SUBMISSION OF THE PRO LIFE CAMPAIGN TO THE 55TH SESSION OF THE COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

The Pro Life Campaign (hereafter called "PLC") welcomes the opportunity to make this submission to the Third Periodic Review of Ireland under the International Covenant on Economic, Social and Cultural Rights.

The PLC makes its comments as the group largely responsible for promoting the insertion into the Irish Constitution of Article 40.3.3. This provision, also known as the 8th Amendment, was inserted by a majority of the Sovereign People of Ireland, and 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."

The PLC has been to the forefront of contributing to the ongoing debate on the human rights of all members of Irish society for over 30 years. As a single-issue organisation, the PLC restricts its comments to matters concerning the right to life and as such, focuses on Articles 3 and 12 of the Covenant.

prolife campaign

Suite 60, Clifton House,
Lower Fitzwilliam Street,
Dublin 2
01 6629275
info@prolifecampaign.ie
www.prolifecampaign.ie

prolifecampaignireland
@prolifecampaign

Introduction

In the course of its work in the monitoring and advancement of human rights law in Ireland, the PLC has sought at all times to ensure that the dignity and innate worth of every human being in Irish society is recognised and defended, regardless of age, creed, ability or social standing. As such, the PLC submits that all rights and obligations attributed to Ireland from the Committee's List of Issues must be viewed from the perspective that the first right to be acknowledged is the inalienable right of every human being to their own life. Without this right, all other rights are meaningless.

This is in keeping with Article 3 of the Universal Declaration of Human Rights, which reads:

"Everyone has the right to life, liberty and security of person."

And again, Article 2.1 of the European Convention of Human Rights, which reads:

"Everyone's right to life shall be protected by law. No-one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."

Ireland has, through its laws, culture and Constitution, recognised and acknowledged that the right to life of every human, born and unborn, is the starting point and foundation from which every other right emanates. It is from this point that the following comments are made.

This model arises from the sincerely held conviction of a majority of the Irish population that the law should protect both mother and child and that while women should receive whatever medical treatment they need while pregnant, the life of their unborn child should also be protected, insofar as this is possible. It is important that ethical distinctions are made at all stages when discussing abortion and its impact on society, particularly where there is mention of "termination of pregnancy" or the need for abortion "where there is a real and substantial risk to the life of the mother."

Regarding the phrase "termination of pregnancy", it is important to remember that all pregnancies are terminated. Most of them terminate with the birth of a normal healthy baby. Some unborn babies die as an unavoidable and unintended result of some life-saving treatment of the mother.

Furthermore, some babies die, in spite of the very best efforts of all involved, as a result of being born too early: such births may occur spontaneously or may be induced in cases where it represents the only, albeit very low, chance of survival for the baby.

Clearly then, there is a huge ethical distinction between necessary medical interventions in pregnancy where the baby may be exposed to some risks, and induced abortion where the life of the baby is directly and intentionally targeted.

It is always the case that when this distinction is included in opinion polls on the right to life issue in Ireland, the Irish public consistently responds overwhelmingly in favour of retaining constitutional protection for the unborn while at the same time ensuring that women receive whatever medical treatment they need during pregnancy.

Article 3

The Covenant provides for the "equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant."

Part 1 – Inequality towards women

It is submitted that the enactment of the Protection of Human Life in Pregnancy Act, 2013, (hereafter called "the 2013 Act") significantly impairs the ability of women to engage fully with their rights under this Article.

In particular, it is submitted that the 2013 Act puts women at a severe disadvantage if they suffer from suicidal ideation during pregnancy by providing for a right to abortion during the full nine months of pregnancy if there is a threat of suicide.

This right is specified in Section 9 of the Act, which provides that it shall be lawful to carry out an abortion where **"three medical practitioners, having examined the pregnant woman, have jointly certified in good faith that -**

(i) there is a real and substantial risk of loss of the woman's life by way of suicide, and

(ii) in their reasonable opinion, that risk can only be averted by carrying out that medical procedure."

It is submitted that there are serious issues with this Act, and in particular the state-sanctioned provisions allowing for abortion where there is a risk or threat of suicide.

The 2013 Act was preceded by two sets of All-Party Oireachtas Hearings in January and May 2013 (hereinafter "the Hearings") At no time during these Hearings was it claimed or shown to be the case that abortion is a treatment of any kind for suicidal ideation.

