care context. GPs manage early pregnancy, crisis pregnancy and most mental health problems in the Irish state, but they have been excluded from the abortion approval process through its focus on obstetricians and psychiatrists and through its location in approved hospitals. GPs alone manage uncomplicated pregnancies until 16 weeks gestation. If a woman presents in early pregnancy with a mental health crisis it will be GPs in liaison with psychiatrists who will be managing her care. There is no clinical need for obstetricians to be involved, as the pertinent issue is mental health rather than obstetric health. Even though GPs are usually the key clinicians involved in crisis pregnancy, they do not play a professional role in the abortion approval process, but may be consulted.

Although guidelines on how to implement the PLDPA in practice have not been published at the time of submission, we understand that they have been agreed and should be published shortly. We are very concerned that the guidelines will not do enough to ensure an appropriate care pathway for pregnant women whose risk to life arises from their mental health. As argued in the next section, an assessment process which requires women in mental distress to be assessed by 3 doctors for clinically unnecessary reasons does not conform to our professional understanding of a medical pathway to care. But the point we want to make here is that we are **very concerned that the guidelines will do nothing to prevent anti-choice psychiatrists from making the assessments and obstructing women’s access to life-saving abortion.**

According to a poll carried out by the anti-choice psychiatrists prior to the passing of this legislation, there were in excess of 100 state psychiatrists who opposed the legislation and the slogan of this group was that “abortion is not a treatment for suicide” (O’Casey, 2013). Although it contravenes basic norms of procedural fairness, there are no clear eligibility criteria in current law or policy to exclude anti-choice psychiatrists from participation in the assessment process. There is a significant risk that women, whose risk to life emanates from their mental condition, could receive prejudiced medical care. This legal situation cannot be said to be a fair and non-discriminatory means for women to access abortion care if suicidal because of an unwanted pregnancy.

3.4. Current law and policy interferes disproportionately with the privacy of pregnant women and girls by subjecting them to an excessive degree of scrutiny during the abortion approval process established by the 2013 Act.

The Act envisages that in certain cases, a woman seeking abortion may have her circumstances reviewed by a total of 6 doctors: 3 on the original approval panel and 3 on the appeal panel. This level of scrutiny is excessive in our view and we are disturbed at the implications for patients’ privacy and dignity.

We would ask the Committee to note the added significance of the contemporary and historical health care context on this scrutiny process. Ireland is a country with a small population of 4.6 million, and confidentiality can be difficult to maintain particularly in rural areas with small towns and villages. Our patients are already fearful about breaches of confidentiality and privacy in healthcare contexts given this context. But this is exacerbated when it comes to stigmatized and controversial health care such as abortion, when women fear harm to their reputation, relationships and employment prospects if an abortion history is revealed. Requiring women who may already be fearful about the confidentiality of their medical records to be reviewed by up to 2 panels of 3 doctors is a disproportionate infringement of their privacy rights in our professional opinion.

As Dr. Anthony McCarthy and colleagues stated during the Joint Oireachtas Health Committee hearings: “much of the public debate about the issue of suicide and its risk in pregnancy has, in our view, been simplistic, sometimes harsh and judgmental, frequently uninformed or misinformed, and contrasts markedly with the way suicide and its risk is usually discussed in other circumstances” (College of Psychiatry 2013). During the associated media coverage (e.g. Reilly 2013) Dr. McCarthy made it clear that doctors, particularly psychiatrists, are very conscious of a history of medical mistreatment of pregnant women. Given the extensive work that doctors have done to promote good public health through patient-centred care, we are concerned that the abortion review panels do not become a means of intimidating pregnant women. We are also concerned that significant damage has already been done by a public debate that too often assumed that suicidal women are untrustworthy and manipulative (O’Keane 2013).

4. The state party has failed to protect women’s rights to be recognized as persons before the law (Article 16) and to be free of cruel, inhuman and degrading treatment (Article 7) by re-criminalising women and girls who seek abortion care with no regard for discriminatory effects (Article 26).

