
# *Valuing All Human Life*

**Submission of the Pro Life Campaign to The All-Party Oireachtas Committee on the Constitution.**

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# *Introduction*

The All-Party Oireachtas Committee on the Constitution is charged with reviewing the issues raised and the solutions proposed in the Green Paper on Abortion within a constitutional perspective, considering the implications of the various proposals for the values on which the Constitution, and our democracy, are based.

The Pro-Life Campaign's Submission is based on the view that all human beings possess an equal and inherent worth by virtue of their humanity, not on condition of size, level of physical, emotional or mental capacity or development, dependence, race, ethnic origin, financial status, age, sex or capacity for interpersonal relationships.

Constitutional democracy is based on the equal and inherent value of every human life and the equality of all before the law. If these values are not respected, one simply cannot have a democratic society. Abortion, denies the equal inherent dignity and worth of the unborn and treats them unequally before the law. If the principle of equality is respected, then one cannot legalise abortion.

The aim of this Submission is to evaluate the options proposed in the Green Paper on Abortion, as requested by the All Party Oireachtas Committee, in terms of their compatibility with these values. To evaluate the seven proposals set out in the Green Paper, it is necessary to take up statements made in other chapters, so this Submission includes a section on the medical issues, one on the legal issues in which the seven options are discussed, and a section on the social context of abortion.

## *The social policy framework in which the issue of abortion should be addressed*

The All Party Oireachtas Committee on the Constitution's call for submissions on the Green Paper's seven options, involves the public in its deliberations, making it a defining moment for Ireland as a modern democracy. The needs of women and children facing crisis pregnancies present us with a profound challenge. The attitude we adopt to them shapes who and what we are and what we stand for as a people.

## *The public back support for women in crisis pregnancy*

People in Ireland today are fair-minded and generous - they see the need to change attitudes and social policies so that every woman facing a crisis pregnancy knows and feels she has real alternatives to abortion. As the recent Pro-Life Campaign/IMS poll found, there is a huge groundswell of public backing for the provision of an ample range of professional, practical and personal supports for them.

## *A referendum to protect the unborn will strengthen public*

***commitment to support for women in crisis pregnancy***

The Pro-Life Campaign believes that the public commitment to putting in place the supports women need will be strengthened by a referendum restoring adequate legal protection to the unborn. Polls show a consistent and substantial majority of the public support such a referendum.

Our Submission responds to the Green Paper on Abortion's review of the medical issues, showing that the legalisation of induced abortion is not needed to safeguard medical treatment of women, and surveys its discussion of the legal issues, in particular answering objections to Option One, a constitutional amendment to ban induced abortion.

The Pro-Life Campaign would welcome an opportunity to make an oral presentation to the All-Party Oireachtas Committee on the Constitution.

**Pro-Life Campaign**
30th November 1999

# *Chapter One: Pregnancy and Maternal Health*

## *Introduction*

In its introduction, as elsewhere, the language used by the Green Paper is unnecessarily confusing and inaccurate. The term *termination of pregnancy* is not an adequate term for induced or procured abortion. As everyone knows, all pregnancies are terminated - most with the normal delivery of a live healthy baby. It is in this sense that the term termination of pregnancy is used in some papers cited in the references found in the Green Paper.[1] Other cited papers speak of early termination of pregnancy in cases where foetal death has already occurred *in utero* - a perfectly correct use of the term that has no implications for induced abortion.[2] We strongly recommend that the Government adhere to the more accurate terms of *induced* or *procured* abortion where it is clear that the intent of the procedure is to procure, by means of the procedure, the death of the unborn child and where, furthermore, the survival of that child would constitute a failure of the procedure.

As indicated in the introduction, Ireland's maternal mortality rate is so low that it can hardly be improved upon. This, we suggest, makes it clear that there can be no grounds to support an argument of medical need for abortion to save women's lives.

The Green Paper quite rightly points out that there are anecdotal and case reports in the medical literature where an induced abortion was carried out with the intent of saving a woman's life. The Green Paper also rightly goes on to point out that there is no evidence to show that this was the only course of action open to the clinicians managing the particular cases and that, accordingly, it is unsafe to conclude that the woman's life could not have been saved by means other than by induced abortion. The mere fact that an induced abortion was carried out in particular circumstances is not evidence that it was necessary. This is particularly so when the source of the article or case report is a jurisdiction where induced abortion is an accepted fact of life and medical practice.

The Medical Council, the statutory body regulating the medical profession in

[1] For example Probst BD *Hypertensive disorders of pregnancy* Emerg Clin North Am 1994 Feb; 12(1):73-89 and Hsieh TT, Kuo DM, Lo LM, Chiu TH *The value of cordocentesis in management of patients with severe preclampsia* Asia Oceania J Obstet Gynaecol 1991 Mar;17(1):89-95

[2] For example Alsulyman OM, Castro MA, McGehee W, Murphy Goodwin T *Preeclampsia and liver infarction in early pregnancy associated with the antiphospholipid syndrome.* Obstet Gynecol 1996;88:644-6 and Elliot D, Haller JS,*Eclampsia: a paediatric neurological problem* J Child Neurol 1989;4:55-60

this country, has repeatedly affirmed that induced abortion is medical misconduct and that doctors have a duty of care to both the mother and her unborn child. In the 1998 Guide to Ethical Conduct and Behaviour it states unequivocally *'the deliberate and intentional destruction of the unborn child is professional misconduct'*.

## *Maternal Mortality*

The Green Paper notes an Irish study of maternal mortality which observed that the absence of the provision of induced abortion in this jurisdiction had not had any detrimental effect on our rates of maternal mortality. It is apposite to note that previous studies of Irish maternal mortality had reached the same conclusion.[3]

In this section the Green Paper also alludes to the fact that so called therapeutic abortion can itself be a cause of maternal deaths. In this regard it should be noted that the Report on Confidential Enquiries into Maternal Deaths in Britain for the triennium 1991-1993 reports 5 deaths directly attributable to legal induced abortion and a further 4 deaths from suicide and/or drug overdose in women who had had legal induced abortions within the previous year.

In the Report on Confidential Enquiries into Maternal Deaths in Britain for the following triennium 1994-1996 there was one death from the induced abortion procedure itself and a further 11 deaths associated with legal induced abortions. One death was a suicide, 2 deaths resulted from thrombosis/thromboembolism, one death each from myocardial infarction and from a ruptured ectopic pregnancy (after an induced abortion had supposedly been performed) and finally 6 deaths occurred in women who had so-called medically indicated induced abortion for cardiac conditions such as primary pulmonary hypertension and Eisenmenger's Syndrome.

A review of maternal mortality from induced abortion over a 15 year period in the United States found 240 woman died as a result of legal abortions: the main causes of death were sepsis, haemorrhage and anaesthetic complications. It is generally accepted that such deaths are underreported.[4]

## *Abortion Trends*

This analysis confirms what has been often noted in the debate about induced abortion: namely, that once legal induced abortion is introduced, for whatever reason, the number of abortions inevitably increases, as those who are tolerant of abortion will use the grounds established by law to fit the need of the particular case. If one can find a reason to abort 180,000 unborn children in any one year in Britain, then one can find a reason to abort any one.

## *Maternal Mortality and Termination of Pregnancy (meaning*

[3] Murphy J, O'Driscoll K *Therapeutic Abortion: the medical argument.* Ir Med J 1982 75:304-6.
[4] Herschel WL et al *Abortion Mortality, United States, 1972 through 1987* Am J Obstet Gynecol 1994; 171: 1365-72

***induced abortion)***

The first section here lacks clarity because of the confusing use of terminology as noted above. It is indeed normal practice to terminate a pregnancy in cases of severe pre-eclampsia and eclampsia but this termination is not an induced abortion but rather the delivery, by medical or surgical means, of a pre-term infant.

The definition of direct abortion as given in this section is both inaccurate and misleading. A direct abortion is not, as stated in the Green Paper, 'the termination of the pregnancy with the objective of preventing or treating the underlying maternal condition'. An example of such a termination of pregnancy would be the early delivery of an unborn child at, say, 27 weeks gestation, in order to treat severe pre-eclampsia in the mother. This child would have a greater chance of surviving following delivery than if the pregnancy were allowed to continue. A direct abortion is, in fact, a procedure, the aim of which is the death of the unborn child, whose continued survival, as noted above, would constitute a failure of the procedure.

The distinction between direct and indirect procedures for the purposes of abortion has already been set out in the Pro-Life Campaign's Submission to the Inter-Departmental Working Group on the Green Paper; Appendix D page 48. Briefly put, all treatments have side-effects. Some are major and life-threatening, some minor and merely irritating. In choosing the best treatment for any patient, a medical practitioner must choose the most effective and least toxic in terms of unwanted side-effects. However, in those situations where the illness is grave and life-threatening, the likely direct benefits of certain treatments may be held to outweigh the risk from unwanted side-effects. But, in those rare and difficult situations where a patient in fact dies as a consequence of an unintended side-effect of treatment it has always been understood by the profession, the patient's relatives, society and the courts that what was sought was the best outcome for the patient, not his death. It was not intended to kill him. For if this was not so clear, who in fact could ever practise medicine as doctors would be continually before the courts answering charges of assault and homicide? Such considerations apply equally strongly to an ill mother in pregnancy, be that illness a consequence of cancer, leukaemia or severe bleeding. To propose that abortion legislation is necessary in order to treat ill mothers where such treatment may result in the death or deformity of the unborn child is tantamount to suggesting that homicide be decriminalised so that doctors wouldn't be charged in respect of a patient's death, say, following major surgery. The idea of legal intervention by a third party to direct that treatment be otherwise than that dictated by good, modern medical practice is risible and irrelevant in a modern context.

***Cancer***

This section broadly represents and endorses the position taken by the Medical Council, Doctors for Life and the Pro-Life Campaign. It is, perhaps, worth re-iterating that chemotherapy and radiotherapy may be given to a pregnant

woman if required. The Green Paper makes the point that such treatments may have deleterious effects on the foetus but, with judicious choice of drugs and careful screening and more accurate radiation dosing and focussing, these effects can be minimised. For more extensive treatment of this issue and appropriate references we attach as Appendix 6 a paper on this topic prepared by Doctors for Life and included in their submission to the Inter-Departmental Working Group on the Green Paper.

### *Cardiac Disease in Pregnancy*

Improvements in diagnosis and surgical technique for correction have led to an increasing number of women with congenital heart disease reaching childbearing age. With one exception, there is no increased mortality associated with pregnancy in such conditions.[5] Eisenmenger's Syndrome is an eponym that is applicable to 12 different congenital cardiac lesions.[6] Recently published retrospective studies of the condition in both males and females indicate that most patients survive for 20 to 30 years, although they can lead adequate though symptomatic lives until late middle age or longer.[7]

As an indication of the rarity of the incidence of pregnancy in Eisenmenger's Syndrome, no more than a couple of hundred cases are reported in the whole of the world medical literature. For example, between 1991 and 1995, only 15 cases were identified in Britain.[8,9] In Ireland, only two cases have been identified in the past 20 years. It is readily acknowledged that pooling of data on rare medical conditions in pregnancy is required to aid management of individual cases.[10] The problem for many patients is that they are scattered as occasional clinical curiosities in practices and non-specialised clinics.[11]

Eisenmenger's Syndrome is a serious and generally life-shortening illness for which no surgical treatment is available. Early consideration of heart-lung or lung transplantation – the only significant interventions that are effective – may be required.[12] When carried out, pregnancy should not pose particular difficulties.[13]

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[5] Schmaltz AA, Neudorf U, Winkler UH: *Outcome of pregnancy in women with congenital heart disease*. Cardiol Young 1999 Jan, 9 (1): 88-96.
[6] Lieber S, Dewilde P, Huyghens L, Traey E, Gepts E: *Eisenmenger's syndrome and pregnancy*. Acta Cardiol 1985, 40 (4): 421-4.
[7] Somerville J: *How to manage the Eisenmenger syndrome*. Int J Cardiol 1998 Jan 5, 63 (1): 1-8.
[8] Chelsea and Westminster Hospital, London: *Eisenmenger's syndrome in pregnancy: maternal and fetal mortality in the 1990s*. Br J Obstet Gynaecol 1998 Aug, 105 (8): 921-2
[9] See, for example, Oakley CM, Nihoyannopoulos P: *Peripartum cardiomyopathy with recovery in a patient with coincidental Eisenmenger ventricular septal defect*. Br Heart J 1992 Feb, 67 (2): 190-2.
[10] Chelsea and Westminster Hospital, London: *Eisenmenger's syndrome in pregnancy: maternal and fetal mortality in the 1990s*. Br J Obstet Gynaecol 1998 Aug, 105 (8): 921-2
[11] Somerville J: *How to manage the Eisenmenger syndrome*. Int J Cardiol 1998 Jan 5, 63 (1): 1-8.
[12] Weiss BM, Atanassoff PG: *Cyanotic congenital heart disease and pregnancy: natural selection, pulmonary hypertension, and anesthesia*. J Clin Anesth 1993 Jul-Aug, 5 (4): 332-41.
[13] Chinayon P, Sakornpant P: *Successful pregnancy after heart-lung transplantation: a case report*. Asia Oceania J Obstet Gynaecol 1994 Sep, 20 (3): 275-8.

Given the rarity of the condition, its serious and life threatening nature and the very high risk of sudden death and death following any surgical intervention, it is hardly surprising that pregnancy is also associated with a high mortality. The only firm conclusion that such studies as have been carried out on patients with severe cardiac disease in pregnancy lead to is this: they should be treated in specialist tertiary referral centres. With care in such centres, it is expected that patients with Eisenmenger's Syndrome will have a 60-80%-plus chance of survival, while foetal survival is now expected to exceed 90%, compared with less than 60% in the past.[14,15] This situation may further improve with anaesthetic advances and heart lung transplants.[16]

It is furthermore clear, that induced abortion is also a hazardous procedure in these patients. As already noted, the Report on Confidential Enquiries into Maternal Deaths in Britain for the triennium 1994-1996 indicated that there had been 6 deaths during or following induced abortions performed because of maternal cardiac disease in that period. There is no evidence in the medical literature that justifies, on ordinary clinical and research criteria, induced abortion in heart disease in pregnancy. In this regard it is also apposite to note that there is no evidence from the annual reports of our maternity units that induced abortion would have altered the outcome in any pregnant woman with cardiac disease. Nor is there any evidence that Irish women with cardiac disease seek induced abortion in Britain on that account.

Nobody would deny that women with serious heart disease, especially Eisenmenger's Syndrome and primary or secondary pulmonary hypertension, should be cautioned about the risks inherent in pregnancy. Nevertheless, with careful cardiac and obstetric management in a tertiary referral centre better than heretofore maternal and foetal outcomes are now expected.[17,18,19,20] Wit improved anaesthetic[21,22] and intensive care the outcome should be better than ever before.

## *Ectopic Pregnancy*

[14] Gummerus M, Laasonen H: *Eisenmenger complex and pregnancy*. Ann Chir Gynaecol 1981, 70 (6): 339-41.

[15] Chelsea and Westminster Hospital, London: *Eisenmenger's syndrome in pregnancy: maternal and fetal mortality in the 1990s*. Br J Obstet Gynaecol 1998 Aug, 105 (8): 921-2.

[16] Weiss BM, Atanasoff PG *Cyanotic congenital heart disease and pregnancy: natural selection, pulmonary hypertension and anaesthesia*. J Clin Anesth 1993 Jul-Aug, 5(4): 332-41

[17] Weiss BM, Atanassoff PG: *Cyanotic congenital heart disease and pregnancy: natural selection, pulmonary hypertension, and anesthesia.* J Clin Anesth 1993 Jul-Aug, 5 (4): 332-41.

[18] Smedstad KG, Cramb R, Morison DH: *Pulmonary hypertension and pregnancy: a series of eight cases*. Can J Anaesth 1994 Jun, 41 (6): 502-12.

[19] Avila WS, Grinberg M, Snitcowsky R, Faccioli R, Da Luz PL, Bellotti G, Pileggi F: *Maternal and fetal outcome in pregnant women with Eisenmenger's syndrome*. Eur Heart J 1995 Apr, 16 (4): 460-4.

[20] Chia YT, Yeoh SC, Viegas OA, Lim M, Ratnam SS: *Maternal congenital heart disease and pregnancy outcome*. J Obstet Gynaecol Res 1996 Apr, 22 (2): 185-91

[21] See, for example, Goodwin TM, Gherman RB, Hameed A, Elkayam U: *Favorable response of Eisenmenger syndrome to inhaled nitric oxide during pregnancy*. Am J Obstet Gynecol 1999 Jan, 180 (1 Pt 1): 64-7

[22] Snabes MC, Poindexter AN: *Laparoscopic tubal sterilization under local anesthesia in women with cyanotic heart disease*. Obstet Gynecol 1991 Sep, 78 (3 Pt 1): 437-40.