In his evidence to the Hearings, perinatal psychiatrist Dr. John Sheehan made the following remarks:

"The notion of carrying out an emergency termination is completely obsolete in respect of a person who is extremely suicidal...In such situations, one can see clearly the intervention usually is to admit such people into hospital, day hospital or home care but the intention is to support and help them through the crisis they are in. It is not to make a decision that is permanent and irrevocable."

There is significant evidence worldwide to support the assertion that abortion is in no way beneficial to a woman suffering from suicidal ideation during pregnancy, and in fact the abortion procedure may be harmful to her mental health.

The Fergusson Study (2008)[1] quotes as follows:

"In general, there is no evidence in the literature on abortion and mental health that suggests that abortion reduces the mental health risks of unwanted or mistimed pregnancy. Although some studies have concluded that abortion has neutral effects on mental health, no study has reported that exposure to abortion reduces mental health risks."

The evidence adduced at the Hearings showed that abortion is not medically indicated as a treatment in the case of threatened suicide in pregnancy. It is also clear that some peer-reviewed studies confirm the testimony of many post-abortive women that abortion itself heightens the risk of future mental health problems. An example is the comprehensive longitudinal Finnish study [2] which shows that women who have abortions are more likely to end their lives through suicide than women who continue with their pregnancies.

Over 100 consultant psychiatrists also objected to the enactment of the 2013 Act on the grounds that abortion is not a treatment for suicidality. [3]

It is clear then, that on the basis of this evidence, women and men are being offered divergent paths in the treatment of suicide. Where men are concerned, the treatment path will remain as it stood before the enactment of the 2013 Act i.e. they will be treated using the norms that have been established by the experience of the international psychiatric community and its peer-reviewed evidence.

Women will however be at a dangerous disadvantage. If presenting with suicidal ideation during pregnancy, the 2013 Act dictates that they may be offered the alleged "treatment" of abortion. This is notwithstanding the fact that there is no evidence whatsoever, from anywhere within the international medical or psychiatric community, to support same.

It is submitted that in addition to placing women in a dangerous situation medically, this provision of the 2013 Act also hinders the advancement of equality generally. Women are hampered and prevented from accessing a true assessment of their psychiatric needs, solely on the basis of their pregnancy, which directs their medical team towards the 2013 Act. This would not be the case for men suffering from suicidal ideation, who are as a result provided with superior health care.

1 David M. Fergusson, L. John Horwood and Joseph M. Boden, "Abortion and mental health disorders: evidence from a 30-year longitudinal study", British Journal of Psychiatry (2008), 193, pp 444-451

2 Gissler, M, et al., "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987 – 2000," European Journal of Public Health, Volume 15, Issue 5, 2005, pp. 459 - 463

3 http://prolifecampaign.ie/main/statement-by-consultant-psychiatrists-expressing-concern-with-government-plans-on-abortion/

Part 2 – Inequality towards the unborn child

The 2013 Act does not go far enough to protect and defend the equal right to life of the unborn child, as recognised by the Irish People in Article 40.3.3. This is an inalienable right under the Constitution and one which the State has guaranteed to respect, and as far as practicable, by its laws, to defend and vindicate.

By allowing abortion to take place during the full nine months of pregnancy where there is a risk of a threat of suicide, the Irish Government has inserted a condition on the Statute books which is without medical evidence to support it.

The 2013 Act means that an abortion can be certified by two psychiatrists and an obstetrician. Not only does this place the unborn child at huge risk from a flawed and dangerous law, it places immense pressure on the medical profession in Ireland.

Psychiatrists are expected to certify an abortion in the absence of medical evidence.
Obstetricians are expected to give the go-ahead to a procedure that may lead to an unborn child being delivered at a stage where they are not sufficiently developed and as a consequence will have serious medical issues for the duration of their lives. In the worst case scenario, they may not survive. This is unacceptable and contrary to the aim of accepting all human life.

Article 12

The Covenant provides for a range of healthcare services under Article 12. Unfortunately, the actions of the Irish Government in 2013 have taken Ireland further away from achieving compliance with some aspects of the Article.

Article 12.1

Article 12.1 notes that State Parties **"recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."**

Physical Health

In a very real way, the 2013 Act has damaged the high standard of care that had been the norm in Ireland. It is noted that Ireland has consistently been a world leader in protecting women during pregnancy.