State party law is not compliant with Articles 2, 16, 7 and 26 because section 22 of the PLDPA has created a **new criminal offence for actions which “intentionally destroy unborn human life”, liable to 14 years imprisonment.**¹ All women and girls who decide on termination of pregnancy in their particular circumstances, but do not have a ‘real and substantial risk’ to their lives, are criminally liable under the Act. Anyone who cares for these women, including their doctors, by providing them with

¹ The Act repealed the old offences of ‘procuring a miscarriage’ and ‘supplying a noxious substance’ under sections 58 and 59 of the Offences Against the Person Act, 1861.

a form of abortion care e.g. early medical abortion that could be said to “intentionally destroy unborn human life” is also potentially liable at criminal law (see section 5 below). In our view, denying a woman the authority to end a pregnancy is a violation of her fundamental rights to conscientious personhood as a moral agent with bodily integrity. It is particularly cruel that Irish women whose pregnancies have fatal abnormalities, who are pregnant as a result of rape or incest, or whose pregnancies pose risks to their physical and mental health are denied abortion at home and have to travel elsewhere (IFPA 2013, CRR 2013). The restriction of domestic abortion and reliance on extra-territorial abortion is disproportionate and discriminatory because it does not stop abortion and disadvantages women who are less well able to travel.

4.1 Criminalising and restricting women’s decisions over their sexual and reproductive bodies is a violation of women’s right to be recognized as persons before the law.

We have long criticized (Doctors for Choice and BPAS 2009) the negative effects on women’s lives of failures to provide abortion as a normal aspect of necessary health care. From our perspective, the criminalisation and legal restriction of women’s decision-making during pregnancy risks their health, exacerbates existing disadvantage, *and* is a failure to recognise women as persons before the law. In law and ethics moral authority over decisions that affect one’s personal life is a key attribute of personhood. Pregnant women are denied this authority when abortion is legally restricted. As Thomson argued over 40 years ago, *even* if one concedes that a fetus is a person, a concession which many contest given the absence of sentience, the values of personal liberty and bodily integrity mean that we do not normally require one person to give up the use of their bodily organs on behalf of another (Thomson 1971, Fletcher 2013b).

We are frustrated that in spite of our willingness to provide abortion care and in spite of increased public acceptance of abortion (Ipsos 2013), the state party has failed to reduce harm to women on this issue. The state’s failure to act to recognize

women's moral agency undermines public and professional faith in its apologies to women for past wrongs and in its statements that it will respect women's rights in all its actions (e.g. Department of Justice 2007). We have tried to challenge the ideology which assumes that abortion restrictions are somehow legally necessary to protect foetal life in a constitutional order which recognizes women's rights. But the state party does not appear to have listened to us and has instead chosen, in 2013, to adopt a new offence criminalizing actions which "intentionally destroy unborn human life". As Dr. Ruth Fletcher (2013) argued in her submission before the Irish Parliament:

The criminalisation of women's decisions to end their pregnancies is a disproportionate and unfair response to the constitutional direction to vindicate the life of the unborn as far as practicable. Criminalisation does not achieve the objective of protecting foetal life and it makes the mental and physical experience of unwanted pregnancy worse. The Legislature has other options under Article 40 3 3 and it does not, as the Explanatory Notes [of the 2013 Bill] suggest, have to criminalise those abortions which fall outside the tests in Heads 2-4 [which became sections 7-9 of the 2013 Act]. The Legislature could regulate the terms under which women access abortion in the Irish health service without punishing those women who fall outside those terms. It could vindicate 'unborn life' by investing in pregnancy-related care and research into miscarriage. In choosing to punish women rather than to adopt more neutral or positive measures for the support of foetal life in pregnancy, the Legislature would be acting unfairly. Head 19 [now section 22] is unfair because it asks women, rather than the state, to bear the weight of the public duty to vindicate foetal life.

4.2 It is particularly cruel and unfair to deny domestic abortion care to women who are severely distressed by their pregnancies as a result of fatal foetal abnormality, of rape or incest, or of serious risks to health.