Tubal gestations, which constitute up to 95% of ectopic pregnancies, do not consist of ongoing viable gestations, but rather are in the process of dying within a confined area. There are no official figures available for the rate in Ireland but reports in the medical press suggest that it is between 0.3% to 1% of all pregnancies. In the United States, the rate is 14 per 1000 pregnancies[23,24] and 11 per 1,000 pregnancies in Sweden.[25] The highest rate occurs in women over 35 years of age,[26] being three-fold higher than in the 15 to 24 age group. The mortality rate from ectopic pregnancy in the United States has fallen by over 80% over the past 20 years.[27] This fall in mortality is not age related but reflects a fall in the overall case fatality. In the past 25 years, there has been one death from ectopic pregnancy in Ireland out of an excess of 1.6 million births. No such death has been recorded for nearly 20 years.[28] Nevertheless, 12 such deaths death occurred in the last triennium examined by the Report on Confidential Committees of Inquiry into Maternal Death in Britain, where an induced abortion on request regime operates. One of these deaths was in a woman who supposedly had an induced abortion but subsequently collapsed and died: post mortem confirmed a ruptured ectopic pregnancy.

Patients with ectopic pregnancy (up to 90%) present because of tubal rupture or bleeding (in which cases emergency intervention is mandatory) or with tubal distension (caused mainly by bleeding into the original gestational sac).[29] Tubal gestations result in either foetal death followed by spontaneous resorption or tubal bleeding/rupture followed by foetal death. In either situation, the outcome for the pregnancy is the same. Hence the determinant of treatment is maternal outcome and the goal of treatment is control of haemorrhage and prevention of maternal mortality.
Thus, surgery has been the mainstay of treatment since the report of the firs successful surgical treatment in 1884.[30] Salpingectomy is the standard surgical treatment for tubal pregnancy regardless of the site of implantation.[31] Linear salpingotomy, making a linear incision in the fallopian tube and subsequently closing the incision, was first described in 1953.[32] Linear salpingostomy, where the linear incision is left open, is currently the preferred surgical method of treating uncomplicated (early-recognised) ectopic pregnancy. However, its use is limited, essentially to those clinical situations where the patient is haemodynamically stable and the tube is unruptured.[33] Systemic methotrexate

[23] Centers for Disease Control: *Ectopic Pregnancy: United States, 1981 - 1983*. MMWR 35: 289, 1986.
[24] Stock, RJ: *The changing spectrum of ectopic pregnancy*. Obstet Gynecol 71: 885, 1988
[25] Westrom L, Bengtsson LPH, Mardh P-A: *Incidence, trends and risks of ectopic pregnancy in a population of wome*n. BMJ 282:15, 1981.
[26] Dorfman SF: *Epidemiology of ectopic pregnancy*. Clin Obstet Gynecol 30: 173-190, 1987
[27] Centers for Disease Control: Current trends: *Ectopic pregnancies: United States*, 1979-1980. MMWR 33:201, 1984
[28] *Vital Statistics 1980-1998*. Department of Health Vital Statistics Unit.
[29] Stock RJ. *Tubal pregnancy; associated histopathology*. Ob Gyn Clin North Am 18(1): 73-94, 1991.
[30] Tait RL: *Five cases of extrauterine pregnancy operated upon at the time of rupture*. BMJ 1: 1250, 1884.
[31] Vancaille TG: *Salpingectomy*. Ob Gyn Clin North Am 18(1):111-122, 1991
[32] Stromme WB: *Salpingotomy for tubal pregnancy*. Obstet Gynecol 1:472, 1953.
[33] Thornton KL, Diamond MP, DeCherney AH: *Linear salpingostomy for ectopic pregnancy*. Ob Gyn Clin North Am 18(1):95-109, 1991

was first used in the treatment of an interstitial pregnancy in 1982.[34] Again, its use is limited, essentially to those situations where the patient is haemodynamically stable and the tube is unruptured.[35]. The presence of ectopic foetal cardiac activity is regarded as an absolute contraindication to systemic chemotherapy,[36,37,38] It offers no advantage over laparoscopic surgery unless the diagnosis of ectopic pregnancy can be consistently established with transvaginal ultrasound (10-15% of cases). Only 12% to 32% of all ectopic pregnancies fulfil these criteria.[39,40] Salpingocentesis is also confined to those situations where the ectopic is small and unruptured.[41] It may be associated with systemic side-effects and the effects of local injection of some substances on the delicate endosalpinx is unknown[42,43,44] and future fertility could be impaired.

Preliminary studies have shown that fertility potential following systemic chemotherapy is only comparable to that of patients treated laparoscopically.[45] Only one-third of women with ectopic pregnancies later deliver children[46] and results have not improved significantly over the last thirty years. The rate of repeat ectopic pregnancy remains high (16%) and the live birth rate relatively low (30 - 40%). A tendency towards a higher live birth rate in those treated conservatively is paired to a clearly higher rate of repeated ectopic pregnancy.[47]

Conceptually, and clinically, the management of ectopic pregnancy does not impact on the debate on induced abortion. The International Classification of Diseases (ICD-10) classifies the diagnosis and management of ectopic pregnancy quite disjunctively from issues in relation to abortion. Some of the so-called 'newer techniques' for the treatment of ectopic pregnancy have been in use for up to a generation. In no other jurisdiction in the world has the issue

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[34] Tanaka T, Hayashi H, Kutsuzawa T, et al: *Treatment of interstitial ectopic pregnancy with methotrexate: Report of a successful case*. Fertil Steril 37:851, 1982.
[35] Ory SJ: *Chemotherapy for ectopic pregnancy*. Ob Gyn CLin North Am 18(1): 123-134, 1991
[36] Ory S, Villanueva A, Sand P, Tamura R: *Conservative treatment of ectopic pregnancy with methotrexate.* Am J Obstet Gynecol 154:1229, 1986.
[37] Sauer M, Gorrill M, Rodi I et al: *Nonsurgical management of unruptured ectopic pregnancy: an extended clinical trial*. Fertil Steril 48: 752, 1987.
[38] 34. Stovall T, Ling F, Smith W et al: *Successful non-surgical treatment of cervical pregnancy with methotrexate*. Fertil Steril 50:672, 1988.
[39] Ory S, Villanueva A, Sand P, Tamura R: *Conservative treatment of ectopic pregnancy with methotrexate*. Am J Obstet Gynecol 154:1229, 1986
[40] Stovall T, Ling F, Buster JE: *Outpatiet chemotherapy of unruptured ectopic pregnancy*. Fertil Steril 51:435-438, 1989.
[41] Saunders NJ: *Non-surgical treatment of ectopic pregnancy*. Br J Obstet Gynecol 97:972-3, 1990.
[42] Lang PF, Honigl W: *Hyperosmolar glucose solution or prostaglandin F-2 alpha for ectopic pregnancy*. Lancet 336:685, 1990.
[43] Ory SJ: *Chemotherapy for ectopic pregnancy*. Ob Gyn CLin North Am 18(1): 123-134, 1991.
[44] Thompsom GR: *Hyperosmolar glucose solution or prostaglandin F-2 alpha for ectopic pregnancy*. Lancet 336:685, 1990.
[45] Stovall T, Ling F, Buster JE: *Reproductive performance after methotrexate treatment of ectopic ectopic pregnancy*. Am J Obstet Gynecol 162:1620, 1990
[46] Oelsner G, Tarlatzis BC: *Radical surgery for extra-uterine pregnancy*. In DeCherney AH (ed): Ectopic Pregnancy. Rockville, MD, Aspen Publishers, 1986
[47] Vancaille TG: *Salpingectomy.* Ob Gyn Clin North Am 18(1):111-122, 1991.

of the treatment of ectopic pregnancies been raised in the debate on induced abortion. To do so now is, at the very least, novel and, at worst, disingenuous. In this regard, it is apposite to note that, in Britain, where an abortion on request regime operates, deaths continue to occur as a result of ectopic pregnancy. And, as noted, there has not been a death from ectopic pregnancy in this jurisdiction for nearly 20 years – notwithstanding (or perhaps because of) the absence of legal induced abortion here. Nor is there any evidence that Irish women have travelled to Britain to avail of the legal abortion regime there because they require treatment for ectopic pregnancy that is not available here. Indeed, this would not be possible, given the emergency nature of the intervention that is required, and that is available in this country. Furthermore the availability of induced abortion has in some instances been directly linked to ectopic deaths. In one study 24 women who underwent induced abortion died as a result of a concurrent ectopic pregnancy and the death-to-case rate was 1.3 times higher than that for women not undergoing abortion.[48]

### *Eclampsia*

As already noted, termination of pregnancy, is in many instances, a standard part of the treatment of eclampsia and pre-eclampsia, usually resulting in the birth of a live premature infant. In the rare cases of early severe eclampsia, pre-eclampsia, HELLP or antiphospholipid syndrome there is a high incidence of intrauterine death. Effective management of the maternal condition is the major determinant of foetal outcome. Not surprisingly neonatal outcome is improved if the pregnancy can be safely prolonged and recent studies have confirmed the success of conservative management in many of these patients remote from term.[49,50] It is to be strongly recommended that such cases should be managed in tertiary referral centres.

### *Other Conditions*

Again the Green Paper uses the term 'termination of pregnancy' is used in an inconsistent and confusing manner when dealing with other conditions in pregnancy. Obviously in a country where induced abortion is legal and widely practised medical practitioners will more readily and easily opt for this course of action when faced with serious maternal illness. Yet, as has been demonstrated time and again, other options are available. Recent advances in drug therapy and the use of intravenous immunoglobulin for pre-eclampsia associated with lupus anticoagulant and antiphospholipid syndrome,[51,52] liver

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[48] Atrash HK, MacKay MPH, Hogue CJR *Ectopic pregnancy concurrent with induced abortion: Incidence and mortality.* Am J Obstet Gynecol 1990; 162:726-30

[49] Schiff E, Friedman SA, Sibai BM. *Conservative management of severe preeclampsia remote from term*. Obstet Gynecol 1994;84:626-30

[50] Abramovici D et al *Neonatal outcome in severe preeclampsia at 24 to 36 weeks' gestation: Does the HELLP syndrome matter?* Am J Obstet Gynecol 1999; 180: 221-5

[51] Katz VL et al. *Human immunoglobulin therpay for preeclampsia associated with lupus anticoagulant and anticardiolopin antibody* Obstet Gynecol 1990 Nov; 76(5 Pt 2): 986-8.

[52] Spinnato JA et al. Intravenous immunoglobulin therapy for the antiphospholipid syndrome in pregnancy. Am J Obstet Gynecol 1995 Feb; 172 (2 Pt 1): 690-4.

transplantation in cases of severe acute fatty liver of pregnancy,[53] as well as advances in intensive care have all improved the outcome for patients affected by these exceedingly rare conditions.

### *Suicide and Pregnancy*

This is an issue that merits particular consideration, given that the Supreme Court in *Attorney General v X & ors* [1992] IR 1 and the High Court in *A & B v Eastern Health Board & ors* [1998] 1 IR 464 found that a threat of self-destruction on the part of a young pregnant girl constituted sufficient justification for induced abortion. The Green Paper rightly points out that notwithstanding the difficulty of predicting suicide, pregnancy appears to have a protective effect against suicide. What the Green Paper fails to point out is that induced abortion itself appears to be a significant risk factor for suicide.[54]

### *Omissions*

While this section of the Green Paper is thorough in its treatment of Pregnancy and Maternal Health it is somewhat surprising that it fails to address the effects of induced abortion on maternal health. This, in our view, is a significant omission. The attached, Appendix H, entitled *Abortion Sequelae: general and psychological* is of interest in this regard.

[53] Pereira SP et al. *Maternal and perinatal outcome in severe pregnancy-related liver disease*. Hepatology 1997 Nov; 26(5):1258-62.

[54] Gissler M, Hemminki E, Lonnqvist J. *Suicides after pregnancy in Finland, 1987-1994: register linkage study*. BMJ 1996: 313(7070) 1431-4.

# *Chapter Two: The Legal Context*

## *Constitutional Protection Before Eighth Amendment*

In this chapter we analyse the Green Paper's presentation of the present legal position. This is set out in Chapter 2 of the Green Paper. Our analysis is necessarily critical in some respects. This should not take away from the fact that the Green Paper contains much in the way of helpful elucidation of the issues.

Paragraphs 2.09 and 2.11, in our view, are an inadequate statement of law in two respects. First, the statement in Paragraph 2.09 that "the courts' judgements" in a number of cases suggest that the Constitution (prior to the Eighth Amendment) "implicitly prohibited abortion" is hard to sustain, since none of the four decisions so held. Three of them *McGee v. Attorney General*[55], *G v. An Bord Uchtala*[56] and *Norris v. Attorney General*[57] contained *obiter dicta* to this general effect by individual judges. In *Finn v. Attorney General*[58], the Supreme Court said nothing on the issue; Barrington J. in the High Court was faced with a situation where the Attorney General had adopted the strategy of neither disputing nor agreeing with the Plaintiff's submission that the Constitution protects the life of the unborn child. Barrington J. observed that, on the basis of the authorities offered to him by counsel for the Plaintiff and in the light of the reasoning he set out earlier in the judgement, he would "have no hesitation in holding that the unborn child has a right to life and that it is protected by the Constitution." It is to be noted that Barrington J. did not seek to express the scope of that protection. He concluded, however, that counsel for the Plaintiff "has failed to convince me that the present proposed amendment, if accepted by the people, will not change or vary the constitutional protection of the unborn child and I have attempted to describe it earlier in this judgement". Since Barrington J. did not enlarge on this conclusion, we can only speculate as to the nature of that change or variation.

The proposition that there was judicial authority that the Constitution "implicitly prohibited abortion" needs closer examination. One can speak of a "prohibition" on induced abortion which is qualified, for example, by exceptions. Although McCarthy J., in one of the *obiter dicta* in *Norris*, observed that "the right to life is a sacred trust to which all the organs of Government" must lend their support, it seems clear from his later judgment in *Attorney General v. X*[59] that, even when he made his statement in *Norris*, he envisaged that the prohibition was less than a complete one. An examination of his analysis of the issue, which, of course, had the Eighth Amendment as its focus, indicates that he regarded it as axiomatic that a prohibition on abortion could never be a total one.

[55] McGee v. Attorney General: [1974] IR 284
[56] G v. An Bord Uchtala: [1980] IR 32
[57] Norris v. Attorney General: [1984] IR 36
[58] Finn v. Attorney General: [1983] IR 154
[59] Attorney General v. X [1992] IR 1

A second inadequacy in the analysis of Paragraphs 2.09 to 2.11 relates to the concerns of those who sought explicit constitutional protection for the unborn. Paragraph 2.11 might suggest that the primary and immediate purpose was to prevent the judicial acceptance in Irish law of the reasoning of the Supreme Court in the United States in *Roe v. Wade*[60]. The real concerns were more immediate. The Constitution in Article 40.3.2 included a guarantee by the State to protect and vindicate the right to life of "every citizen". On its face, this excluded the unborn, who are not citizens. Even if that protection were to be judicially interpreted as extending as far as the unborn, it was a matter of complete uncertainty as to how extensive that protection might be. There was, moreover, evidence that the Irish courts were likely to transform the right of marital privacy into a more generalised right of uncertain parameters. Against the background of this opaque and uncertain protection for the right to life of the unborn, it was considered prudent to ensure that the Constitution should afford transparent protection to the lives of everyone, born and unborn, on the principle of equality. The purpose was to give full legal protection against the introduction of induced abortion, judicially or legislatively.

## *Attorney General Versus X*

In Paragraph 2.15, the account of the decision in *The Attorney General v. X*[59] refers to the Supreme Court's "accept[ance]" of the evidence that had been adduced in the case. In fact, little evidence on the crucial issues came before the High Court, as Hederman J's dissenting judgment makes plain. No evidence was received from a psychiatrist. No obstetrical evidence was adduced on the wider subject of the medical treatment of women during pregnancy. The majority judgments reveal the detrimental effect on their analysis which these omissions caused.

Paragraph 2.17 fails to state the concern of those who opposed the Supreme Court's decision in *The Attorney General v .X*[59], on the basis that it misunderstood and misinterpreted the Eighth Amendment. The effect of the

Eighth Amendment is to prohibit the direct termination of the life of anyone – whether born or unborn. It was the contention of those who opposed the decision on this basis that such a direct termination is both unnecessary and unjust. So far as the risk of suicide as a ground for abortion was recognised by the decision, the concern was not that there might be "possible abuse" of this ground but, more radically, that suicide simply *is not* a ground for abortion.