"Trends in Maternal Mortality 1990 to 2010, WHO, UNICEF, UNFPA and the World Bank: Estimates, (2012)", [4] which compares maternal mortality rates around the world according to the same criteria and using the same method over a twenty year period, looks at this issue.

It finds that over the period in question, Ireland is in the joint fifth group of safest countries in the world for women in pregnancy with an average maternal mortality rate of 6 maternal deaths per 100,000 live births. Over this period, Ireland's maternal mortality rate was half that in Britain and under a third that in the US. Over the same period, our maternal mortality rate fell by 12% while the rate in Britain rose by 23% and in the US rose by 65%.

This was an outstanding achievement for Irish medical practice, making Ireland's maternal mortality rate a striking testament to the appropriateness of the principle underlying the practice of Irish medicine in relation to women in pregnancy, in stark contrast to the dramatically poorer records of Britain and the US, both of which have wide-ranging abortion regimes.

These figures were available to the Irish Government during the Hearings. Recently, there have been discussions regarding the current rates. Attempts to cast doubt on Ireland's rate by comparing the report quoted above with a report drawn up using different parameters fail for a number of reasons. Firstly, reports can only be fairly considered when like is compared with like. Secondly, even in the comparisons made, Ireland was still shown to rank higher with no legalisation of abortion, than Britain with its wide-ranging abortion availability. And thirdly, because until a table for all states is compiled using the new parameters, we won't know what difference it will make to the overall ranking.

Savita Halappanavar

Doubts were understandably raised on the safety of Ireland in the wake of the Savita Halappanavar tragedy. There are a number of points which should be made at this juncture in order to ensure that Ireland's medical profession is not unfairly castigated as a result.

In the wake of Ms. Halappanavar's death, there was considerable discussion around the fact that she died due to the fact that abortion was not legal in Ireland. Three separate independent investigations were carried out into her death. None of them highlighted the lack of abortion as a causal factor.

As is clear from the recommendations of the Coroner's Inquest, the exhaustive investigation of the sequence of events that led up to her death established that the actual cause of her death was infection with a virulent anti-biotic resistant strain of E. Coli compounded by a series of systems failures that delayed the realisation by the medical team of the gravity of the risk to her life, and the timely implementation of the appropriate responses to it.

Going further, the HIQA Report recommended the "development and implementation of a National Maternity Services Strategy", making a series of 34 recommendations for implementation.

It is submitted that what was required in the aftermath of Ms. Halappanavar's death was clarity of the law, and this could have easily been achieved through re-statement of existing medical practice under the two patient model, and the provision of guidelines for the treatment of sepsis.

[4] Trends in Maternal Mortality 1990 to 2010, WHO, UNICEF , UNFPA and The World Bank: Estimates, (2012) http://whqlibdoc.who.int/publications/2012/789241503631_eng.pdf

Mental Health

There has already been some discussion in this submission on the issue of how the 2013 Act distorts and destroys the appropriate treatment of women suffering from suicidal ideation in pregnancy. The matter becomes more pressing when viewed through the lens of Article 12.1, and the requirement of State Parties to ensure that their laws provide ease of access to the enjoyment of the highest attainable standard of mental health. Under the 2013 Act, this is clearly not possible for women.

Concerns were expressed the Hearings by Dr. Sam Coulter Smith, Master of the Rotunda Maternity Hospital, who said:

"There are significant concerns in all areas of the medical profession in relation to this Bill when it comes to suicidality. Our overriding concern relates to the lack of evidence to show that termination of pregnancy is an appropriate treatment for women who are deemed to be at risk of suicide. As obstetricians we are expected to practice evidence-based interventions and first and foremost to do no harm" [5]

At a more fundamental level though, the case can be made that the 2013 Act will disrupt the treatment of suicide in Ireland generally and not just when pregnant women are affected.

This all-encompassing aspect has been highlighted in a recent book [6], where the authors make the point that the 2013 Act is based on no less than "four shaky assumptions":

- Suicide risk among pregnant women, described as "remote".
- The inability of doctors to adequately predict suicide among pregnant women or anyone else.
- The fact that abortion has not been proven to be an adequate treatment for suicide ideation.
- The question of whether this reason for an abortion would be exploited under the law. [7]

The authors make a final point in the conclusion to their section on the 2013 Act which is of note here:

"There are consequences, however, to the state sanctioning an inaccurate understanding of suicide, which should concern all of us. Can we reasonably expect the state to introduce other evidence-based policies that relate to suicide when, on this occasion, evidence was at best not taken sufficiently into account and, at worst, blatantly ignored?"