In Ireland the circumstances of women and couples who have had to travel abroad for abortion care after a diagnosis of a fatal anomaly (FFA) such as anencephaly or

Edward's Syndrome has received considerable public sympathy and attention through the interventions of Termination for Medical Reasons and their supporters.

Several public commentators (e.g. Schweppe and Spain 2013, Fletcher et al 2013c) have argued that the government could and should have legislated for abortion in circumstances of FFA, but they did not. This decision does not reflect public or medical professional opinion with approximately 90% of both doctors and the Irish public supporting abortion services in such a situation (Murphy 2012, Ipsos MRBI Poll 2013). As discussed by the Centre for Reproductive Rights (2013) in support of cases being taken against Ireland for cruel, inhuman and degrading treatment of women with fatal foetal abnormalities, women have clearly been greatly distressed by having to travel for a termination of pregnancy in such circumstances (see more generally Sifris 2013). Their stories have been documented in multiple media such as on the webpages of Terminations for Medical Reasons⁴, in the national press and through published research. Examples of clinical situations which Irish GPs shared in a 2012 include the following (Murphy et al. 2012):

A woman with 2 children who travelled to France to have a termination of pregnancy because of severe deformities to her fetus- quite late in pregnancy and patient very traumatised after it and bleeding a lot.

I had a lady who was diagnosed with an anencephalic fetus, she could not afford to travel to UK for a termination of pregnancy

Woman carrying an anencephalic baby had to travel to UK at 20/40. Should have been allowed here as pregnancy was non-viable.

A colleague in practice had a patient who had to travel to England for termination of pregnancy with a fetal anomaly incompatible with life- very

⁴ <http://www.terminationformedicalreasons.com>

wrong that she had to do this, does not demonstrate a caring attitude of Irish state.

A woman had a major congenital anomaly detected at 23 weeks, incompatible with life- she already had a child and was a carer for her husband with a major chronic disease. It caused chaos that she had to leave the country and made a mockery of the law in this state.

A DfC member has contributed the following statement for the purposes of this submission:

A recurring source of distress for my patients who terminate because of FFA is the inability to bring home the remains & have a burial or ceremony with family members. Recently UK clinics have offered cremation and to post the ashes here, but this takes weeks and prolongs the grieving process in these cases. The consequences of having to rely on extra-jurisdictional abortion care has the effect of further marking these families as different and 'abnormal' given funerals normal occur within 48-72 hrs of passing in Ireland.

The Abortion Support Network is a UK based voluntary organization which raises funds and provides practical support to Irish women travelling to the UK for abortion care. Since October 2009, ASN's members have stepped in to provide care that the Irish state refuses to its citizens and residents. They report annually on their activities. Between 2009 and the end of 2011, 31 women told the volunteers that they had serious health complications which were aggravated by pregnancy or meant that they had been warned against pregnancy (ASN, 2012). 21 women said that they had serious mental health problems and 4 had learning disabilities. 26 women said that they were in or trying to escape abusive relationships, while 9 were living in shelters. 19 reported that they were pregnant as a result of rape. Women in such circumstances are not stopped by the criminal law from terminating their pregnancy. Rather they have to endure further hardship and expense in travelling abroad, as well as rejection by their home state, at a time of need. This treatment of

women who are clearly already distressed by their pregnancies amounts to cruel, inhuman and degrading treatment in our view.

Scientific and technological developments have meant that early medical abortion is now available online and women are inducing their own abortions through use of 'abortion pills' or abortifacients during the first 9 weeks of pregnancy. When early medical abortion is used with good quality clinical information and with appropriate medical back-up it is a very safe procedure and some states such as Sweden, France and the USA permit home use (Department of Health (England and Wales), 2008). But in Ireland women who would self-induce through ingestion of imported abortion pills are liable to criminal prosecution and a sentence of 14 years. As a result, they are unlikely to use medical back up should complications occur and a safe medical procedure can become unsafe through the chilling effect of the law. Again this seems to us to be a completely disproportionate and dangerous use of the criminal law against what should be a safe and reliable method of fertility control. It is deeply troubling to us that methods which have made abortion safer and more accessible and which have enhanced women's control are being criminalized, restricted and driven underground.