## *Information And Travel Amendments*

Paragraph 2.20 misrepresents the purpose and effect of the Information Amendment. This Amendment has been interpreted by the Supreme Court as going far beyond a *clarification* of the previous position. It gives constitutional legitimacy to the provision of specific information that the Supreme Court, in two earlier judgments, had identified as amounting to

[60] Roe v. Wade: 410 U.S. 113 (1973)

*assistance* in the destruction of the right to life of unborn children.

The brief reference in Paragraph 2.21 to the Supreme Court's decision in the Abortion Information case might give readers the impression that this decision was uncontroversial. In fact it has been subjected to stringent criticism from legal experts with widely varying views on the abortion issue. The failure by the Green Paper to bring this criticism to the attention of the reader contrasts with its willingness to engage in criticism (from a different standpoint) of Geoghegan J's judgment in *A and B v. Eastern Health Board*[61] in Paragraph 2.26. That criticism is based on a premise that appears to regard the freedom to travel as involving a *right to abortion outside the jurisdiction*. Geoghegan J. was perfectly correct in repudiating such an interpretation of the Travel Amendment.

## *Medical Ethics – Direct And Indirect Effects*

The discussion in Paragraphs 2.27-2.30 of the divergence between medical ethics and the judgment in the Supreme Court in *The Attorney General v. X*[59], is striking in its failure to comment on the fact that the Court reached its conclusions without regard to expert obstetric and psychiatric evidence and on the basis of a mistaken assertion by counsel for the Attorney General that the Eighth Amendment permitted abortion in certain circumstances. A further weakness in the Green Paper's discussion in this context is its complete failure to examine the philosophical and legal basis for the distinction between a direct attack on the life of the person, born or unborn, and the death of that person as an unintended side-effect.

The Green Paper deals with the distinction mistakenly in paragraph 1.09 and in a hostile manner in paragraph 7.20. In failing to inform the readers of the philosophical and legal basis for this distinction, the Working Paper in paragraphs 2.27-2.30 gives the false impression that the divergence between the Supreme Court judgment in *The Attorney General v. X*[59] and medical ethics raises problems for medical ethics. In fact the problems are with the judgment itself.

Finally, the apparent suggestion in Paragraph 2.30 that particular constitutional and legislative approaches "might require some adjustment" in the ethical norms enunciated by the Medical Council is a cause of serious concern. The idea that medical ethics should change because the particular content of a positive law changes reveals a complete misunderstanding of the relationship between ethics and law. The whole point about ethics is that normative values are not subsidiary to and dependent on positive law.

[61] A&B v. Eastern Health Board [1997] Unreported High Court Judgement

# *Chapter Three: The State's Obligations under International, European Union and Community Law*

## *Some Criticisms*

The Green Paper discussed Ireland's obligations under international and European Union and Community law in Chapter 3. As with Chapter 2, it contains much useful material. Our comments, which include specific criticisms should not detract from this.

An overall weakness of Chapter 3 is its failure to address aspects of the international conventions and other human rights agreements which have a significant impact on the issue of the protection of life. The reader is given almost no guidance as to probable future developments at an international level. Since there are strong reasons for apprehending that the present momentum in the law will lead to further changes that augur badly for the unborn, the failure to refer to this dimension is regrettable. It is, of course, true that no one can predict the future with any degree of certainty but it is equally true that particular legal concepts, once received into a legal system, national or international, have a strong potential for growth, to the detriment of other concepts. To ignore that potential is to fail to give a fully meaningful assessment of the law,.

A preliminary observation may be made concerning the language adopted in the Green Paper in this context. In Paragraph 3.09, the comment is made that States that are Parties to the European Convention of Human Rights enjoy a very wide margin of discretion in regulating induced abortion. The following sentence appears :

> "However, it is not clear what limitation there may be to their discretion at both the liberal and restrictive ends of the spectrum."

The context suggests that "liberal" connotes an abortion regime in which the unborn child receives diminished protection from having its life terminated and that "restrictive" connotes a legal system where more extensive protection is assured. The use of labels is important and significant. Most people would prefer to support liberal rather than restrictive policies. A "liberal" abortion regime, as envisaged in the Green Paper, is one in which there is very restricted protection for the right to life of the unborn child. The authors of the Green Paper may seek to defend the use of these partisan labels on the basis that they are no more than sociological descriptions, devoid of value-endorsement. This may, perhaps, have been the motivation for their use, but the effect is to adopt the campaigning language of one particular political perspective, which supports a wide-ranging abortion regime.

The Green Paper analysis of the right to life of the unborn under the European

Convention on Human Rights is helpful so far as it goes. It can, however, be criticised for its failure to address the issue in greater detail.

It makes no criticism of the strategy of the majority of the European Court of Human Rights in the *Open Door Case*[62] to avoid the formidable argument made by the Irish Government that there is an obligation to protect the right to life of the unborn under Article 2 and that Article 10 justifies laws that have this goal. Nor does the Green Paper seek to consider the protection that Article 60 of the Convention gives to Article 40.3.3 of the Constitution. Article 60 provides that:

> "Nothing in this Convention shall be construed as limiting or derogating from any of the human rights and fundamental freedoms which may be ensured under the laws of every High Contracting Party or under any other agreement to which it is a party".

A strong argument can be made that Article 60 confers effective protection on Article 40.3.3. (See Blayney J.'s dissenting judgement in *Open Door Counselling v. Ireland*[62] at the European Court of Human Rights).

In assessing how the new European Court of Human Rights may determine the issue of the protection of the life of the unborn child from abortion, one has to be conscious of social and practical realities. The Court will be sensitive to the fact that wide-ranging abortion regimes exist in many Contracting States and that a decision to the effect that the unborn child is an equal member of the human community who is entitled to equal protection from a direct attack on his or her life would cause huge controversy and opposition from countries whose laws do not provide that protection.

There is clear evidence that, in the cases in which the abortion issue came before the Commission or Court, a strong element of political pragmatism played a role in their determination.

Legal commentators continue to debate the question of the scope of protection afforded the unborn child in Article 2: see e.g. Freeman, *The Unborn Child and the European Convention of Human Rights: To Whom Does Everyone's Right to Life Belong?*, 8 Emory International Law Review 615 (1994) and Thompson *International Protection of Women's Rights: An Analysis of Open Door Counselling Ltd. & Dublin Well Woman Centre versus Ireland*, 12 Boston University International Law Journal. 371 (1994). The truth of the matter is that future decisions by the Court in this area will inevitably be affected by international political considerations. No one can tell what lies ahead. All that one can say is that the Convention is a legal instrument which has potential danger for the legal protection of the right to life of unborn children. How great that danger may be is not possible to assess with certainty but, all the evidence suggests that the legal protection of unborn children that extends to direct attacks on their lives will not be consistent with how the new Court is likely to interpret the Convention. The Green Paper goes much of the way in conceding that in Paragraph 7.27.

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[62] Open Door Counselling v. Ireland 15. E.HRR. 2 44 (1992)

### *Incorporating Convention into Domestic Law*

At present the Convention is not part of Irish domestic law. The effect of the Maastricht Treaty is to require the European Union to respect the fundamental rights guaranteed *inter alia* by the Convention and general principles of community law: see Paragraph 3.04. Inevitably debates will take place as to the impact of Protocol No. 17 on this development. The Government is also considering the possibility of incorporating the Convention as part of our domestic law.

If it were to be done, the manner of its implementation would be crucial. A constitutional amendment baldly incorporating the Convention without providing effective protection would be strongly opposed by the Pro-Life Campaign as the Convention does not provide adequate and just protection for the right to life of unborn children. The new European Court of Human Rights is most unlikely to act on the philosophical acknowledgement of the human status and rights of the unborn child that underlies Article 40.3.3 properly interpreted.

# *Chapter Four: Possible Constitutional and Legislative Approaches*

## *Pro-Life Campaign Supports Option One*

In this chapter we discuss the seven possible approaches that the Green Paper canvasses in Chapter 7. The Pro-Life Campaign supports the first option, which is a complete ban on abortion. We do so because this is the just and workable solution. It respects the crucial principle that everyone – whether born or unborn – is entitled to have his or her life protected from direct attack. It is in harmony with medical ethics. It leads to doctors treating pregnancies as involving two patients and ensuring that the best of medical care is given to the mother and the unborn child. It is one of the reasons why Ireland is the safest place in the world for pregnant mothers – safer than countries that have greater resources and have wide-ranging availability of induced abortion.

## *The First Option*

The first option represents what the Eighth Amendment was intended to achieve and universally understood to have achieved. The wording of the majority in the *Attorney General v. X* was contrary to the understanding of all who had debated the issue prior to the Eighth Amendment. Mr. Justice Hamilton, in a lecture delivered at Fordham University School of Law on 28 March 1996 (*Matters of Life and Death*, 65 Fordham Law Review 543, at 551) observed that "no party, of any persuasion, foresaw the manner in which the Supreme Court would interpret those words in *Attorney General v. X*[59]).

The first option has the further advantage of being clear. There is no uncertainty as to what it envisages. Abortion is a direct attack on the life of the unborn. Other procedures which may impact indirectly on the unborn child in a harmful – even fatal – way are not what is envisaged. Pregnant women are perfectly entitled to receive all necessary medical treatment even where this detrimentally affects the unborn child as an uni9ntended side-effect.

The Ethical Guidelines of the Medical Council are based on this distinction, which is well recognised as a grounding medical and legal principle. The law relating to the palliative care of the dying patient cannot be properly understood without regard to this distinction, which is not dependent on any religious doctrine. Cf. *Vacco v. Quill* 521 U.S. 793 (1997)[63] and *R v. Cox* 12 BMLR 38.

Those who rely on the distinction are perfectly willing to explain how it translates into practice in the context of medical treatment of pregnant women. If anyone is in any doubt as to what this involves, all that he or she need do is see what Irish medical practitioners do every day in maternity hospitals. The practice on the ground is entirely harmonious with medical ethics. There is no mystery, no complicated abstraction. Unborn children are not exposed to the risk of having their lives subjected to a direct attack.

[63] Vacco v. Quill 521. U.S. 793 (1992)

Since the Green Paper makes much of the difficulty which it perceives in finding an acceptable wording for a constitutional protection on abortion, it must be emphasised that the position which the Pro-Life Campaign supports is one that has no ambiguity. It is based on a coherent philosophical and ethical grounding (which incidentally is not the case in relation to any of the other options). If specificity with regard to any medical procedure is considered necessary or desirable, such specificity can be prescribed. There is no objection in legal principle to a constitutional amendment with a high degree of specificity. So, for example, if anyone professes to be in doubt as to whether, with a complete ban on induced abortion, it would be lawful for a pregnant woman with cancer to receive radiation treatment, the answer can be spelled out that it is indeed lawful.

The Green Paper in Paragraph 7.25, makes the following curious argument:

> "It is possible that the ethical guidelines currently in force may be changed in the future, for example to reflect a different, more liberal, ethical approach or to take account of developments in medical practice. An explicit constitutional prohibition on direct termination of pregnancy would circumscribe the Medical Council's freedom to draw up guidelines as it considered appropriate, if it sought to adopt a more liberal approach."

The fact is that *at present*, as a result of the Supreme Court's decision in *Attorney General v. X*[59], the law has been stated in a way which conflicts with the Ethical Guidelines of the Medical Council. The authors of the Green Paper express no concern for the difficulties for medical practitioners that the present law has created. Instead, it puts forward as a criticism of the option of bringing the law back into harmony with medical ethics, a hypothesis that, if at some future time the Medical Council wanted to change the ethical guidelines "to adopt a more liberal approach" (i.e. to favour the direct attack on the life of the unborn child), the law would be at variance with the Medical Council's wishes. Why the authors of the Green Paper should base a criticism on a hypothetical development and not make a similar and far stronger criticism of the *present* position is a mystery.

The Green Paper, in Paragraph 7.27, expresses concern as to whether a complete prohibition on abortion is compatible with "the State's obligations under the European Convention on Human Rights". The Pro-Life Campaign has a similar concern but regards this potential incompatibility as being an added reason why the Constitution should prescribe such a prohibition. In our submission, the protection of the lives of unborn children is a pre-eminent requirement of justice. The State's obligations to protect the lives of human beings, born and unborn, are clearly more important than any obligations deriving from international treaties, to which the State may be party at any particular time.

Moreover, the Constitution should give effect to the democratic wishes of the Irish People It is essential that the electorate be given the opportunity to reject abortion if that is its wish. The first option is the only one that offers this opportunity..

## *Pro-Life Campaign Opposes All Other Options*

The Pro-Life Campaign is opposed to the other options canvassed in the Green paper.

## *The Second Option*

The second option, of amending the Constitution to provide for the Supreme Court ruling in *Attorney General v. X* but removing suicide risk as a ground for abortion is objectionable from the standpoint of justice. It would subject the unborn child to a direct attack on his or her life. This violates the equality of human beings. As we have stated above, it is inconsistent with medical ethics and practice.

If the Constitution were to be amended in terms consistent with the second option, and abortion were to become lawful by virtue of democratic endorsement, the likelihood is that a wide-ranging abortion regime would, in due course, become established. This has been the general experience in other jurisdictions. While it is true that levels of abortion differ from jurisdiction to jurisdiction, one thing is certain. No jurisdiction in which abortion is lawful on the grounds of life-threatening conditions has an abortion regime that is, in practice, as restrictive as what the Green Paper envisages in its discussion of the medical dimension in Chapter 1. Even if legislation accompanying the constitutional amendment proposal were drafted narrowly, the Oireachtas would be free, in the future, to amend the legislation to introduce a less restrictive regime which would be consistent with the Amendment.

Paragraph 7.35 gives rise to serious concern. It appears to involve a subdued reiteration of the threat by the then Minister for Justice, Mr. Padraig Flynn, in November 1992, that if the electorate rejected the proposed constitutional amendment on the substantive issue (which was identical to the second option listed in the Green Paper), the Government would introduce legislation on the lines of the Supreme Court decision in *Attorney General v. X*[59]. That threat was anti-democratic and intimidating. It was designed to frighten those who were opposed to the Supreme Court holding on the ground that it removed the complete prohibition on abortion. Such people were placed in an illegitimate dilemma: to vote against the proposed amendment and by so doing giving full effect to the Supreme Court holding or vote in favour of it, thus reducing the effect of that holding.

The Pro-Life Campaign strenuously opposed that threat and advised those who opposed abortion to vote against the proposed amendment. Paragraph 7.35 speaks in terms of the *possibility* of reviving this threat. This is totally unacceptable from a democratic standpoint. The electorate must be given the democratic opportunity to re-iterate its complete opposition to abortion. A strategy designed to intimidate voters into voting for some abortion in fear of something worse is profoundly violative of democratic principles.

## *The Third Option*

The third option, of leaving the Supreme Court's holding in *Attorney General v. X* in place, is unacceptable. Under this holding abortions may be carried out at all stages of pregnancy, including the period where the unborn child is viable. The Pro-Life Campaign opposes this option on the grounds that it violates the principle of equality of human beings and subjects unborn children to the direct termination of their lives, which subverts their most important human right.

### *The Fourth Option*

The fourth option is equally unacceptable, for the same reasons. The discussion of this option in the Green Paper may be criticised on the ground that, in contrast to the first option, which is subjected to hostile analysis, the discussion of the fourth option is strongly supportive, using rhetoric that amounts to partisan advocacy. Referring to the establishment of an authorisation process by an expert committee, the Green Paper asserts in Paragraph 7.44 that:

> "Such a provision would act as a 'double lock' against the possibility feared by many people that 'suicide risk' justification could provide a back door to abortion on demand."

In Paragraph 7.46, the Green Paper states:

> "Whichever approach was taken in such legislation to suicide risk-related termination of pregnancy, the legislation would guarantee that it did not become a 'back door' to the availability of abortion on demand in Ireland."

International experience completely contradicts this advocacy. In England, the *Abortion Act 1967* provided for procedures by the medical profession before an abortion could be carried out. These were represented as establishing a significant barrier to abortion. In fact they gave no protection to unborn children from abortion.

The English legislation extended to abortion on the ground of a purported risk to the mother's health, which is not what the fourth option envisages, but the disparity between what was promised and what turned out to be the case is worth noting.