This worrying question widens the debate on abortion in the area of suicidality. Irish society is making huge strides in terms of developing support structures to cope with what has become a growing suicide problem. The 2013 Act stands in stark contrast to that new wave of hope. It cannot be said to be contributing in any way to the "highest standard of care" envisaged by Article 12.1.

5 Dr. Sam Coulter Smith, Master of the Rotunda Maternity Hospital, Oireachtas Hearings, Friday, 17th May 2013

6 "Suicide: A Modern Obsession", Derek Beattie and Dr. Patrick Devitt, Liberties Press 2015

7 Britain's biggest abortion provider, the British Pregnancy Advisory Service, openly admits "it is not the case that that majority of women seeking abortion are necessarily at risk of damaging their mental health if they continue their pregnancy. But it is significant that, because of the law, women and their doctors have to indicate that this is the case." – Abortion Review, 2nd May 2012, http://www.abortionreview.org/index.php/site/article/963

Abortion Regret and the Negative Effect on Women

It is also noted that the most recent reports of the numbers travelling to the UK to avail of abortion services there, released by the Department of Health [8] indicates that the rate is falling, a pattern which has been the case for over ten years.

In 2013, 3,679 Irish women travelled to England and Wales for abortions, down from 3,982 in 2012, a 7.6% decrease. 2013 is the twelfth consecutive year that Irish abortions have declined and this represents a 44.8% decline since the high of 6,673 abortions in 2001.

While each abortion represents a distinct personal tragedy for the mother and baby involved, the decline in numbers must nonetheless be welcomed. Even though it is difficult to draw firm conclusions, it is also notable that a recent report from the HSE/Crisis Pregnancy Programme [9] showed an increase in the number of women expressing abortion regret. In that study, 44% of women expressed varying degrees of regret about their abortions up from 33% in a similar HSE study in 2003.

The question of abortion regret must also be considered in the context of ensuring that women avail of the highest standard of medical care. Irish abortion recovery groups like Women Hurt [10] have sought to spread the message that grief and pain following abortion is a natural reaction in the wake of such a traumatic and life-changing event but that recovery is possible.

It is becoming more and more clear that abortion is itself a damaging event for a woman and one from which she may need to spend a considerable amount of time recovery. As such, it should not be placed in the bracket of "medical care" but rather falls within the definition of "harm". As such, it is submitted that there should be no question of the State promoting abortion in any way, either through its cultural influences or legislation.

It is submitted that in the light of all of the prevailing evidence about the negative effects of abortion on women, the willing promulgation of abortion as a form of pseudo-healthcare would amount to severe negligence where the welfare of women is concerned.

Abortion and the question of "torture"

In addition, concern is expressed at any suggestion that a failure to legalise abortion amounts to "torture". It is noted that this assertion has been made by organisations actively canvassing for the introduction of abortion. It is deemed only appropriate that this accusation should be addressed at this time.

The concern to protect women and babies finds its outlet in the 8th Amendment of the Constitution. To suggest that this concern is, in any way, similar to any kind of torturous practice, is obscene and a subversion of the normal desire of the State to protect its born citizens and those of unborn human beings living on the cusp of citizenship and all of the benefits it brings.

Attention is drawn to the genuine cases where "abortion" and "torture" can genuinely be connected, namely the barbaric practice of babies born alive and left to die followed so-called "botched abortions". The PLC points to the **Confidential Enquiry into Maternal and Child Health, 2007**,[11] commissioned by the UK Government, where it was discovered that 66 infants survived National Health Service termination attempts in hospitals in England and Wales during 2005. Instead of dying during the abortion procedure as intended, they survived and were able to breathe unaided but received no medical attention or care and were left to die. Official records show that one of these babies survived for 10 hours.

This is no gold standard of medical care. Concern is expressed that should Ireland be pressurised to adhere to the mistaken belief that abortion should be further legalised, similar human rights abuses would follow and the achievement of the aims set out in Article 12 would slip further and further away.