There is now considerable evidence that Irish women, some of whom may be unable to travel, are taking abortifacients purchased online or procured in Ireland (Murphy 2012, IFPA 2013). Up to 11% of GPs have managed a woman who has taken an abortifacient, the majority of which were sourced on the internet or bought illegally in Ireland. We also know that in 2011, Irish Customs Authorities seized 635 abortifacients (15 mifepristone and 620 misoprostol tablets) representing 28 attempted supplies, addressed to 20 females and 8 males (O'Reagan 2012, IFPA 2013). Anecdotally, hundreds of Irish women are procuring medical abortifacients over the internet and taking them in Ireland. Doctors for Choice fears that women will now be frightened, because of the possibility of a lengthy prison sentence, into delaying presentation to their doctor after they take an (illegal) medical abortifacient, if a complication arises.

4.3 Restricting domestic abortion care and relying on extra-jurisdictional care has discriminatory effects.

Members of Doctors for Choice have observed how criminalized restrictions impose additional barriers for women who already have difficulty in accessing necessary health care because of obstacles due to poverty, migration status, age, disability or vulnerability. We have seen how having to travel for abortion care can have damaging effects on women’s health and well-being. These harms should be prevented in our view by permitting the provision of abortion care at home. We note the particular futility of generating such harms when the assumed objective of domestic abortion restrictions – the continuation of pregnancy – is not achieved.

Recent research assessed the experiences of Irish GPs who had cared for women who travel abroad for abortion services (Murphy et al. 2012). It highlighted how the health of Irish women was affected specifically because of the requirement to travel outside the state for safe, legal and accessible abortion services. Five themes of ill-health due to the requirement to travel were identified: physical ill-health, psychological ill-health, social ill-health (financial, family and isolation), impairment of the doctor-patient relationship and impairment of the doctor-doctor relationship. Examples taken from the published research are provided in the following table.

Qualitative Analysis of those who feel a woman’s health suffers specifically because of the requirement to travel overseas for termination of pregnancy
Physical health effects from travelling
<i>“..came back from UK- saw her and transferred her to hospital with septicaemia- she died. No follow up. This occurred over 20 years ago.”</i>
<i>- “Many women do not attend for aftercare with their Irish GP as they are ashamed or</i>

embarrassed and often present too late with infection/ bleeding etc.”

- “Poor aftercare leading to anaemia and persistent vaginal discharge.”

Psychological health effects from travelling

- “Stress of travelling, follow up, post op infection. Psychological effects- dealing with abortion in aftermath, secrecy regarding planning trip.”

- “Because of secrecy and time needed to travel”

- “Emotionally, psychologically- the feeling of doing it covertly and making provision for family remaining at home”

- “Poor supports afterwards as “taboo”. Increased guilt as felt doing something illegal more stressed with having to leave country at a very difficult period in life.”

- “The embarrassment, loneliness and secrecy attached to travel are added burdens on the expectant mother”

- “Feeling of doing something illegal as well as the secrecy and trouble to travel”

- “Illegality and having to travel abroad adds to the traumatic effect of what is already a complex situation and a decision not taken light-heartedly by many women.”

- “Shame and stigma of having to travel abroad results in shame about coming forward for post-ToP care.”

Social health effects from travelling (financial, isolation and family)

Finances:

- “Some have not travelled for financial reasons and regretted it.”

- “People can’t always afford and have borrowed money.”

Isolation:

- *“Burden of financial pressure often leading to having to travel alone.”*
- *“Social isolation in emotionally challenging situation.”*
- *“Travelled alone as has no money”*

Family:

- *“Emotionally, psychologically- the feeling of doing it covertly and making provision for family remaining at home etc.”*
- *“Social ill-health due to compromised relationship(s) with GP/ friends/family due to knowledge of her having had an abortion, or compromised relationship due to the woman with-holding this knowledge from others.”*

Doctor-patient relationship

- *“Limited psychological support after TOP. Negative view of Irish Healthcare as a result, leading to damaged doctor/ patient relationship.”*