The Green Paper, in its consideration of the fourth option, fails to take account of the profound cultural transformation which the establishment of expert committees with the power of authorising abortions in Irish hospitals would involve. The basis of authorising abortion is that the unborn child's life is an inferior one, which may be directly attacked. Once that basis is accepted, there is likely to be a tendency to weaken one's concern for that life. If it is possible to terminate a life in some cases, what reason, in principle, is there for not doing so in other cases? The international experience of the past thirty years could not be clearer: once abortion is legalised in some instances there is a momentum for further extension with no principle of justice available to create a coherent barrier.

It is important to address, and refute, the argument in Paragraph 7.47 of the Green Paper that legislation is "capable of being more comprehensive and detailed than general provisions set out in the Constitution, and more capable of discriminating between desired and undesired consequences". If the reader is being invited to prefer a legislative solution to a constitutional amendment, for this reason, the argument is seriously misleading. The protection of the right to life of unborn children is a constitutional matter (and was even before the passage of the Eighth Amendment). The precise specification of this protection is also a constitutional matter. If it is considered necessary for the purposes of clarity to engage in detailed specification,

this can and should be done, not by legislation *per se,* but at the constitutional level. As things stand, legislation, in order to be constitutionally valid, would have to harmonise with the Supreme Court's holding in *Attorney General v. X*[59] This would be quite unacceptable from the standpoint of justice and of the protection of the unborn child's right to life.

### *The Fifth Option*

The fifth option set out in the Green Paper is very close – if not in substance identical – to the fourth option and equally unacceptable.

### *The Sixth Option*

The sixth option, of reverting to the pre-1983 position, is also unacceptable. The Green Paper is to be commended for making it clear that, far from providing an easy solution, this would create a range of uncertainties for the unborn child. These uncertainties would concern the scope of abortion that would be lawful. At a minimum it would go as far as the ground stated in *Attorney General v. X*[59] but there is a real prospect that it would range wider, possibly far wider. As is pointed out in Paragraph 7.57, in cases such as *R .v. Newton and Stungo*[64] it has been suggested that Section 58 of *Offences Against the Person Act 1861* may be interpreted as permitting abortion on grounds of physical and mental health. This would be likely to escalate in practice, into induced abortion on demand.

The Green Paper might with benefit have addressed in detail how a future court after Article 40.3.3's removal would be likely to address issues of privacy, health, autonomy and equality in the context of induced abortion. There is a real prospect that the court would come to a conclusion that would be seriously detrimental to the interests of the unborn child. The act of the electorate in removing the protection afforded by Article 40.3.3 might be generally interpreted as implying a decision that the unborn child receive less protection under the Constitution than Article 40,3,3 provides.

### *The Seventh Option*

The seventh option, of permitting abortion on grounds beyond those specified in *Attorney General v. X*, is obviously unacceptable to anyone who is concerned to protect the right to life of unborn children as equal members of the human community.

[64] R. v. Newton & Stungo [1958]

# *Chapter Five: The Social Context*

## *Introduction*

While calling on the government to restore the fullest possible protection to the unborn, the Pro-Life Campaign also calls upon the Government to tackle in a creative and sensitive manner, the disturbing and growing number of crisis pregnancies. In a recent poll conducted by Irish Marketing Surveys (June 1999) on behalf of the Pro-Life Campaign, 80% of respondents who expressed an opinion favoured the Government mounting a campaign to offer women in crisis pregnancy positive alternatives to abortion. What is singularly lacking is a coherent Government strategy for addressing what everyone agrees is the very disturbing rise in the number of Irish women seeking abortions in Britain. However, the rising trend of abortion is not inevitable. Statistics from Poland and certain areas in the USA show, when the conditions that pressurise women to opt for abortion are addressed, the trend can be slowed down and even reversed.

Some pointers as to how this might be done can be gleaned from the recently published report *Women and Crisis Pregnancy. A Report Presented to the Department of Health and Children.* The report, compiled by Evelyn Mahon, Catherine Conlon and Lucy Dillon, was commissioned by the Government in 1995. It sought to identify factors which contribute to the incidence of crisis pregnancies and the issues which resulted in women choosing the option of abortion.

In their analysis of 88 women who choose abortion the researchers point out that only 17 women used 'right to choose' language to explain or justify their decision. The main themes related to the abortion decision were:

| **Themes Related to Abortion Decision** | **Number who mentioned themes (Total is 88; More than one theme per woman)** |
|---|---|
| Career/ job concerns | 36 |
| Stigma of lone parenthood | 30 |
| Child needs | 30 |
| Financial concerns | 28 |
| Not ready for a child now | 27 |
| Could not cope | 24 |
| 'My body, my right' | 17 |

## *Providing real alternatives to abortion*

As can be seen from the above table most of the factors which could be said to pressurise a woman into choosing abortion are amenable to social and/or financial support. We suggest the Government should review again the funding it gives to the voluntary organisations that help women with crisis

pregnancies to continue with the pregnancy. With more funds at their disposal these organisations would be able to provide more support and counselling, appropriate accommodation and other practical help including financial assistance where needed. It seems essential that the Government would back up its commitment to the right to life of the unborn by giving funding **only** to organisations that fully respect that life. To do otherwise leaves the government open to the accusation of hypocrisy. A woman with a crisis pregnancy should be given all the support and help she needs to cope during the pregnancy and until she can make an informed decision regarding her child's future.

The fact that some women chose abortion because they did not think they would be able to provide the sort of good quality care they thought the child was entitled to is a challenge to policy makers to see that adequate practical help is available. This has great significance also for the handicapped and people with multiple special needs. A health education policy that encourages and supports women in nurturing and protecting their unborn children should also challenge society to recognise the value of all life and the need to meaningfully respond to the actual concerns of women with crisis pregnancy.

### *Rising abortion trend is not inevitable*

One of the key factors that drives women to choose abortion is the dread that having a child will wreck her life and career, her whole identity, that she will effectively lose control of her life. Sophisticated research pioneered by the *Caring Foundation (USA)* has identified the underlying emotional and psychological motives prompting women to opt for abortion. This research has led to the development of effective strategies to address the concerns of women with crisis pregnancies. The work of the *Caring Foundation* originated in Missouri, where ads have been airing for a number of years, and that state has the fastest dropping abortion rate in the United States - almost six times the national average. From 1988 to 1992 the abortion rate dropped just 5 per cent nationally, but 29% in Missouri. If the Government here committed itself to making the necessary resources available, similar programmes could be adapted to work in Ireland and would substantially enhance the work of existing caring agencies offering positive alternatives to abortion.

### *Redefining adoption*

The recent *Women and Crisis Pregnancy* report points out that whereas 71% of non-marital births were adopted in 1971 only 7% of non-marital births were adopted in 1991. In their analysis of the women who actually chose adoption rather than lone-parenthood or abortion, the report mentions that the women

> *see adoptive parents as people who would be made extremely happy with the opportunity to rear their child, an experience they would otherwise be deprived of…*

and this was a factor which helped make the decision to opt for adoption.
Given that a conservative estimate of infertility is 1 in ever 10 couples, this is an aspect that should receive much more attention.

Of the 88 women in the study who chose abortion some did in fact consider the option of adoption. Yet they ultimately rejected this option because they felt they would not be able to go through the pregnancy and then part with the baby.

The study suggests that changing attitudes to lone parenting and the availability of legalised abortion in Britain have been the main factors in the declining number of adoptions. While we cannot change the fact that abortion is legal and readily available in Britain, positive health education policies directed at promoting and facilitating adoption would encourage and reassure more women to avail of this option, thus helping to reduce the abortion rate and minimise the physical and emotional harm endured by women following abortion.

Recently, much criticism has been levelled at some social workers for showing ideological opposition to adoption. There is need for the public to be better informed about the changes that have taken place in adoption procedures in recent decades. Negative media coverage of now abandoned procedures may have coloured peoples perception against adoption. While the negative attitudes of some social workers towards adoption is hopefully being addressed, there is a responsibility for the social services as a whole, to take a more proactive role in lessening the trauma for birth mothers and would-be-adoptive parents by encouraging and promoting contemporary procedures of adoption with the degree of commitment and dedication they deserve.

The Green Paper's discussion of this developing area deserves further consideration and research on possible new models of 'open adoption' is desirable.

### *Respite care for babies with multiple special needs*

The failure on the part of successive governments to provide adequate respite care for families with multiple special needs is inexcusable and demands to be addressed as a matter of urgent priority.

*Zöe's Place* is the first baby hospice of its kind caring for babies who have multiple special needs. All of the babies have life threatening or life shortening conditions.

The hospice is run by the *Life Health Centre* in Liverpool and offers respite and palliative care to babies and their families from birth. *Zöe's* is dedicated to

providing a loving, supportive environment for babies and families, ensuring that pain and other symptoms which can cause acute distress and anxiety are controlled or prevented.

As well as caring for babies with multiple special needs, under the supervision

of fully qualified children's nurses, *Zöe's* provides support and encouragement to families in relieving some of the stresses and strains by sharing the task of caring for the babies, thus giving parents the space to devote time to their other children and engage in normal everyday pursuits.

The Pro-Life Campaign strongly urges the All-Party Committee on the Constitution to reject abortion on the grounds of disability as incompatible with the equal dignity and respect for all human life, and to urge the Government to take immediate action in providing the necessary respite care and supports for people with disability and their families.

# *Conclusion*

The Pro-Life Campaign proposes that the All-Party Oireachtas Committee on the Constitution base its approach to the resolution of the abortion issue on the principle that all human beings possess an equal and inherent worth by virtue of their humanity, not on condition of possessing certain other qualifications of size, level of physical, emotional or mental capacity or development, dependence, race, ethnic origin, financial status, age, sex, or capacity for interpersonal relationships.

It makes this proposal because it believes that constitutional democracy is based on the equal and inherent value of every human life and the equality of all before the law.

Abortion, denies the equal and inherent dignity and worth of the unborn, treating them unequally before the law. A fully inclusive society committed to treating everyone equally before the law cannot endorse the legalisation of abortion.

## *A balanced and even-handed approach - support for women and protection for the child*

The woman facing crisis pregnancy, and the unborn child within her, are members of society, equal to the rest of us, equally entitled to whatever social support they need to be able to enjoy equal life-opportunities.

The Pro-Life Campaign recommends to the All-Party Oireachtas Committee on the Constitution the approach of the medical profession which sees every pregnancy as involving not one patient but two, the mother and the unborn, and acknowledges that it has an ethical and professional responsibility of best care towards the lives and health of both. The Pro-Life Campaign urges the All-Party Oireachtas Committee on the Constitution to adopt this balanced, even-handed approach - support for women and protection for the child.

## *Support for women who have been through abortion*

The woman who has been through abortion, and the child she has lost, are victims. The women who has been through abortion is a woman at risk of physical and emotional harm, in need of personal support, but surrounded by

social silence and denial that makes it harder for her to recover from what she has been through, a woman at risk of social exclusion. The Pro-Life Campaign urges the All-Party Oireachtas Committee on the Constitution to make the provision of adequate support and counselling for women who have been through abortion another priority in its recommendations.

## *Only a constitutional amendment to ban abortion is Compatible with*

## *an ethos of social inclusiveness and equal respect*

This Submission has reviewed the medical legal and social issues raised in the Green Paper on Abortion and evaluated the seven options it presented in terms of their compatibility with social inclusiveness and equality before the law.

A balanced and even-handed approach requires that we commit ourselves to building a society where there is adequate and appropriate support for women in crisis pregnancy, and where all the children of the nation, born and unborn, are cherished equally.

As the recent Pro-Life Campaign/IMS poll found, there is a huge groundswell of public backing for the provision of an ample range of professional, practical and personal supports for them, and a consistent majority supports a referendum offering the electorate a clear opportunity to ban abortion.

We believe that a referendum restoring adequate legal protection to the unborn will strengthen public commitment to putting in place the supports women in crisis pregnancy need to give them real alternatives to abortion.

Having considered carefully the seven options set out in the Green Paper on Abortion the Pro-Life Campaign believes that only the first option, a constitutional amendment banning induced abortion, is compatible with respect for the inherent dignity of all human lives, and the equality of all before the law. Only this option would seek to ban induced abortion entirely. None of the other six options is compatible with these principles and each would allow a different level of legal abortion.

This Submission has shown, in its response to the Green Paper on Abortion's review of the medical issues, that the legalisation of induced abortion is not needed to safeguard medical treatment of women. And in our review of its discussion of the legal issues, we have answered the objections to Option one, a constitutional amendment to ban induced abortion.

In conclusion, the Pro-Life Campaign sees legalised abortion as fundamentally incompatible both with the acknowledgement of the equal inherent value of each and every human life and with the commitment to building an ethos of equal respect and social inclusiveness.

**We invite the All-Party Oireachtas Committee on the Constitution:**

- to recommend the restoration of adequate legal protection to the unborn
- to recommend a Constitutional Referendum to reverse the effects of the X decision
- to urge that this referendum be held at the earliest possible date
- to rge the implementation of measures to give women in crisis pregnancy positivre alternatives to abortion

- to provide more support for counselling agencies who advise women on alternatives to abortion

# Appendix A:

# The Green Paper Options On Abortion

| | |
|---|---|
| OPTION ONE: | Absolute constitutional ban. |
| OPTION TWO : | Amend Constitution to restrict X case. |
| OPTION THREE : | Leave things as they are. |
| OPTION FOUR : | Do no amend Constitution but legislate to restate abortion ban. |
| OPTION FIVE : | Legislate according to X case. |
| OPTION SIX : | Revert to pre-1983 position. |
| OPTION SEVEN : | Allow abortion on wider grounds than X case. |

## Appendix B

# Equal Respect, Extract From PLC

### Green Paper Submission

The subject of abortion raises issues across a wide range of disciplines, including law, medicine, sociology and politics. These issues are important and need to be addressed by the Interdepartmental Working Group on the Green Paper on Abortion, but they can only be adequately considered when certain underlying issues have been identified and reflected upon. The position adopted by the Working Group on these underlying issues will already point the way towards the conclusion it will reach on the question of how to deal with abortion.

**The Value of the Human Individual**

These prior issues concern the value of the individual human life. Public discussion has tended to shy away from these ixssues tending to regard them as exclusively religious matters, not relevant to discussions and decisions of policy and law in a secular civic society. The question of the value of the human being as such, however, goes right to the heart of the most important issues on which we can reflect, relating to the meaning and significance of human existence, to the inherent value of each and every human life, to the rights that derive from the very fact of human existence, to the relationship between rights and responsibilities, and to human freedom.

**Not an exclusively religious question**

These issues have been addressed by the various religions, but that does not mean that they are in any sense exclusively restricted or relevant only to religious debate. Implicitly or explicitly, they underpin the common life of secular society also, and inform all public policy and law. It is our intention in these opening remarks to draw out the underlying attitude towards the individual human life and its dignity, and the protection which society should adopt towards it in public policy and law, that underlies and informs Irish society today, and to suggest to the Working Group that it is this attitude that should inform and guide its work and recommendations on abortion and the legal protection of the

unborn, because it is the approach that alone corresponds to the inherent dignity and worth of every human individual, on which democracy is ultimately based, and because it is the animating principle of Irish society and public life today.

**The State and the law cannot be "neutral" on this question**

For individuals or society as a whole to refuse to address these questions overtly would, we submit, be mistaken. After all, the attitude taken on how one leads one's life follows from the prior attitude one adopts to the value and dignity of that life. And how a society gives or denies protection to human beings and their acts depends in the last resort on how human beings are valued and respected.

Nor can the facing of these prior issues be evaded by holding that society should adopt a neutral stance with regard to them. Where society and the law adopt a "neutral" stance towards a right which up until that moment had enjoyed social support and legal protection, they are in effect transferring the weight of social endorsement and legal protection from actions which uphold it to actions which undermine, transgress or destroy it.

What public policy had heretofore sought to discourage by the enactment and enforcement of laws is from now on no longer to be discouraged. What hitherto had been prohibited by law and punished by law is henceforth no longer to be prohibited and punished but rather positively to be allowed by law, and indeed is even itself declared to be a right to be supported by public policy and law. The rhetoric of state and legal "neutrality" cloaks a reversal of social policy, a removal of social disapproval, a lifting of social and legal protection.

**The value of every human being is inherent in their humanity**

We propose that the Working Group adopt explicitly as its foundation the view that underlies the status of the Irish Republic as a constitutional democracy, namely, the view that perceives human existence as of profound significance.

According to this view, people are inherently valuable and their value therefore does not derive from the external estimate of their fellow human beings. Because they are inherently of value, they must be respected. What is of value must be respected and should never logically be treated with disrespect.

In this view, human beings are recognised as inherently valuable by virtue of their very humanity, rather than by virtue of their size, physical, emotional or mental capacity, autonomy or dependence, level of bodily, emotional or mental development, race, ethnic origin, wealth or poverty, age, sex or capacity for interpersonal relationship.