[8] Summary Abortion Statistics, England and Wales: 2013.

[9] Irish Contraception and Crisis Pregnancy Study 2010 (ICCP 2010), published in May 2012 (HSE/CPP)

[10] www.womenhurt.ie

[11] Confidential Enquiry in Maternal and Child Health, 2007, 2010

Article 12.2 (a)

Article 12.2 (a) requires State Parties to carry out such steps as may be necessary to achieve **"the reduction of the still-birth rate and of infant mortality and for the healthy development of the child".**

This aim is severely hampered by the provisions of the aforementioned 2013 Act, which allows the early delivery or abortion of the unborn child for the full nine months of pregnancy where there is a threat of suicide. As has been discussed, this Act is not supported by any medical evidence and the provisions are so far removed from the aim of Article 12.2 (a), namely to ensure **"the healthy development of the child"**, that they cannot be considered to be in line with the concept of a true model of human rights law in any way.

Concerns were raised in the Hearings on this point, notably by Dr. Sam Coulter Smith, Master of the Rotunda Maternity Hospital:

"The fact that there is no gestational limit in respect of the third scenario relating to suicidality is a major ethical issue for obstetricians.... (who are) faced with an enormous ethical dilemma." [12]

Concerns were also expressed at the involvement of obstetricians in the ending of unborn human life under the proposed legislation in the case of a risk of threatened suicide where this action was not supported by any medical evidence:

"I am not certain how a psychiatrist can reach a decision on this matter where to date I do not believe any evidence has been produced...I am extremely concerned as an obstetrician that I would be drawn into a situation in which a termination of pregnancy will be done for psychiatric reasons without very clear evidence that this is to the patient's benefit." [13]

- Dr. John Monaghan, Consultant Obstetrician, Portiuncula Hospital, Galway.

Nothing more than a cursory consideration is given to the rights of the unborn child in the 2013 Act and this is borne out by the fact that even though the certification of two psychiatrists and an obstetrician is required, in reality the two psychiatrists will make the final decision. If they are in agreement, the obstetrician's opinion will be redundant. There is no requirement on the psychiatrists to produce evidence to support their opinion that an abortion is required to treat the woman in question. Indeed, no such evidence exists and this has already been shown at the Oireachtas Hearings. The life and development of the unborn child can be arbitrarily interfered with in this way and it is unconscionable that this situation should be allowed to continue.

In this context also, the PLC points to the disturbing vista allowed by the 2013 Act, whereby the Act provides that if a mother presents at the "fringes of viability", the baby should be delivered early and rushed to an intensive care neonatal unit.

This amounts to nothing more than a pretence at a duty of care to the baby and an overall injustice to his or her wellbeing. Inducing pregnancy at the fringes of viability severely impacts on the baby's development. She is exposed to brain damage, blindness or loss of life itself. The intervention can be made in the full knowledge that the consensus of psychiatric evidence is that the termination of pregnancy would confer no benefit on the mother.

Proposing legalisation in the case of sexual assault or babies with life-limiting conditions

Abortion is not healthcare. Abortion is life-ending, not life-saving. The Committee will be aware of various campaigns by groups seeking to introduce abortion in the case of rape, incest and for other exceptions such as babies diagnosed with a life-limiting condition or terminal illness.

[12] Health Committee Submissions, May 2013
[13] Health Committee Submissions, May 2013

Part 1 – Babies diagnosed with life-limiting conditions

In the case of babies with specific disabilities or special needs, the introduction of abortion would move Ireland further away from compliance with the requirements of the Covenant. Ending the life of an unborn child because of a disability does not equate to the provision of "all medical service and medical attention in the event of sickness", as per Article 12(d). It is submitted instead that further work must be done in the area of perinatal palliative care in order to ensure that all families can avail of the support and care that they and their families need during times of great stress.

The manner in which we address the needs of families of babies diagnosed with life-limiting conditions goes to the heart of the value we place on unborn life and the care we give to pregnant women in deeply distressing situations. It is important that there is a real reflection with understanding and compassion as policy is determined to address these difficult cases.

• Babies with life-limiting conditions ("lethal foetal abnormality")

It is at times proposed by organisations supporting further liberalisation of the abortion law in Ireland that certain conditions exist which the medical profession can determine are 'not compatible with life after birth' (the example being given of cases of anencephaly, in which there is a failure of the brain and top of the skull to form properly).