Impairment of inter-doctor communication

- *“Lack of follow up and medical liaison between doctors in the case of suicidal woman was a huge problem.”*
- *“Unknown clinic and clinicians in UK, lack of continuity of care.”*

5. The state party has failed to protect and fulfill the right to freedom of conscience appropriately in abortion law and policy (Article 18)

Doctors for Choice are concerned that current abortion law and policy gives disproportionate weight to anti-abortion beliefs in a manner which compromises best clinical practice. Although we welcome positive developments, the state party has not done enough to date to ensure that anti-abortion beliefs do not obstruct the provision of lawful abortion care in a timely and sensitive manner. There is a key imperative to distinguish

between individual conscience and institutional religious power in a context where disproportionate protection has historically been given to hospitals implementing Catholic social teaching. We are also concerned that law and policy refuse to acknowledge adequately the consciences of pro-choice medical professionals and of abortion-seeking women.

Historically doctors who conscientiously object to the provision of abortion have had considerably more accommodation by professional policy and practice than doctors who are conscientiously committed to the provision of abortion (on conscientious commitment more generally see Dickens and Cook, 2011). Doctors and other healthcare professionals who believe that abortion should be available in order to reduce harm to women, have not been adequately protected or accommodated by the public health service. Health care professionals who are against abortion have been accommodated by professional practice and policy to a degree which undermines legal and ethical obligations to reduce harm to pregnant women. The harmful effects of institutionalized Catholic social teaching on women's lives and health has been evident, including through the practice of symphysiotomy in Ireland long after it was abandoned elsewhere, and through the practice of incarcerating young pregnant women in the Magdalene laundries. In this context, we are concerned that institutional power does not masquerade as 'conscientious objection' in a manner that evacuates the legal and ethical significance of conscience (see further Daly 2013).

The PLDPA recognizes a right to conscientiously object to the provision of life-saving abortion but places an obligation on the medical professional to ensure the transfer of a woman's care. The Mater Misericordiae University Hospital, a well known Catholic hospital, has recently announced that it will abide by the Act in spite of a former Board member's declaration that the Act was against the hospital's ethos (Holland 2013). We welcome these developments in the regulation of conscientious refusals, but we are concerned that law and policy do not do enough to ensure that anti-abortion beliefs do not obstruct access to lawful and necessary abortion care (see further Fletcher, forthcoming 2014). As DfC member and Professor of Psychiatry, Veronica O'Keane has stated publicly (2014), there is

nothing in the current legislation, guidelines or policy to ensure that doctors who are against abortion for all reasons do not obstruct the delivery of abortion care under the Act.

There is still no abortion service for women even though the Act came into force in January 2014. The absence of any appropriate pathway to abortion care, six months following the enactment of the legislation, means that there is no effective access. In particular, DfC objects to the state party's failure to:

- (a) enact an abortion service in a manner that is effective and caring for the women who need it,
- (b) clarify eligibility criteria which would stop anti-choice doctors from participating in and obstructing the services
- (c) re-assure women that they will be believed and trusted rather than challenged and excessively scrutinized in accessing lawful health care

In relation to this latter point we object to the almost exclusive emphasis on the psychiatrist's role as one of strictly assessing whether a woman is suicidal or not because of an unwanted pregnancy. It is only if the continuation of the pregnancy will result in the suicide of the woman, in the opinion of the psychiatrist, that an abortion can be permissible. We believe that the conscience of the woman herself should not be 'overruled' by a psychiatrist in relation to the potentially life-threatening prospect that an unwanted pregnancy may pose to her mental health. Our concerns have been exacerbated by gaps in relation to the forthcoming PLDPA guidelines, which have not been published at the time of this submission. Given that the Act requires two psychiatrists to do the assessment of suicidal women under section 9, the guideline for implementing this process will be very important in securing effective delivery of the lawful service. If a psychiatrist objects to participation this could delay and undermine the service, so effective scrutiny of objectors' reasons and effective referral will be key.