**An inclusive approach based on human equality**

This is an inclusive approach based on human equality. All, it

recognises, are equal, as human beings. On this approach, the human family is composed of all its members and no further conditions are appropriate for recognition and acceptance as a fellow-member by society. As history and contemporary experience show, societies all too often single out some individuals and categories of people for unjust treatment, sometimes treating some as non-members of the human family or as second-class citizens. By explicitly adopting this inclusive approach, the Pro-Life Campaign believes that the Working Group will be aligning itself clearly and strongly against such exclusion and with the positive inclusive thrust of Irish society, and of humane and enlightened international opinion, at this moment in history.

Since every human life has inherent value, no innocent human life should be damaged, let alone directly and intentionally taken. It is this approach which seeks to incorporate the fundamental values on which contemporary Irish society as a secular democracy is presently based, that the Pro-Life Campaign respectfully recommends to the Working Group.

**Building an ethos of equal respect**

When one looks critically at the Republic of Ireland today, one cannot help being struck by the commitment to building an ethos of equal respect. There is a growing sense of justice, an aspiration towards inclusiveness and mutual respect. There is a sense of shared responsibility, and a desire to offer help and support to those in difficult and painful situations that arises from an awareness of social solidarity.

Above all, there is a healthy and mature concern for honesty, generosity and compassion in acknowledging difficult realities and addressing them in a way that does not sweep them under the carpet or try to deal with them in a short-sighted manner that involves hurt to the weaker members of our society.

The Pro-Life Campaign invites the Working Group to see the restoration of adequate legal protection for the right to life of the unborn as part of this drive towards building an ethos of equal respect. Modern Ireland is trying to be a society where problems are faced honestly rather than being denied and hidden away. Bitter experience teaches that injustices done to vulnerable people and innocent lives taken cast long shadows and old wrongs and hurts return to haunt later generations.

This search for greater frankness, fairness and kindness is part of the historic wider struggle to take the violence out of every aspect of Irish society. More and more it is becoming clear that “solutions” which seem convenient and appealing in the short-term, even though they involve hurt or wrong to some marginalised members of society, not only fail truly to solve the problems but also store up additional problems for tomorrow.

The Pro-Life Campaign sees the question of the legal protection to be given to mother and unborn as situated within the overall struggle of contemporary Irish society for equality, for equal respect for all human beings, regardless of age or size, power or gender, for equality of life-opportunities, for equal treatment.

The Pro-Life Campaign sees the woman with a crisis or unexpected pregnancy, and the unborn child within her, as members of society, equal to the rest of us, equally entitled to whatever social support they need to be able to enjoy equal life-opportunities.

It recommends to the Working Group the attitude of the medical profession which sees every pregnancy as involving not one patient but two, the mother and the unborn, and acknowledges that it has an ethical and professional responsibility of best care towards the lives and health of both.

The Pro-Life Campaign sees the woman pushed towards abortion by the lack of practical assistance and personal warmth and reassurance, and her unborn child, as members of society who are singularly vulnerable and voiceless, singularly at risk of social exclusion or marginalisation, singularly in need of, and entitled to, support and help from society.

The Pro-Life Campaign sees the woman who has been through abortion, and the child she has lost, as victims of violence. The women who has been through abortion is a woman at risk of physical and emotional harm and heartbreak, in need of personal support, but surrounded by social silence and denial that makes it harder for her to recover from the violation she has been through, a woman at risk of social exclusion.

The Pro-Life Campaign sees legalised abortion as fundamentally incompatible both with the acknowledgement of the equal inherent value of each and every human life and with the commitment to building an ethos of equal respect. From this starting point of commitment to building an ethos of equal respect, and following its imperative of equal recognition, support and protection and equality before the law, equal treatment and equal life opportunity, the Pro-Life Campaign concludes that the option which is most suited to deal with abortion is the holding of a referendum which would give the people a clear opportunity to restore the protection of the right to life of the unborn which the people intended in 1983.

# Appendix C

# Extract From PLC Green Paper Submission

## REJECTION OF THE PROPOSED TWELFTH AMENDMENT OF THE CONSTITUTION IN NOVEMBER 1992

Anxious to respond to the changed legal situation after the X case, the then Government decided upon the route of Constitutional referendum. However, its Amendment did not allow for a full reversal of the Supreme Court judgment and, if approved, would only have removed the threat of suicide as a ground for legal abortion. The Government argued that it was necessary to leave the option of legal abortion open because medical circumstances could arise in which direct abortion might be necessary to save the life of a pregnant woman. The Amendment which the Government asked the electorate to support, therefore, would have allowed 'limited' abortion i.e. abortion on the grounds of a real and substantial risk to the life of the mother (not including the risk of her suicide) and the Government stated that if its proposal was rejected it would then bring in laws to give effect to the full decision of the Supreme Court in the X case, i.e. allowing abortion in even wider circumstances, including threatened suicide of the mother.

The Government's proposed 1992 Amendment was:

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

The Pro-Life Campaign rejected these arguments, pointing out that the medical evidence did not support the view that abortion was a necessary part of any treatment, and that rates of maternal mortality in Ireland were in fact lower than in countries with liberal abortion laws. The Campaign opposed the Government's Amendment on the basis that it would have meant legalised abortion.

Many in the medical profession also opposed the Amendment In a letter to *The Irish Times (16-11-1992)* signed by over 30 obstetricians and gynaecologists, the point was made that 'the wording allows for abortion on a wider scale than that acknowledged by the Government', and that, 'The question of what constitutes a substantial risk will always be highly subjective.' The consultants concluded: 'The choice now offered to the electorate is,

therefore, not a reasonable one nor, on the basis of Irish obstetric practice, can it be said to have any medical justification or scientific merit.'

The holding of the referendum coincided with the (unrelated) fall of the Government, and the subsequent general election campaign seriously affected the amount of debate on the abortion issue. Three comments might be made about the Government's campaign for a 'Yes' vote in that 1992 referendum:

- The Government spent a large sum of public money on its campaign, a practice subsequently found illegal by the Courts in the McKenna case;
- The ballot papers were misleadingly entitled 'Right to life', despite the fact that the proposal was to provide for abortion, on so-called 'limited' grounds;
- The Government's advertising campaign promoted a 'Yes' vote for the 'Right to Life';
- Pressure was put on people who were anti-abortion by the oft-stated threat that if they rejected the proposal before them for 'limited' abortion, they would be faced with legislation allowing much more abortion.

Even in these circumstances, which created widespread confusion, the Government's proposal was defeated by 65% to 35%. The national distribution of the votes makes it clear that those who voted against the Amendment were mainly those who opposed abortion and that among the 'Yes' voters were many who opposed abortion but who wished to prevent legislation for still-more wide-ranging abortion.

It is beyond argument that the electorate rejected the proposal to allow for induced abortion in limited circumstances. Any future referendum should give the opportunity to prohibit induced abortion in all circumstances, thus returning to the situation which existed in law before the X case.

**Future options**

The Pro-Life Campaign advocates a complete prohibition on induced abortion, similar to the situation that existed prior to 1992. This would, of course, necessitate a constitutional amendment.

How best can abortion be constitutionally prohibited? Several different wordings could advance the purpose in a perfectly satisfactory way. This purpose is clear: to restore the legal position to what it was understood to be prior to the Supreme Court decision in the X case. The Constitution should protect current practice in every Irish hospital as regards medical treatment and care afforded mothers and their unborn children during pregnancy. Fortunately Irish doctors and nurses have held firm to medical ethics and consequently abortions do not take place in Irish hospitals, in spite of the mistaken Supreme Court judgment.

While including a formula which we believe would achieve the stated objective, we are not in any way suggesting that there are not other forms of words which could be

used. However, as an example of what could be included in Article 40.3.3o we suggest that a single sentence be added to the first sentence of the sub-section. The first two sentences would thus read as follows:

> *The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.*
> *No law shall be enacted, and no provision of this Constitution shall be interpreted, to render induced abortion lawful in the State.*

This formula aims to be as plain and as easily understood as possible. The term 'induced abortion' has a clear meaning in medicine, and is clearly understood and recognised by clinicians. An induced abortion is in contrast to a spontaneous abortion or miscarriage, and refers to a procedure or intervention which is directed at, and has as its primary or predominant or sole object, the death of an unborn child.

It is equivalent to a procured abortion, as contemplated and prohibited by the provisions of the Health (Family Planning) Act 1979, a termination of pregnancy, pursuant to the provisions of the British Abortion Act 1967 and a procuring of a miscarriage, pursuant to the provisions of the Offences Against the Person Act 1861.

There is a legal dictum, 'ordinary words have ordinary meanings'. The words 'induced abortion' are ordinary words, with an ordinary meaning which is readily understood and which does not lend itself easily to misinterpretation.

The effect of this change would be to protect the excellent standard of medical care in Irish hospitals. Irish mothers would continue to receive all the medical treatment that they need during pregnancy, even when this may impact detrimentally on the unborn as an injurious or even potentially fatal side effect. Abortions would not be carried out. That is what the electorate voted for in 1983. There is a democratic obligation to give the electorate the opportunity now to exercise that choice.

As already mentioned, it is possible to achieve this purpose by a wide variety of wordings. For example, a wording published by the Pro-Life Campaign in October 1992 adds to Article 40.3.3o as follows:

> *The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.*
>
> *It shall be unlawful to terminate the life of an unborn unless such termination is the unsought side-effect of medical treatment necessary to save the life of the mother where there is an illness or disorder of the mother giving rise to a real and substantial risk to her life.*

The effect of this wording would again be to render abortion unlawful, while making

it clear that necessary medical treatment impacting detrimentally on the unborn as an unsought side-effect is not illegal. Again, the wording captures the reality of the present medical practice in Irish hospitals.

# Appendix D

# Extract From PLC Green Paper Submission

## THE MEDICAL QUESTIONS[65]

**The provision or prohibition of abortion is not a medical issue.**

In pregnancy, a doctor uniquely has a simultaneous duty to two patients. In general the promotion of maternal well-being enhances that of her unborn child. Conversely, enhancing the well-being of the unborn child must not endanger his/her mother's life. If the mother does not survive neither will the child (save in very exceptional circumstances).

Despite the Medical Council's statement to the contrary, the idea that abortion is a 'medical treatment' and may be necessary to save a mother's life has been frequently expressed in media comment and in two judgments, one from the High Court and another from the Supreme Court. The vast body of evidence that contradicts this statement was not considered in either case before the Courts and has received little comment in the media.

The Pro-Life Campaign contends that:

- abortion is never necessary to solve complications in pregnancy;
- there is a real distinction between treatments presently regarded as ethical which may lead indirectly to damage or death to the unborn baby, and induced abortion;
- abortion is not a necessary part of the treatment of cancer in pregnant women;
- abortion is not necessary to prevent a women with an unwanted pregnancy from committing suicide;
- abortion is not a compassionate way forward in cases of rape;
- abortion should not be contemplated as a way of preventing the birth of a handicapped child.

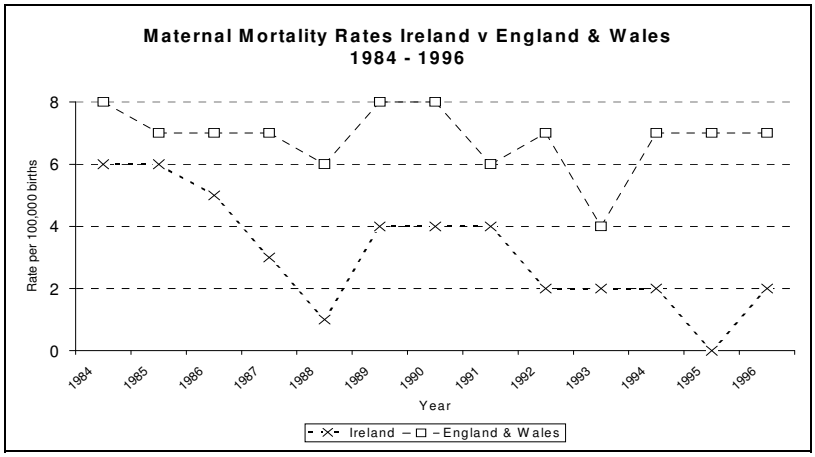
[65] This sections draws upon the work done by Doctors For Life, an affiliate of the Pro-Life Campaign. A more detailed examination of the medical issues is contained in the submission made by Doctors for Life to the Green Paper Group.

## Maternal Mortality

Irish maternal mortality figures are excellent. They compare more than favourably with those of England and Wales, Scotland and Northern Ireland.[66]

Between 1984 (the year after the passing of the Eighth Amendment) and 1996 (the last full year for which figures are available) Irish maternal mortality figures have been consistently better than those in England and Wales (Table 1). In 1996, for instance, there were 50,390 births in Ireland and there was 1 maternal death.[67]

**Table 1**




In 1982, a review all maternal deaths in the National Maternity Hospital, Dublin over a ten-year period revealed that there were 21 maternal deaths from a total of 74,317 births.[68] Analysis of the cause of death in each case led the authors of the study to conclude that the availability of induced abortion would not, in any way, have reduced the number of maternal deaths over the study period. A more recently published 1996 countrywide study of maternal mortality in Ireland between 1989 and 1991 revealed five direct maternal deaths arising from 157,752 births giving a rate of 3.2 per 100,000. The authors commented:

> The Republic of Ireland is unusual in the developed world in that termination of pregnancy is not available, This does not appear to have influenced these figures significantly, the maternal mortality rate directly due to obstetric causes being half that in the nearest European neighbour, i.e. England and Wales.[69]

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[66] Vital Statistics 1984 - 1996, Central Statistics Office, Cork. One death that occurred in 1993 was not registered until 1995. There were no maternal deaths recorded for 1995.
[67] Vital Statistics 1996 Yearly Summary, Central Statistics Office, Cork.
[68] Murphy J, O'Driscoll K: Therapeutic Abortion: The Medical Argument. *Ir Med. J* **75**:304-6, 1982.
[69] Jenkins, DM, Carr C, Stanley J, O'Dwyer T. Maternal Mortality in the Irish Republic 1989 -1991. *Ir Med J* **89** 140 - 141, 1996.

Independent United Nations figures further re-inforce this finding and confirm that Ireland has the lowest maternal mortality rate in the world. Britain and the United States, where abortion on demand is freely available, rank joint 14th on the league table for industrialised countries.[70] The excellent Irish maternal mortality figures owe nothing to the fact that some Irish women travel to the UK for abortions. Analysis of the stated reasons for abortions in non-residents shows that in no case was the abortion sought to save the life of the mother.[71] Because of a countrywide hospital confinement rate in excess of 99% of total births and the publication of annual reports by the three Dublin Maternity Hospitals (which together, account for nearly half of all births in the country), the published figures suggest that Irish maternal mortality figures are complete and that the data are accurate. In Britain, however, there appears to be some discrepancy between official figures published by the Central Statistics Office and those compiled by the Committee of Inquiry into Maternal Deaths in the United Kingdom, reporting every three years, which suggests a degree of under-reporting. Such is not the case in Ireland.[72] Accordingly, a recent United Nations publication[73] which suggests an alarmingly high Irish maternal mortality rate and which is based on mathematical models related to the fertility rate and "sisterhood surveys" - rather than actual collection and collation of data - does not reflect either the reality of the situation or the excellence of Irish obstetric care for mothers and their babies.[74]

**Abortion Trends**

***General*** Given that the majority of abortions carried out on Irish women are carried out in England and Wales, it is apposite to consider the abortion regime operating in that jurisdiction. Furthermore, it is clear from British statistics, that abortions on Irish women account for the majority of abortions carried out there on non-resident women. There is no evidence to suggest that Irish, or Irish resident, women avail of abortion regimes in other European jurisdictions.

***Great Britain*** Abortion on demand was not the intention of abortion legislation introduced in Britain in 1967. Rather it was sought to help the "hard cases". In the House of Commons it was stated that the Act would benefit mothers "broken down physically and emotionally with the continual bearing of children."[75]

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[70] *The Progress of Nations* 1993, 33 - 39 UNICEF, New York, USA.

[71] Abortion Statistics 1974 - 1996 (Series AB) Office of Population Census and Surveys, HMSO, London

[72] See: Jenkins, DM, Carr C, Stanley J, O'Dwyer T. Maternal Mortality in the Irish republic 1989 - 1991. *Ir Med J* **89** 140 - 141, 1996 at 140.

[73] The Progress of Nations 1996, UNICEF, New York

[74] In contrast, see: The State of the World's Children 1996, UNICEF, New York which records an Irish maternal mortality rate closer to the national calculation.