It is submitted that the introduction of abortion in these cases would represent a failure to interrogate the medical assumptions on which such a proposal relies. Morevoer, it would mean that we are overlooking any approach other than termination of pregnancy to address cases where a baby is diagnosed with a life-limiting condition. This is regrettable. In this submission, we endeavour to redress the balance.

• Terminology – and the facts

The word 'lethal' is clear in its meaning – that it causes death. Notwithstanding that it is used in clinical practice to convey the poor condition of the unborn child, the concept of lethality has come in for considerable criticism in recent years. A review of the international medical literature reported in the British Journal of Obstetrics and Gynaecology in 2012 revealed 'no agreed definition of a 'lethal fetal or congenital malformation" and no agreed list of conditions that might fit this description.[14] The malformations most commonly cited in lists of lethal abnormalities are not actually lethal in the strict sense, ie they do not invariably cause death in utero or in the newborn period regardless of attempted supportive treatment. Prolonged survival has been reported in all of the conditions usually described as lethal. Regarding the anencephaly examples given by the Department, studies have reported over 70% live births of offspring conceived with anencephaly.[15] Cases have been reported of survival to 10 months and 2.5 years.[16] Cases of prenatal diagnosis of Trisomy 18 and 13 have been cited as examples of lethal abnormalities in debate about the criteria for availability of termination of pregnancy in this jurisdiction. Survival of individuals with these conditions has been reported to 50 and 27 years respectively.[17] Children who survive with these conditions have been reported to show awareness of people around them, to react to sound and to learn and remember.[18]

If these are the facts, one must ask why some prominent medical practitioners use such unhelpful terminology and even advocate the availability of termination of pregnancy in these circumstances. Many reasons have been offered. One suggestion is that medical practitioners may be ignorant of the facts. A survey of obstetricians in Australia, New Zealand and the UK regarding the survival of offspring with Trisomy 18 supports this view.[19] Practitioners may also be uncomfortable with uncertainty, or may feel that it might be easier for women to choose termination of pregnancy or palliative care if they believe that survival of the unborn child is impossible. Wilkinson and others also observe, somewhat chillingly, that practitioners may be aware that death of the unborn child is not inevitable, but believe that it will not have a life worth living.[20] Thus the use of this terminology may be laden with value judgments of medical practitioners, and mislead couples about the prognosis of an unborn baby with grave abnormality.

In summary, the use of terminology like 'lethal' or 'fatal' foetal abnormalities 'is used for a heterogenous group of conditions to imply an ethical conclusion rather than to present a clear prognosis: it obscures rather than aids communication and counselling.' [21] This terminology diminishes, if not removes entirely, the ability of a woman in these circumstances to make informed decisions about the management of her pregnancy and care of her unborn child.

The introduction of abortion where a poor pre-natal diagnosis is made severely limits the ability of unborn human beings to be treated in accordance with accepted norms.
The medical literature demonstrates that life-prolonging treatments might indeed be inappropriate for some of these unborn babies following birth, in cases where the burden of treatment would cause suffering to the offspring which would outweigh any benefit which the treatment might produce. Equally, treatment aimed at prolongation of life including intensive care might be appropriate, depending on the circumstances. These decisions are made on the basis of information which is available following the birth of these unborn babies.

It is sometimes proposed by abortion advocates that the lives of these babies should be ended because they are seriously abnormal. Their lives may well be short. Medical practice on this island has been to care for both patients as far as is practicable, and to strive for natality rather than mortality. Abortion would represent more than non agressive management of these unborn babies, and more than the deliberate hastening of their demise. Further, it would lead to deliberate foeticide on the basis of assertions by ill-informed medical practitioners. This would constitute a radical departure from the doctor's primary duty to do no harm, and from the duty to practice evidence based medicine insofar as is possible.

It is timely to mention perinatal palliative care at this juncture. Where it is clear that a baby will have a very short time to live, perinatal palliative care offers a safe and caring environment for the couple and their baby.

14 DJC Wilkinson and others, 'Fatally flawed? A review and ethical analysis of lethal congenital malformations' (2012) 110(11) British Journal of Obstetrics and Gynaecology 1302-1307.