We are particularly concerned that guidelines will undermine delivery of this already very limited service by allowing psychiatrists to opt out by *preference*, rather than by reference to a *genuine conscientious objection*. All publicly employed health care professionals, including psychiatrists, have a duty to deliver health care to patients and they cannot excuse

themselves from that duty by reason of distaste, inconvenience or disagreement alone. The right to conscientious objection allows medical professionals to refuse to provide abortion care if care provision would do them psychological harm by requiring them to go against their sincerely held moral beliefs. As the European Committee of Social Rights (2014) held recently in relation to Italian state regulation of conscientious objection, there is a need for the state to distinguish between the expression of a professional preference and the expression of a genuine conscientious objection. The state has a duty to ensure that the timely and sensitive delivery of lawful health care is not compromised by rules that permit staff to opt out of care provision.

In our experience, the dominance of the anti-abortion ethos has also compromised medical education and training in this area. Needless to say, we also object to the infringement of our pro-choice consciences through the criminalization of our support for abortion-seeking women under section 22 of the PLDPA.

6. The state party is not compliant with the right to freedom of expression because women and health care professionals are overly restricted in their handling of information relating to abortion care (Article 19)

The exchange of information in a health care setting is normally regulated by reference to principles of informed consent (on European human rights standards in this regard see *RR v Poland* 2011, *P and S v Poland* 2012, Westeson 2013). But in the context where the provision of abortion care will occur in another jurisdiction, Irish law restricts the free expression of information relating to abortion. As well as being a breach of free expression standards, this restriction may also contribute to physical and mental harm if the information is needed, and obstructed, for health care purposes. This restrictive legislation,

popularly known as the 'Abortion Information Act, 1995',⁵ regulates the provision of information pertaining to abortion services abroad. It prohibits the 'promotion' of abortion and the making of an abortion appointment on behalf of the pregnant woman. Secondly, the Abortion Information Act does not regulate the provision of false health care information by so-called rogue crisis pregnancy agencies. This is because they do not provide information about abortion services in other jurisdictions and so do not fall under the scope of the legislation. This is another example of how pro-choice consciences which support women's authority over their reproduction are penalized and restricted when potentially harmful anti-choice conscience is accommodated with little scrutiny. As a result, truthful and reliable information which women need in order to implement their right to avail of abortion in another jurisdiction is restricted while the circulation of untruthful, anti-choice information in independent agencies (e.g. that abortion causes breast cancer) is not regulated.

Irish doctors are very uncertain about how much information and support they can give to a patient who is in need of abortion care. On the one hand the 1995 Act's restrictions leave doctors feeling legally obliged to limit clinically appropriate expression, such as direct correspondence with abortion clinics. On the other hand, they feel legally required to discuss parenthood and adoption even if that is clinically inappropriate e.g. where a woman is clearly distressed by the possibility of future parenthood. The 1995 Act limits medical capacity to care effectively for individual patients. But it also restricts Irish people's access to information about abortion services abroad by preventing health professionals from 'advocating' abortion services.

Section 3 of the Act is entitled "*Conditions governing the giving of Act information at meetings or in certain publications.*" It specifically states that a health professional cannot discuss any information that "*is likely to be required by a woman for the purpose of availing herself of services provided outside the State for the termination of pregnancies*" or discuss services or persons that provide abortions in the UK in the specific places. Examples of where information should be censored are; at a meeting, in a book, a newspaper, a journal,

⁵ Regulation of Information (Services outside the State for Termination of Pregnancies) Act 1995 <http://www.irishstatutebook.ie/1995/en/act/pub/0005/index.html>

a magazine, a leaflet, a pamphlet, a film, on radio or on television. Whilst the Act does state that it may be lawful to discuss such information in these locations it states that this is only possible if it *“is not accompanied by any advocacy or promotion of, the termination of pregnancy”*. This in effect renders meaningful discussion about abortion information illegal, namely all information that is *“required by a woman for the purpose of availing herself of services provided outside the State for the termination of pregnancies”* and *“relates to such services or to persons who provide them”*. Section 4 also penalizes the circulation of abortion information in the public sphere by prohibiting *“display of certain public notices, or distribution of unsolicited publications, containing Act information”*. DFC believes that these restrictions offend basic civic principles of public deliberation and free expression.