[75] Hansard: House of Commons Debates, 22 July 1966.

The Abortion Act 1967, which came into effect on the 27th April, 1968 permitted abortion by a registered medical practitioner on any or a combination of six statutory grounds, i.e. where it was certified as justified by two medical practitioners on the grounds that:

1. the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;
2. the continuance of the pregnancy would involve risks of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated;
3. the continuance of the pregnancy would involve risk of injury to the physical or mental health of any existing child(ren) in the family of the pregnant woman greater than if the pregnancy were terminated;
4. there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped;or, in an emergency, certified by the operating practitioner as being immediately necessary -
5. to save the life of the pregnant woman; or
6. to prevent grave permanent injury to the physical or mental health of the pregnant woman. [76]

The Abortion Act 1967 was amended by the Human Fertilisation and Embryology Act 1990[77] with effect from 1st April 1991 and the statutory grounds were re-defined as follows:

A. the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated; (previously **Ground 1**)

B. the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;

C. the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman.

D. the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) in the family of the pregnant woman; (previously **Ground 3**)

E. there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped; (previously **Ground 4**)or, in an emergency, certified by the operating practitioner as being immediately necessary -

[76]Abortion Act, 1967 s. 2.
[77]Human Fertilisation and Embryology Act 1990 s. 37.

F. to save the like of the pregnant woman; (previously **Ground 5**) or G.to prevent grave permanent injury to the physical or mental health of the pregnant woman (previously **Ground 6**).[78]

In addition to creating the new **Ground B** - essentially a subset of the old Ground 2 - the 1990 act also:

(i) reduced the 28 week presumption of foetal viability in the English Infant Life Preservation Act 1929 to 24 weeks in respect of Grounds C and D;

(ii) removed all time limits in respect of Grounds A and E; and

(iii) allowed for the selective reduction of a multiple pregnancy.

2 since 1968 the number of total abortions has nearly quadrupled with one in five pregnancies ending in induced abortion.

Analysis of the stated grounds for abortions carried out on residents of England and Wales for the years 1974[79] to 1996[80] reveals that Ground 1/A is relied upon in less than 0.25% of abortions (from a high of 1% in 1974). That is not to say that these abortions were even necessary to save the life of the mother. Analysis of the stated grounds (in terms of the underlying conditions) indicates that none were suffering from conditions in which an abortion would improve the prognosis or outcome. Ground 2/BC alone accounts for between 80% and 90% of all abortions, with the other grounds making up the remainder. Suspected congenital malformation in the unborn child accounts for less than 1% of all abortions.[81] (Table 2) The re-classification of the grounds in 1991 has not altered this tren

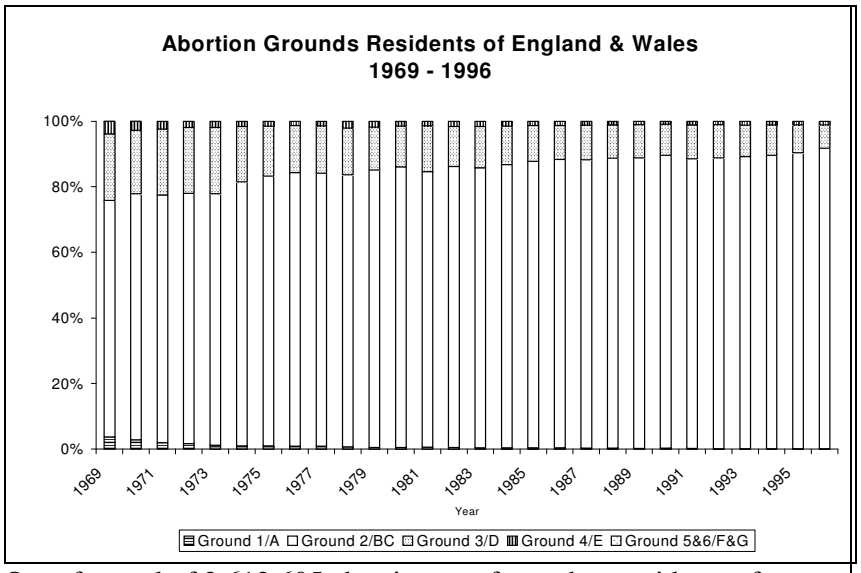
**Table 2**

[78] Abortion Act, 1967 s. 2 as amended by the Human Fertilisation and Embryology Act 1990 s. 37.

[79] When the current AB Series was first published by the Office of Population Census and Surveys (OPCS), HMSO, London.

[80] The last full year for which figures are available.

[81] Abortion Statistics 1974 - 1996 Series AB Office of Population Census and Surveys (OPCS), HMSO, London.




Out of a total of 3,613,605 abortions performed on residents of England and Wales between 1969 and 1996, 3,094,056 (over 86%) were performed on Ground 2/BC alone, with increasing reliance on psychological grounds. Three conditions account for 99% of all psychological disorders relied upon: personality disorder, depression not elsewhere classified and neurotic disorders.

The stated ground profile for non-residents shows a similar but more marked trend i.e. ground 1 is relied upon in 0.02% of cases (from a high of 5.7% in 1974) and ground 2/BC alone accounts for approximately 95% of all abortions. Suspected congenital malformation in the foetus accounts for less than 0.2% of all abortions (Table 3). Again, this trend has not altered following the re-classification of grounds in 1991.

**Table 3**

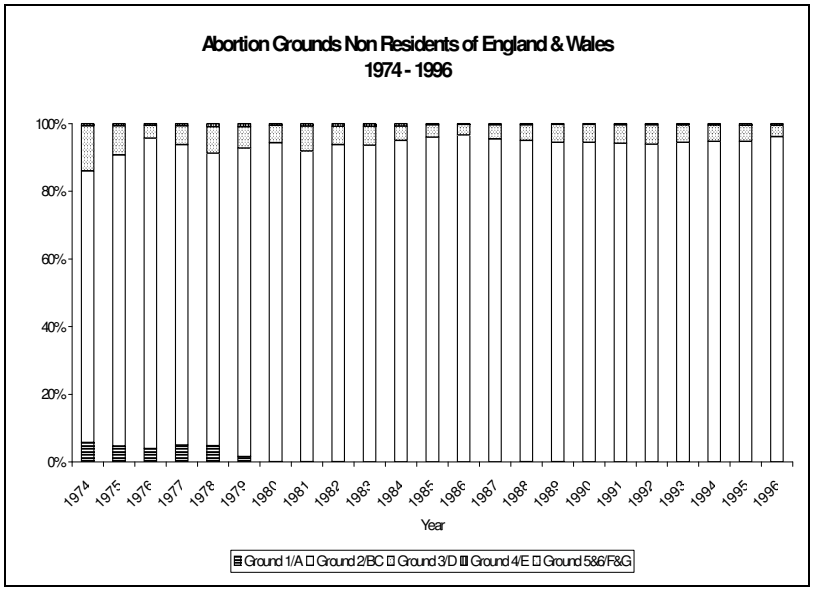



**Table 2**

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Out of 213,178 abortions performed on non-residents of England and Wales between 1984 and 1996, there was not a single case of Eisenmenger's complex, significant heart disease or cancer of the breast; other cases of unspecified neoplasia accounted for 0.003%. Ground 2/BC accounted for 203,112 (95%) cases. Overall, psychological reasons account for over 98% of all stated reasons. Although it has not been possible since 1994 to ascertain from the published data the clinical condition stated as the reason for abortion in non-residents, because of the manner in which the data is compiled, there are no indications whatsoever to suggest that Irish women seek abortions in Great Britain because they suffer from life-threatening conditions that are not treated, or treatable, in this country, because of the non-availability of induced abortion. Indeed, the recently (February 1998) published study Women and Crisis Pregnancy - a report presented to the Department of Health and Children, similarly confirmed that Irish women who seek abortions in Great Britain do so for social/personal reasons rather than because they suffer from medical conditions which are not being treated here because of the non-availability of induced abortion.

*Comparative Abortion Rates*

The present Irish abortion rate is approximately one in eleven. This compares to a British rate of approximately one in five. On occasion, those who support making abortion available in Irish hospitals have argued that there is not a direct link between the legal availability of abortion, and the actual numbers of women who have abortions. The Dutch experience has been cited to support this: allegedly, the abortion rate in the Netherlands is similar to the Irish rate, despite the easy availability of abortion in Holland.

The Dutch figure does not stand up to closer examination. According to the Dutch State statistical agency, 'Figures on abortion, though available from the early 1970s, are not complete. The data refers mostly to abortions performed in abortion clinics. Therefore, data such as age, nationality, parity of most women who have abortion in a hospital are not known. Moreover, not all report s are available to us.'[82]

[82] Letter from the Centraal Bureau voor de Statistiek, Prinses Beatrixlaan 428, Postbus 4000, 2270 JM Voorburg. 21 March 1997.

Moreover, it appears that the Dutch figure does not include what are officially classified as 'menstrual extractions', which are carried out from 16 to 44 days after the missed period. This procedure may account for many early abortions.

In short, the Dutch abortion figures do not include all abortions carried out in Holland and therefore are not comparable to the Irish or British figures.

**Existing medical practice**

In the world of clinical practice, the professional and legal prohibition on induced abortion did not inhibit medical practitioners from providing the best and most appropriate treatment and care for pregnant mothers.

The medical profession's approach to the issue of such treatment is outlined in the 1994 edition of the Medical Council's Guide to Ethical Conduct and Behaviour and to Fitness to Practise:

> It has always been the tradition of the medical profession to preserve life and health. Situations arise in medical practice where the life and/or health of the mother or of the unborn, or both, are endangered. In these situations it is imperative ethically that doctors shall endeavour to preserve life and health…
>
> While the necessity for abortion to preserve the life and health of the sick mother remains to be proved, it is unethical always to withhold treatment beneficial to a pregnant woman, by reason of her pregnancy.

*Foreseeability ('direct' and 'indirect')*

Foreseeability is not the test of intention in a complete prohibition on induced abortion. In everyday clinical practice, harm or injury to a patient can be readily foreseen as a consequence of some types of medical intervention. Nevertheless, especially in instances of life-threatening conditions, it is perfectly permissible to use treatments that are associated with serious or even life threatening side effects. In such circumstances, the doctor's judgment may well be that it is proper to incur grave risks in the management of grave conditions.[83]

This is an essential component of ethical practice but does not, of itself, preclude running serious risks in grave conditions. In summary, the risks of treatment must be proportionate to the condition being treated and the expected benefits. In pregnancy,

[83] For example, in the treatment of leukaemia, induced myelosuppression exposes the patient to the risks of overwhelming sepsis and severe haemorrhage. Nevertheless, in the circumstances, such risks are assessed as acceptable in terms of the desired outcome of cure. However, the medical and ethical principle governing such decisions is that the therapeutic option chosen must be the most effective and least toxic. Thus, if there are two treatments, Treatment A and Treatment B, of equivalent therapeutic efficacy, the ethical obligation is to chose that which is associated with the least severe side effects.

where uniquely, there is a simultaneous duty to two patients, *a fortiori*, these considerations apply – with due regard to side effects not alone to the mother but also to her unborn child. In no circumstances, however, is it permissible to compromise the therapeutic objective merely by virtue of the mother's pregnancy. In this regard, the Medical Council's position on induced abortion as a therapeutic option reflects the reality of such an approach and ought to be reflected in the law on abortion.

A clear judicial expression of the underlying principle, in a case involving a charge of attempted murder of a patient by her consultant physician, which encapsulates the essentials of ethical (and lawful) treatment was stated thus:

> We all appreciate … that some medical treatment, whether of a positive, therapeutic character or solely of an analgesic kind … designed solely to alleviate pain and suffering, carries with it a serious risk to the health or even the life of the patient. Doctors … are frequently confronted with, no doubt, distressing dilemmas. They have to make up their minds as to whether the risk, even to the life of their patient, attendant upon their contemplated form of treatment, is such that the risk is or is not medically justified. Of course, if a doctor genuinely believes that a certain course is beneficial to his patient, either therapeutically or analgesically, even though he recognises that that course carries with it a risk to life, he is fully entitled, nonetheless to pursue it. If sadly, and in those circumstances the patient dies, nobody could possibly suggest that in that situation the doctor was guilty of murder or attempted murder. …
>
> There can be no doubt that the use of drugs to reduce pain and suffering will often be fully justified notwithstanding that it will, in fact, hasten the moment of death, but … what can never be lawful is the use of drugs with the primary purpose of hastening the moment of death. … It matters not by how much or by how little [a] death is hastened or intended to be hastened … even if [it be the case that death was only hours or minutes away] no doctor can lawfully take any step deliberately designed to hasten that death by however short a period of time. … Alleviation of suffering means the easing of it for so long as the patient survives, not the easing of it in the throes of and because of deliberate purposed killing.[84]

Even more recently, the High Court in London reiterated the principle that high doses of pain-killers which were necessary to relieve pain can be given, even when – as an indirect and unintended (but

[84] *R v Cox* 12 BMLR 38 (Winchester Crown Court per Ognall J and approved in *Airedale NHS Trust v Bland* 1993 1 All ER 821 (HL).

foreseeable) side effect - they shorten life.[85] There is no reason to suggest that the courts in this jurisdiction would differ from this statement of the law in its articulation of the underlying principles in relation to the death of an unborn child during the course of the treatment of an ill mother.

*Abortion and the treatment of cancer*

The simultaneous occurrence of cancer and pregnancy is uncommon with a reported incidence of 0.07% to 0.1%.[86,87]

Numerous studies have shown over and over again that the outcome for pregnant women with cancer is no different than that of women who are not pregnant, when matched for age, stage and cancer type.

Cancer treatment involves the following modalities either singly or in combination

⇒ surgery

⇒ chemotherapy

⇒ radiotherapy

Surgery can, and frequently is, performed without undue difficulty on a pregnant women. Excluding caesarean sections, approximately 50,000 pregnant women per year in the United States will undergo a surgical procedure.[88]

The unborn child has developed all its organs and limbs by the 12th week of pregnancy. Hence chemotherapy can be given to a women in the second and third trimester without causing any abnormality in the unborn child. With judicious selection of chemotherapeutic agents pregnant women can be treated even in the first trimester.

Some drugs cannot cross the placental barrier, some others appear not to cause malformations. If the folic acid antagonists are excluded the incidence of congenital malformation is 6% for single agents.[89] Fortunately, methotrexate, the principal folic acid antagonist used, is not part of any curative regimen for which a therapeutically equivalent substitute is lacking.[90]

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[85] *Irish Independent*, 29 October 1997

[86] Mulvihill JJ, McKeen EA, Rosner F, Zarrabi MH. Pregnancy outcome in cancer patients. *Cancer 60*: *1143 1987.*

[87] Doll DC, Ringberg QS, Yarbo JW. Antineoplastic agents and pregnancy. *Seminars in Oncology 16(5) 337 1989*

[88] Barron W, The pregnant surgical patient: Medical evaluation and management. *Ann Intern Med 101:683-691 1984*

[89] Mulvihill JJ, McKeen EA, Rosner F, Zarrabi MH. Pregnancy outcome in cancer patients. *Cancer 60*: *1143 1987.*

[90] Mulvihill JJ, McKeen EA, Rosner F, Zarrabi MH. Pregnancy outcome in cancer patients. *Cancer 60*: *1143 1987.*

To optimise the efficacy of radiotherapy for cancer patents who are pregnant, the following factors must be considered: the potential effects of the therapy on the unborn child, the stage and prognosis of the mother's disease and the possible risks to the patient of restricting cancer treatment. The risk to the unborn is negligible if the foetal exposure does not exceed 0.1Gy.[91].

Where cure is a realistic goal, therapy should not be modified in such a way as to compromise its achievement. If there is no hope for cure or even significant palliation, the primary goal may become the protection of the foetus from any harmful effects of anticancer therapy and the delivery of a healthy infant. Therapy should be individualised for each patient and patient choice must be respected.

*Abortion and suicide*

Pregnancy reduces the overall risk of suicide compared with a population that is not pregnant.[92] This has been confirmed over and over again in studies in the U.K., the U.S and most recently in Finland. In a study in the U.S. the estimated suicide rate for pregnant women is 0.6 per 100,000 compared to 3.5 per 100,000 for non-pregnant women and 16 per 100,000 for men.[93]

A study in the U.S. found that the number of suicides of pregnant women was only one third of that expected.[94]

Suicidal thoughts are relatively common in normal adolescent girls occurring in up to 16.5% while in girls referred for psychiatric treatment suicidal thoughts occurred in 36%.[95,96] Actual suicide rates for teenage girls were 0.0003% for those aged 10-14 and 0.0034% for those aged 15-19 years.[97]

Prediction of suicide is at the basis of the decisions in Irish Courts relating to abortion. Numerous studies have attempted to predict suicide in high risk populations. The most thorough assessment showed that the prediction of suicide was wrong 97 times out of 100.[98] There is no literature on the association between threats and completion of the act since threats are so common and completed suicide is so rare. Thus, extrapolating clinically or statistically from threats to complete suicide would be impossible.