15 Monika Jaquier, Report about the birth and life of babies with anencephaly' (2006), www.anencephalie-info.org/e/report.php, accessed 17 January 2015; M Jaquier, A Klein, E Bolthauser, 'Spontaneous pregnancy outcome after prenatal diagnosis of anencephaly' (2006) 113(8) British Journal of Obstetrics and Gynaecology 951-953.

16 G McAbee and others, 'Prolonged survival of two anencephalic infants' (1993) 10 American Journal of Perinatology 175-177; TK Koogler, BS Wilfond, LF Ross, 'Lethal language, lethal decisions (2003) 33 Hastings Centre Report 37-41.

17 B Bhanumathi, N Goyel, Z Mishra, 'Trisomy 18 in a 50-year-old female' (2006) 12 Indian Journal of Human Genetics 146; Y Yunca, J Kadandale, E Pivnick, 'Long-term survival in Patau syndrome' (2001) 10 Clinical Dysmorphology 149. Futher examples, including in cases of other foetal conditions usually described as lethal are described in the Wilkinson paper, n 6 supra.

18 M Barr, MM Cohen, 'Holoprosencephaly survival and performance' (1999) 89 American Journal of Medical Genetics 116-120; LJ Fenton, 'Trisomy 13 and 18 and quality of life: treading softly' (2011) 155A Americal Journal of Medical Genetics 1527-1528; B Yorgason, One Tattered Angel: A Touching True Story of the Power of Love (Shadow Mountain 2003).

19 DJC Wilkinson and others, 'Perinatal management of trisomy 18: a survey of obstetricians in Australia, New Zealand and the UK' (2014) 34 Perinatal Diagnosis 42-49.

20 n 6, 1305.

21 ibid, 1302.

• Perinatal palliative care

"Perinatal hospice care is an innovative and compassionate model of support offered to parents who find out during pregnancy that their baby might have a life limiting condition. This style of care aims to help parents embrace whatever time they may have with their baby before and after birth. The support begins at the time of diagnosis like a "hospice in the womb". This is not necessarily a place but it is a frame of mind. It can be easily incorporated into standard pregnancy and birth care as a comprehensive team approach." [22]

There is currently no formal country-wide perinatal palliative care protocol in place for dealing with families in the difficult situation where their baby has been diagnosed with a life-limiting condition in the womb.

At their recent AGM (April 2015), the Irish Medical Organisation (IMO) passed a motion calling on the Minister to **"bring forward proposals and make provision"** for access to perinatal palliative care in Ireland.

The PLC recommends the organisation and development of an integrated palliative care service for children with life limiting conditions and their families involving both statutory and voluntary providers, and including the delivery of care in all settings. Apart from the clinical care, there are lots of other elements that can provide support and help for families. Something as small as putting a sticker on the front of a patient file (a butterfly or a star) that alerts the health care workers that are dealing with the pregnant woman to the pre-natal diagnosis so that she and her family can be dealt with sensitively. Longer scans can be included where siblings and grandparents are included. Appointments can be set at times where parents are not surrounded by other parents of healthy babies.

Though the lives of children diagnosed with pre-natal conditions may well be short, medical practice in Ireland has been to care for both patients as far as is practicable, and to strive for natality rather than mortality. In this context a developed strategy for perinatal palliative care is key.

Perinatal palliative care is the gold standard and a policy should be formally established that would offer the highest standard of care in every Irish maternity hospital. Where it is clear that a baby will have a very short time to live, perinatal palliative care offers a safe and caring environment for the couple and their baby. This must be agitated for.

Some babies diagnosed prenatally with terminal illness will live only for a few minutes, hours, or days. Families should be informed about perinatal palliative care and be offered contact details of parents who have had similar experiences so that they can lean on and support one another. Families who have had the advantage of perinatal palliative care feel that the support and care that was given to her and her family in the hospital from the point of prognosis to birth brought the positives of the experience of the short life and death of her child to the fore. It made it easier to deal with the sad reality that the child would die and made the grieving that bit easier.