Despite a majority of doctors being pro-choice, and an overwhelming majority favouring abortion in limited circumstances (Murphy 2012), it is clear that a doctor’s potential to advocate for their abortion-seeking patients is significantly limited. This chilling effect means that many health professionals are reticent to discuss abortion publicly. As a result, Irish women generally do not hear health professionals endorse abortion as a valid, normal gynaecological procedure. This further delegitimises the experiences of those that have procured safe and legal abortion services abroad and heightens the stigma that they are subjected to at home.

Irish GPs know that 1:10 Irish women have had an abortion and that 22% of all crisis pregnancies end in abortion. Termination of pregnancy remains one of the most common gynaecological procedures an Irish woman will undergo. Approximately 150,000 Irish women are reported officially as having had an abortion in the UK since 1983. GPs must be able to advocate that this is a valid decision, which Irish women frequently undertake, or else their health needs will suffer. If a woman chooses an abortion and requires support, doctors should be able to legitimise her decision by explaining these facts fully to her, whilst also being able to discuss other options. Doctors need to be able to talk about abortion openly and honestly in the consultation room so that women can make the right choice for themselves and to lessen any negative health effects that may arise from stigma and the requirements to travel. This Act prevents doctors from appropriately advocating on patients’ behalf in the consultation room and DFC believes this is wrong.

Information relating to abortion is required to be accompanied by information on parenting and adopting under the Act (section 5(b)(ii)). Women facing a crisis pregnancy generally have three choices; continuation of the pregnancy (in ~ 60% of cases they choose this), abortion (~20%) and adoption (less than 1%). In our experience women are very well aware of their options and it is disrespectful of them to suggest that they 'need to be told' of these options. In the context of a crisis pregnancy, women should have non-directive counseling, support and compassion available to them, if they want these services. This Act limits the ability of Irish GPs and other health professionals to give appropriate non-directive support. Clinicians should be left to address the needs of their patients without being required to bring up options in a manner which is paternalist and patronizing at best, and which may be disturbing and upsetting for the woman in some circumstances.

Doctors are uncertain in their interactions with UK abortion providers (such as BPAS and Marie Stopes) as the scope of section 8, in apparently preventing direct referrals, is unclear. Doctors are proscribed from making an appointment or 'any other arrangement' with an abortion provider in another jurisdiction. This can negatively affect patient care. Doctors are frequently in the position of needing to contact abortion providers in the UK on behalf of women, often as a result of illiteracy, poor computer skills, inadequate coping skills and isolation. By contacting abortion providers directly and gaining information pertaining to travel, costs, accommodation, many doctors believe they would be supporting their patients in a clinically appropriate manner. Yet these actions could possibly fall within the scope of section 8. No health professional should be placed in this situation and DFC recommend removal of this censorship.

Even if the health of a pregnant woman is at risk (bleeding, pre-eclampsia etc.) it is still illegal under the Act for a doctor to refer such a patient to a clinic abroad. Similarly Irish obstetricians often feel unable to refer women, pregnant with an anencephalic fetus (that choose to proceed with an abortion), to the UK. That women, in the midst of an incredibly difficult situation, must self-refer and arrange this procedure in isolation, with little support from the Irish medical profession, is harmful and absurd. These barriers to care stigmatise the patient, isolates her from the health services and can cause detrimental health effects.

Conclusion

Our professional expertise and experience indicates clearly that Irish women's Covenant rights are not being respected, promoted or fulfilled in the context of reproductive decision-making and access to abortion care. DfC will continue to ask the state to be more proactive in implementing women's sexual and reproductive rights. As Professor Veronica O'Keane (2013) argued before the Hearings "Irish women have often been portrayed as passive, unreliable and sometimes manipulative. This language should be recognized as obstructive". We ask the Human Rights Committee to assist Irish civil society in its ongoing struggle to hold the state accountable for the protection of women's rights to life, freedom from cruel, inhuman and degrading treatment, conscience, equality and privacy, as recognized persons before the law.

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