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[91] Nakagawa K, Aoki Y, Kusama T, Ban N, Nagawa S, Sasaki Y. Radiotherapy during pregnancy: effects on fetuses and neonates. *Clin Ther 19(4) 770-7 1997*

[92] Sim M: Abortion and the psychiatrist. *BMJ 2:145, 1963.*

[93] Minnesota Maternal Mortality Committee. *Am J Obstet Gynecol 6:1, 1967.*

[94] Marzuk P M, et al: Lower risk of suicide in pregnancy. *Am J Psychiatry 154 (1) 122-3 1997*

[95] Achenbach & Edelbrock: Manual for youth self-report and profile. *Dept of Psychiatry, University of Vermont, 1987.*

[96] Rey JM, Bird KD: Sex differences in suicidal behaviour of referred adolescents. *B J Psychiatr 158:776-781, 1991.*

[97] Eisenberg L: Adolescent suicide: On taking arms against a sea of troubles. *Paediatrics 315-320, 1980.*

[98] Pokorney A D: Prediction of suicide in psychiatric patients. *Arch Gen Psychiat 40 249-257 1983.*

All studies on suicide concur that depression is the most closely associated factor with suicide. Depression should be looked for and treated in any pregnant woman with suicidal ideation.

*Abortion and sexual assault*

Sexual assault is a crime of violence. Post-traumatic symptoms which occur immediately may not be integrated for a number of years. A distinct sub-category of post-traumatic symptoms experienced by victims of sexual assault includes shame, feeling dehumanized and reduced capacity for intimacy. Long term effects include anxiety, depression and impaired social adjustment.[99,100]

Social support is the most important single factor influencing rehabilitation after sexual assault. The social support network provides an atmosphere for feeling loved, valued and esteemed. The goal of treatment is: "*to regain a sense of safety .... a sense of self and (to) reestablish sharing .... relationships with men, women and society*".[101]

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

Abortion is freely available on demand in the U.S. Hence any woman pregnant as a result of rape can get an abortion without difficulty. The fact that so many do *not* choose this option in these circumstances seriously challenges the assumption made by so many that abortion is somehow beneficial to a woman who has been raped. In one study in 1996 of the prevalence and incidence of rape there were 34 cases of rape-related pregnancy. Only 17 women chose abortion and of the women who did not choose abortion 10 actually kept the baby after delivery.[102]

In a study of 37 pregnant rape victims in the USA in 1979[103] identified through a social welfare agency, 28 choose to continue

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[99] Bownes T, O'Gorman EC, Sayers A: Assault characteristics and post-traumatic stress disorder in rape victims. *Acta Psychiatr Scand 83: 27-30,1991.*

[100] Moscarello R: Psychological management of Victims of Sexual Assault. *Can J Psychiatry 35; 25-30,1990.*

[101] Bassuck EL: Crisis theory perspective on rape. In McCombie SL (ed*): The rape crisis intervention handbook.* Plenum Press, New York, 1980.

[102] Holms M M, Resnick H S, Kilpatrick D G, Best C L: Rape related pregnancy: estimates and descriptive characteristics from a national sample of women. *Am J Obstet Gynecol 175(2) 320-4 1996*

[103] Mahkorn S: Pregnancy and Sexual Assault. In *Psychological Aspects of Abortion Mall and Watts (eds) 5: 1979.*

the pregnancy, five had an abortion and four were lost to follow up. Of this 28, 17 chose adoption and 3 kept the child themselves and the placement of the remaining eight was undetermined.

Several reasons were given for not having an abortion. First, many women expressed the feeling that abortion was another act of violence. Secondly, some saw an intrinsic meaning or purpose in the child. Thirdly, at a subconscious level, some victims felt that by continuing the pregnancy, they would in some way conquer the rape.

Issues relating to the rape experience, not the pregnancy, were the primary concern for over 80% of the pregnant rape victims. The remaining 20% placed primary emphasis on their need to confront their feelings about pregnancy. In the group (28 of 37) who carried their pregnancies to term, the majority saw their attitude toward the child improve consistently throughout the pregnancy.[104]

*Abortion and heart disease*

The incidence of heart disease in pregnancy is extremely low.

The spectrum of heart disease in pregnancy has been changing over the last thirty years with a fall in the incidence of rheumatic heart disease and a relative increase in the numbers of pregnant women with congenital heart disease (both corrected and uncorrected). The balance comprises miscellaneous cardiac problems and acquired conditions.[105]

With early detection and successful correction of congenital heart defects, Eisenmenger's syndrome has become increasingly rare in developed countries in recent decades. The incidence of Eisenmenger's syndrome in pregnancy is very low.[106] By 1992 there had been less than 150 reported cases in the world literature over the previous 45 years. One case has been reported in Ireland since 1969. There is not a single reported case of the condition among the 115,567 abortions performed on non-residents in England and Wales between 1984 and 1990.[107]

The most recent review of pregnancy in women with Eisenmenger's syndrome is from the Heart Institute of the University of São Paulo, Brazil. It reviewed the outcome of 13 pregnancies in 12 women with Eisenmenger's. Three women in the series died: one had refused hospitalization, another died at home unexpectedly and the cause of death was unclear, and the third woman died in the puerperium of a femoral artery thrombosis

[104] Mahkorn S: Pregnancy and Sexual Assault. In *Psychological Aspects of Abortion Mall and Watts (eds) 5: 1979.*
[105] Clark SL: Cardiac disease in pregnancy. *Ob Gyn Clin North Am 18(2):237-256, 1991.*
[106] Gleicher N, Midwall J, Hochberger D, Jaffin H: Eisenmenger's syndrome in pregnancy. *Ob Gyn Surv 34(10):721741, 1979.*
[107] Office of Population Census and Surveys (OPCS): Abortion Statistics 1984 - 1990, HMSO, London.

having discontinued anticoagulant therapy.[108] This confirms other case reports that show that with intensive pre-, intra- and post-partum care these women can be taken safely through pregnancy and labour and even through caesarian section.[109,110] With advances in intensive care and in the critical understanding of the pathophysiology of this condition over the last 10 to 15 years pregnancy and labour have become safer for these patients.

Other cardiac conditions can be safely managed in pregnancy. There were no maternal deaths in a review of 214 pregnancies in 182 women with valve prostheses.[111]

Numerous reports of cardiovascular surgery during pregnancy include successful correction of most types of congenital and acquired cardiac disease. Maternal mortality is dependent on the specific nature of the procedure being performed and is not increased by pregnancy. [112] Successful pregnancy following heart transplantation has also been reported.[113,114]

**Consequences of abortion**

Notwithstanding some high profile cases of abortion survivals the mortality rate for the unborn child in abortion is effectively 100%.

While the introduction of so-called 'lunch-time' or 'quickie' abortion would seem to emphasise the safety of the procedure for the mother yet there is significant maternal morbidity and even mortality.

*Maternal mortality following abortion*

The Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1991-1993 reports 5 deaths directly related to abortion, a further 2 deaths due to suicide within 42 days of the abortion and another 2 deaths in women known to be substance abusers who died of injecting substance abuse overdose within 1 year of an abortion.[115]

A surveillance of pregnancy related deaths carried out by the U.S. Centres for Disease Control and Prevention found that 1 in every 20

[108] Avila W S, Grinberg R, et al: Maternal and fetal outcome in pregnant women with Eisenmenger's syndrome. *Europ Heart J 16, 460-464, 1995*

[109] Spinnato JA, Kraynack BJ, Cooper MW: Eisenmenger's syndrome in pregnancy: epidural anaesthesia for elective caesarean section. *N Eng J Med 304(20):1215-1217, 1981.*

[110] Atanassoff P, Alon E, Schmid ER, Pasch T: Epidural anaesthesia for caesarean section in a patient with severe pulmonary hypertension. *Acta Anaesthesiol Scand 34(1):75-77, 1990.*

[111] Sbarouni E, Oakley C M: Outcome of pregnancy in women with valve prostheses. *Br Heart J 71: 196-201 1994*

[112] Bernal JM, Miralles PJ: Cardiac surgery with cardiopulmonary bypass during pregnancy. *Obstet Gynecol Surv 41:1, 1986.*

[113] Hedon B: Heart Transplant Patient gives Birth to Twins. *Ob Gyn News 26:30, 1990.*

[114] Eskander M, Gader S, Ong B Y: Two successful vaginal deliveries in a heart transplant patient. Obstet Gynecol 87(5) 880, 1996

[115] Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1991-1993.

maternal deaths was due to induced abortion.[116]

A study of maternal mortality in Finland found the suicide rate following abortion was much higher than that associated with birth. The mean annual suicide rate was 11.3 per 100,000; the rate associated with birth was 5.9; the rate associated with induced abortion was 34.7.[117]

*Abortion begets abortion.*

A study of 2,925 women in Norway showed that the incidence of repeat induced abortion doubled from the second to the third abortion, indicating that the likelihood of choosing an abortion is increased by having done so before.[118] In a review of women having abortions in 1987 59% were under 25 years of age and 42% had had a previous abortion[119] and in a review of 2,001 women seeking abortion in Wichita, Kansas in 1991-1992 34% had had a previous abortion.[120] In a study of 163 patients seeking abortions who attended Irish Family Planning Association clinics in a 1 year period 10 of the women had had an abortion in the past with 4 of these having had 2 abortions. One teenager had 2 abortions during the study period of 1 year and returned for a third abortion one month after the study ended.[121]

*Medical complications following abortion*

Incidence of postabortal upper genital tract infections varies across populations. Incidence rates range at 5-20%. Infecting organisms include Chlamydia trachomatis, Neisseria gonorrhoeae, Mycoplasma hominis, Ureaplasma urealyticum, Group B streptococci and Human Papillomavirus. Long term sequelae of postabortal infection include chronic pelvic pain, ectopic pregnancy, dyspareunia and infertility.[122,123]

Previous induced abortion has also been shown to be associated with clinically significant neurotic disturbances in subsequent pregnancy and it is postulated that this phenomenon may reflect a

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[116] *CDC Obstet Gynecol 88 161-67 1996*

[117] Gissler M, Hemminki E, Lonnqvist J. Suicides after pregnancy in Finland 1987-94: register linkage study. *BMJ 1996 313(7070) 1431-4*

[118] Skjeldestad FE, The incidence of repeat induced abortion - a prospective cohort study. *Acta Obstetricia et Gynecologica Scandinavica 1994 73(9) 706-10.*

[119] Henshaw S K, Koonin LM, Smith J C. Characteristics of U.S. women having abortions, 1987. *Family Planning Perspectives 1991 23(2) 75-81*

[120] Westfall J M, Kallail K J. Repeat abortion and use of primary care health services. *Family Planning Perspectives 1995 27 (4) 162-5*

[121] *Irish Medical Times* April 18, 1997 page 5.

[122] Sawaya G.F., Grady D., Kerlikowska K., Antibiotics at the time of Induced Abortion: the case for universal prophylaxis based on meta-analysis. *Obstet Gynecol 1996 87(5) 884-90*

[123] Stray-Pedersen B, et al; Induced abortion: micrological screening and medical complications. *Infection 1991 19(5) 305-8*

reactivation of mourning which was previously suppressed.[124]

A number of studies have suggested that induced abortion may be a risk factor for developing breast cancer. One study suggested that women aged 45 or younger who have had induced abortions have a relative risk of 1.5 (50% increased risk) for breast cancer compared to women who had been pregnant but never had an induced abortion. The highest risk was for women who had an abortion younger than age 18 or older than 30.[125] A meta-analysis of 28 papers concludes that even one abortion significantly increases the risk and that overall the relative risk of breast cancer for women who have had an abortion is 1.3.[126]

[124] Kumar R., Robson K., Previous induced abortion and ante-natal depression in primiparae: preliminary report of a survey of mental health in pregnancy. *Psychological Medicine 1978 8(4): 711-5*
[125] Daling JR, Malone KE, Voigt LF, White E, Weiss NS, *J Natl Cancer Inst 1994 2*
[126] *Journal of Epidemiology and Community Health 1996 50: 481-96*

# Appendix E

# Extract From PLC Green Paper Submission

## DEMOCRACY

### Introduction

The Pro-Life Campaign based this Submission to the Interdepartmental Working Group on the Green Paper on Abortion on the view that all human beings possess an equal and inherent worth simply in virtue of their humanity, and not on condition of their possessing certain other qualifications of size, physical, emotional or mental capacity, autonomy or dependence, level of bodily, emotional or mental development, race, ethnic origin, wealth or poverty, age, sex or capacity for interpersonal relationship.

The Pro-Life Campaign adopted this view and proposes it to the Working Group because it believes that this view alone adequately acknowledges and respects the equal dignity of all human beings, because this view of equal and inherent worth is the foundation of the Republic's constitutional democracy, and because this view is the animating spirit behind the contemporary drive in Irish society to build an ethos of equal respect.

Having examined the legal and medical issues indicated by the advertisement inviting submissions, it is now proposed to evaluate the key point in each issue in the light of the principle of equal respect and to draw some conclusions from this evaluative review of the issues, which are proposed to the Working Group as the Pro-Life Campaign's recommendations.

### Morality and the law in a secular democracy

It is sometimes argued that laws in a secular democracy should not embody morality because to do so would be to impose the religious or moral values of some, whether a majority or a minority, on others. It is undoubtedly true that in a secular democracy, religious freedom is a basic civil right, that one should not be forced to accept religious beliefs and practices. Muslims should not be forced by the civil law to recite the Angelus, nor should Catholics be forced by the civil law to observe Ramadan.

It does not follow from this, however, that a secular democracy has to exclude every moral principle and precept that is taught by every religion -- if it did, the result would be social anarchy. In order to have a society at all, certain minimal moral conditions have to be met by most of the members most of the time, and these are required of their adherents by the main religions. For example, the

Bible enjoins respect for the civil authorities, payment of taxes, the requirement of corroborative evidence in legal proceedings on serious charges. A secular democracy is quite entitled to enact laws requiring obedience of lawful civil authorities, payment of taxes and corroborative evidence on serious charges, notwithstanding the fact that these moral requirements are also enjoined on their adherents by religions, *because it needs them in order to exist and function properly as a secular society*.

If this is true for all societies, it is especially true for constitutional democracy. A democracy is a society governed by the whole population through elected representatives, in accordance with laws that reflect the will of the people. The Concise Oxford Dictionary (9th edition) defines democratic as "favouring social equality." What makes a society truly democratic, therefore, is a spirit of respect for social equality. Take that away and even though the structures and procedures may remain, the ethos, the spirit, of democracy is gone.

Democracy is government according to the rule of law, where the law is the fabric of rights and responsibilities, entitlements and liberties, ordering human interaction. Human rights are just and reasonable claims on others to do or refrain from doing actions which impede the natural human existence, life and development of each human being. The minimum moral condition for having a democratic society at all, therefore, is a shared respect for social equality.

The fundamental human right is the right to life. It is only if one is alive, if one's life is respected and protected, that one can possess and exercise all the other rights such as the right to rational self-determination which are so important in a democratic society.

The foundation of democracy, in the literal sense of that upon which the rest of the edifice is based and built, is equality before the law. And since life is the fundamental good, the right to life, and to the protection of the law for one's life, is the fundamental human right and protection on which the rule of law in a democracy is grounded. Take that away and the rest is undermined, weakened and unbalanced.

It is appropriate and legitimate, and indeed, necessary, for the laws in a democratic society to recognise and protect the right to life, especially of the weaker members of society, the voiceless and powerless. It is for this reason that abortion should not be legalised.

The advertisement seeking submissions to the Working Group invited interested parties to address the "constitutional, legal, medical, moral, social and ethical issues which arise regarding abortion." On the basis of the view presented of the equal and inherent worth of every human life, the Pro-Life Campaign submits that in a secular democracy abortion is wrong on each and every

one of these grounds.

*Abortion is morally wrong*

Abortion is wrong *morally* because it is the direct and deliberate taking of an innocent human life.

*Abortion is legally and constitutionally wrong*

It is wrong in terms of *legal ethics* because the purpose of law in a democracy is to protect and vindicate the rights of the members in a just and equal manner, but abortion legalises the treating of some human lives unequally and unfairly under the law.