Baby Teddy Houlston:

Some babies are born healthy and go on to live long lives in the company of their loved ones. Some, like Teddy Houlston, are life-savers at birth. Baby Teddy became the youngest organ donor in the UK in 2014 when he was diagnosed with anencephaly. Despite the fact that abortion is legal up to birth in the UK where the unborn baby has any disability, Teddy's parents decided against it. Instead, they made the courageous decision to donate their son's organs when he passed away shortly after birth. Teddy's kidneys were then used to save the life of an adult. Teddy's story is a reminder that everyone can achieve something amazing during their life, no matter how short that life may be. His life-saving act has since inspired another couple in Northern Ireland whose baby girl has also been diagnosed with anencephaly. They have decided to continue with their pregnancy, meet their baby and make memories with her for as long as they can and, allow her to become a lifesaver like Teddy by donating her organs if and when she passes away.

22 www.perinatalhospice.org

Part 2 – Sexual Crimes

The PLC does not endorse an abortion as a 'solution' to the tragedy of a sexual assault on a woman, which results in pregnancy.

The PLC believes that to offer an abortion in such circumstances ignores the fact that it involves the taking of an innocent unborn life and the exposure of the women to emotional hurt and possible psychological harm. The reality is that our willingness to offer social support is the single most important factor influencing a better psychological outcome for women in crisis after a sexual assault.

There are very few peer reviewed studies on pregnancy following sexual assault but a study by Sandra Mahkorn [23] called Pregnancy and Sexual Assault showed that there is a better social and personal outcome for women who chose to continue a pregnancy, despite harrowing initial circumstances. Recent peer reviewed studies from Finland and New Zealand, [24] [25] to name just two, also show a better outcome for women who continue their pregnancy compared to women who opt for abortion.

The landmark Roe v Wade decision, which legalised abortion in the United States, is a very clear example of how abortion advocates uses emotive cases simply to promote abortion. Ms Norma Mc Corvey (Jane Roe from Roe v. Wade) admits she was exploited by pro-abortionists at the time and now campaigns publicly against abortion.

Punishing the rapist not the child

If we are to be truly concerned about protecting women we would seek stronger sentences for rapists and real justice for those who are victims of rape. Rape is an unimaginable and horrendous crime – however we do not suggest ending the life of an innocent to rectify any other crime.

23 Mahkorn S: Pregnancy and Sexual Assault. In Psychological Aspects of Abortion Mall and Watts (eds) 5:

24 Gissler M. et.al., "Injury, Deaths, Suicides and Homicides Associated With Pregnancy, Finland, 1987 - 2000", European Journal of Public Health; Vol.15 (5):459-463, 2005.

25 Fergusson et.al., 'Abortion in young women and subsequent mental health,' Journal of Child Psychology and Psychiatry 47:1 pp 16-24, 2006

Conclusion

As a society, we cannot claim to be true defenders of human rights unless we also protect the right to life of unborn babies. What's at stake in this debate is the value of life, and the sad experience is that once laws permitting abortion are introduced, they diminish the society's respect for the inherent value of every human life, born or unborn.

There is an unceasing challenge on law makers and society at large to create a more welcoming and inclusive environment for expectant mothers and their unborn children. By all means, let us debate these issues openly, honestly and with all the facts in front of us. But equally, we cannot shy away from the implications and brutal reality of what legal abortion entails for the mother and her unborn child.

Part 1: The lessons of the recent past

• It is clear that the attempt to address Ireland's issue of unplanned pregnancy through the 2013 Act has failed. Women and their babies have been left in a severely unequal and dangerous situation as a result.

• The desire of the Irish People to retain constitutional protection for the unborn has endured and is met with their equal desire to ensure that women receive whatever medical treatment they need while pregnant.

• The pressing requirement for a meaningful response to the needs of families whose babies are diagnosed with life-limiting conditions has been highlighted recently by the Irish Medical Organisation which has requested that proper palliative care be put in place.

Part 2: Recommendations

• The repeal of the offensive and contraindicated sections of the 2013 Act, and the enactment of legislation that will ensure that women suffering from suicidal ideation in pregnancy will receive treatment to the same high, peer-reviewed standard as that afforded to men suffering from similar mental issues. Such legislation must recognise the ethical duty of care owed to the unborn as living members of Irish society, both in recognition of their rights and of the desire of the Irish People as expressed through Article 40.3.3.

• The continued protection of Article 40.3.3 and the defence thereof by the Irish Government, abiding by its duty to respect the will of the Irish People.

• The putting in place of proper perinatal palliative care as requested by the Irish Medical Organisation, in discussion with various family groups who have highlighted and expressed the need for this support structure.