Abortion is wrong *legally* because in a democracy, the law exercises, in addition to its regulative function, a declarative, educative and normative role. What the law forbids, the society as a whole thereby declares, in the most formal, authoritative and official manner, to be impermissible.

When the law prohibits abortion, the society as a whole thereby declares in the most formal, authoritative and official manner that it throws the full moral weight of its backing behind the humanity of the unborn and its equal right to life as a human being equal in inherent worth to every other member of society.

When a society which hitherto has made abortion unlawful turns around and legalises abortion, it is declaring the dislodging of the old norm of recognition, equal respect, social support, and the protection of the law for the humanity and right to life of the unborn. The legalisation of abortion is the denial by society as a whole in the most authoritative and official manner of the equal humanity and inherent worth of the unborn as a fellow member of the human family and fellow member of society. It is the revoking of equal respect from the unborn as a human being, and the formal withdrawal of society's support and the law's protection for his or her life and right to life.

And in place of equal recognition, respect, support and protection, by legalising abortion, the society as a whole is declaring permissible what hitherto it had declared to be impermissible, namely, the direct and intentional killing of that innocent and defenceless human life by another member of society.

Small wonder, then, that when the law declares permissible what hitherto it had declared to be the unlawful taking of innocent human life, an ever increasing number of the members of the society come to believe that this killing of the unborn actually is morally permissible.

For this reason, Article 40.3.3$^{o}$ should be retained, and the people should be offered an opportunity to amend it along the lines

suggested in this Submission so as to reverse the effect of the Supreme Court ruling in the *X* case and to restore the protection to the right to life of the unborn which the people intended in enacting Article 40.3.3$^{o}$ to ban completely abortion in the Republic.

As regards a legislative approach, legislation is at all stages secondary to the basic constitutional provisions. Sections 58 and 59 of the 1861 Act harmonise with a constitutional approach which prohibits abortion, and the Pro-Life Campaign has no objection in principle to any legislative model which would harmonise with such a constitutional provision.

As made clear in the discussion above of the decision of the people in the referendum of 25th November 1992 to reject the amendment that would have inserted into the Constitution a right to abortion in certain instances, that amendment was unacceptable to the majority because it did not offer them the opportunity they wished to have to decide whether or not they want to ban abortion here altogether.

It is clear from the submission to this Working Group by the Irish Family Planning Association, the Irish affiliate of the International Planned Parenthood Federation, the most powerful international pro-abortion body in the world, that what the proponents of legalised abortion want is for abortion no longer to be regarded as a criminal matter at all but simply a matter of "women's health." This involves a complete denial of the humanity and equal and inherent worth of the unborn and is a view only held by a minuscule and entirely unrepresentative handful of people. The Irish Family Planning Association's proposal would require two referenda to be implemented, and in terms of realistic politics in the Republic today, given the balance of opinion among the general public on abortion, there is not the remotest chance that such referenda would pass.

Democracy, in Lincoln's memorable phrase from the Gettysburg Address, is government of the people, by the people for the people. It is that form of government in which the most important questions are put to the people as a whole for their decision. Article 6 of the Irish Constitution recognises explicitly the "right" of the people "in final appeal, to decide all questions of national policy, according to the requirements of the common good."

If any matter is a question of national policy it is surely whether or not abortion should be legalised. This matter, more than many other issues, should be put to the people as a whole for their decision. The common good in a democracy means the fabric of key social conditions that facilitate the existence, development and well being of all the members of the society, so it should surely include a legal framework that at the very least binds the society in its laws to respect the equal and inherent worth of all its members by acknowledging and pledging itself to protect their equal right to life.

The signatories of the Easter Proclamation pledged to defend religious and civil liberty, to seek equal rights and equal opportunities for all members of the society, and to cherish all the children of the nation equally. How can the Republic today claim a true continuity of commitment to these pledges if equal and inherent worth of the unborn as members of society is denied? Will not the commitment to religious and civil liberty ring hollow if legal protection is removed or withheld from the most elementary liberty of the unborn, the liberty to be born, to live? Surely the Republic cannot honestly claim to be respecting equal rights and equal opportunities for all as long as the unborn are denied equal legal protection for their right to life, equal opportunity to be born and to live. All the children of the nation are not being cherished equally as long as the laws of that nation withhold the protection of the law from the right to life of those children who are unborn. Abortion is wrong *constitutionally* because it is incompatible with these democratic pledges of equality.

Abortion is wrong *constitutionally* also because the purpose of the Constitution is to safeguard the most important rights of the members of society from unjust attack. In a constitutional democracy, the insertion of certain personal rights in the Constitution serves as an additional protection for them, withdrawing them from easy access in the cut and thrust of day to day politics, where otherwise they might be infringed when political expedience or a temporary social crisis seemed to require it.

But the right to life is the fundamental right; the unborn are among the most voiceless and vulnerable members of society, and abortion destroys the life of the unborn, so it is especially appropriate and imperative that the protection of the Constitution be given to the right to life of the unborn, having due regard, as Article 40.3.3$^{o}$ requires, to the equal right to life of the mother.

*Abortion is medically wrong*

It is wrong in terms of *medical ethics* because it violates the first principle of medical ethics, on which the whole practice of medicine has been based down through the centuries, *primum non nocere*, first do no harm, and the Hippocratic Oath, which originated outside the Judaeo-Christian tradition, that prohibits the procuring by a doctor of an abortion. Abortion makes the medical profession a party to the deliberate shedding of innocent blood.

Abortion is wrong *medically* because, as shown above, the provision of abortion is not really a medical issue at all as abortion is never necessary to save the life of a mother; it is not a necessary part of the treatment of cancer or heart disease in pregnant women; it is not an appropriate medical response to suicidal inclinations;

and it is not a truly compassionate response where pregnancy has resulted from sexual violence.

Medical treatments in which the loss of the life of the unborn follows as a foreseeable though undesired side-effect are *not* the same morally, legally or medically as induced abortion. All medical treatments involve side-effects, often foreseeable, and the practice of medicine is quite familiar with the distinction between foreseeable direct and indirect effects.

Abortion to prevent the birth of a handicapped child is medically wrong because when a doctor treats a pregnant women he or she has an ethical and professional duty of best care towards not one but two patients, the mother and the unborn child, and the fact that a patient is suffering from a disability is not a reason to seek to bring about the death of that patient. On the contrary, a human being is not any the less human or worth any less because they suffer from a disability. We are equal in worth to the other members of the human family and the society into which we are born by virtue of our humanity, and not as a result of having passed some kind of quality control test.

*Abortion is socially wrong*

Abortion is wrong *socially* because in a democracy all the members are equal and their lives have an equal and inherent value, but abortion treats some unequally and regards their lives as of lesser or no inherent worth, but rather allows some to decide upon the value of the lives of others, and actually to dispose of those lives, according to their own wish or convenience.

It is also wrong *socially* because by allowing some to bring about the death of others, it undermines, weakens and destroys the sense of human brotherhood and sisterhood, breaking the bonds of fellowship that bind the members into a society.

When, as in this submission, we look at the grounds on which legal abortion is available in Britain, we realise that the legalisation of abortion is wrong *socially* also because it throws the weight of society's moral approbation behind the violation of its own most intimate bonds, the bonds uniting mother and unborn, father and unborn, born and unborn brothers and sisters. It signals a rejection of the handicapped. It signals a rejection of the weak. If the most vulnerable can lawfully be killed, then any lesser abuse may well be visited on the less vulnerable. The medical and legal professions are those to whom we have to turn in our moments of greatest distress and weakness. Legalised abortion involves both of these professions in the taking of innocent life, in the violation of the most fundamental right of the most voiceless members of society. Democracy is that form of society animated by a spirit of social equality. If the legislature or judiciary in a democracy make laws

that deny the equal humanity and inherent worth of some of the members of the society, as happens when abortion is legalised, they thereby render the society entrusted to them ever more undemocratic, less suffused by a spirit of respect for equality, and they alienate ever more radically those who are affronted by this attack on the fundamental rights of the innocent and defenceless. Legalising abortion saws away the very branch on which democracy rests, the respect for social equality.

Proponents of legalising abortion argue that, because of the tragic fact that several thousand women go to Britain for abortions, abortion should be legalised in the Republic. This is a false and hypocritical argument. What is tragic is that those women undergo abortion, not that the abortions happen in Britain. They would be just as tragic if they happened in the Republic.

Abortion is only tragic because it is the taking of the life of an unborn child, and for that reason is profoundly distressing for the women. If it were a medical operation like having an appendix removed, it would not be tragic. It is gross insensitivity and hypocrisy for the proponents of abortion to trade on the tragedy by suggesting that it constitutes a reason for legalising abortion in Ireland. The only way to avoid the tragedy is to avoid what makes it tragic, namely, the abortion itself. The tragedy is not any less tragic because it happens in the Republic rather than happening in Britain.

The Pro-Life Campaign is deeply concerned that so many women feel they have to have recourse to abortion and is committed to pressing for the introduction of measures that will help them to find another way to resolve the terrible dilemma in which they find themselves, but it insists that each of these abortions is tragic, not because it happens in Britain, but because it happens at all, because it involves the taking of an innocent human life and the violation of a vulnerable women.

The Pro-Life Campaign further points out that the clear and ineluctable lesson of international experience is that the legalisation of abortion is followed by a massive increase in the numbers having recourse to abortion. If every women going for an abortion is tragic, and it is, this is a reason for not going down the road of legalising abortion here, because were it to be legalised here, the certainly foreseeable consequence would be a huge rise in the numbers of women who would have recourse to it.

As an expression of its concern that every effective measure that will help women not to turn to abortion should be explored, the Pro-Life Campaign wishes to draw the attention of the Working Group to the findings of the opinion poll published in the *Sunday Independent* (30 November 1997), which found 87% of people in favour of Government action to make adoption easier where a single mother is unable or unwilling to care for the child, and 59% in favour of a major Government campaign to persuade single

expectant mothers to allow their pregnancies to proceed to birth.

These replies point to the existence of an emphatic public desire that public policy not only ban abortion but discourage women under pressure from having abortions by positive measures, such as making other options easier, and by a social education campaign to encourage them to give birth. The Pro-Life Campaign wholeheartedly shares this desire and urges the Working Group to make the identification and implementation of such measures one of its principal recommendations.

# Appendix F: Submission made by the Pro-Life Campaign to the All-Party Oireachtas Committee on the Constitution in January 1997 in response to the report of the Constitutional Review Group.

## SUMMARY OF SUBMISSION

*Constitutional Review Group's Proposals on Definition*

'The Pro-Life Campaign is of the view that the protection of the law should extend to all life from conception to natural death. Any attempt to limit this protection by way of statutory definition or otherwise is both unconstitutional and undesirable.'

*Possible approaches*

'The position of the Pro-Life Campaign is simple and clear. Irish medical practice has no difficulty in distinguishing between abortion and medical treatment for the mother. Irish obstetricians make the distinction every day in the hospitals. They do not carry out abortions, since they recognise that the Supreme Court was mistaken, legally and medically, in its holding in the X decision. The Irish electorate should be given the democratic choice, in a referendum, to restore full protection to the unborn, consistent with contemporary medical practice.

'The Pro-Life Campaign, therefore, rejects the proposal of the Review Group to legislate to allow abortion and stands by the alternative approach of a referendum to allow the electorate to constitutionally prohibit abortion.'

## INTRODUCTION

The legal situation in regard to abortion has been unsatisfactory since the Supreme Court in 1992 interpreted the Eighth Amendment, inserted by the electorate into the Constitution to expressly prohibit abortion, as actually allowing abortion, potentially on wide grounds.

Since then, there have been various efforts to tackle the matter; the constitutional referenda in November 1992, the increased funding to various non-governmental agencies, and the Regulation of Information (Services outside State for Termination of Pregnancies) Act 1995. None of these addressed the core problem of whether abortion should be permitted or

prohibited. The Pro-Life Campaign promotes the latter position, and furthermore holds that abortion raises such fundamental questions about the nature of society and respect for life that it must be left to the electorate to decide, by way of a referendum which gives a clear choice.

## PROPOSALS ON DEFINITION

Before examining the various approaches by which the law might be clarified, the Report of the Constitutional Review Group (henceforth referred to as the Review Group) raised a problem of definition, pointing out that:

> There is no definition of 'unborn' which, used as a noun, is at least odd. One would expect 'unborn human' or 'unborn human being'. Presumably, the term 'unborn child' was not chosen because of uncertainty as to when a foetus might properly be so described.[127]

The Pro-Life Campaign regards this statement with some degree of puzzlement. Article 40.3.3° is in the personal rights section of the Constitution and must therefore refer to unborn human beings. Moreover, the adjectival noun is of standard usage in the Constitution. For instance in Article 45.4.1:

> The State pledges itself to safeguard with especial care the interests of the weaker sections of the community, and, where necessary, to contribute to the support of the infirm, the widow, the orphan, and the aged.

In its discussion of Article 45.4.1, the Review Group did not suggest that the use of the adjectival nouns 'the infirm' and 'the aged' denoted any uncertainty about their humanity.[128]

The Review Group goes on to state:

'Definition is needed as to when the "unborn" acquires the protection of the law...'

and

'a definition is essential as to when pregnancy is considered to begin; the law should also

[127] Report of Constitutional Review Group, Dublin, 1996. Page 275.
[128] Review Group, Pages 391-4

specify in what circumstances a pregnancy may legitimately be terminated and by whom.'

and finally

'If the definition of "pregnancy" did not fully cover what is envisaged by "unborn", the definition would need to be remedied by separate legal provisions which could also deal with other complex issues, such as those associated with the treatment of infertility and *in vitro* fertilisation.'[129]

The Review Group concludes that these definitions should be introduced by way of legislation.[130]

This is a surprising recommendation as it is not within the ambit of the Legislature to define the scope of constitutional protection given to human life: that is the prerogative of the Courts. Furthermore, the Pro-Life Campaign views with grave concern any effort to limit the protection of the law so that it does not extend to all life, from conception to natural death.

**The Pro-Life Campaign is of the view that the protection of the law should extend to all life from conception to natural death. Any attempt to limit this protection by way of statutory definition or otherwise is both unconstitutional and undesirable.**

## THE POSSIBLE APPROACHES

On the substantive issue of abortion, the Review Group considered five options:

**a) introduce an absolute constitutional ban on abortion**

**b) redraft the constitutional provisions to restrict the application of the X case decision**

**c) amend Article 40.3.3° so as to legalise abortion in constitutionally defined circumstances**

**d) revert, if possible, to the pre-1983 situation**

**e) regulate by legislation the application of Article 40.3.3**[131]

[129] Review Group, Page 275
[130] Review Group, Page 279
[131] Review Group, Page 276.

This Submission will deal with the two primary options, 'a' and 'e'. Some comments upon the Review Group's approaches are to 'b', 'c' and 'd' are made in the appendix.

**The first option, to introduce an absolute constitutional ban on abortion, is the option supported by the Pro-Life Campaign.**

Of this approach, the Review Group said:

> According to a press report (*The Irish Times*, 10 September 1992), the Pro-Life Campaign considers "a complete prohibition on abortion is legally and medically practicable and poses no threat to the lives of mothers". Reference is made to "the success of medical practice in protecting the lives of mothers and their babies", and it is claimed that "a law forbidding abortion protects the unborn child against intentional attack but does not prevent the mother being fully and properly treated for any condition which may arise while she is pregnant".[132]

The Review Group goes on to state that it would not be safe to rely on such understandings, because:

> ... if a constitutional ban were imposed on abortion, a doctor would not appear to have any legal protection for intervention or treatment to save the life of the mother if it occasioned or resulted in termination of her pregnancy.[133]

The Pro-Life Campaign believes that this conclusion is unsafe, and without grounding in either the legal and medical understanding of the treatment of mothers and their unborn babies, or the medical profession's own ethical guidelines which reflect the fact that '...the necessity for abortion to preserve the life or health of the mother remains to be proved...'[134]

There is a crucial distinction, ignored by the Review Group, between those cases where the death of the unborn may result as an indirect effect of appropriate medical treatment, and cases involving the intentional killing of the unborn child. The established medical practice of over a century has always required that mothers be fully and properly cared for during pregnancy.

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[132] Review Group, Page 277
[133] Review Group, Page 277
[134] A Guide to Ethical Conduct and Behaviour and to Fitness to Practise. The Medical Council. Fourth Edition, 1994. Page 36. (Henceforth cited as 'Medical Council')

It is important to realise - and this point appears to have escaped the Review Group - that a mother is not denied the appropriate treatment because of possible but undesired and unintended consequences for her baby.

Treatments directed at protecting the life of the mother, and not involving any direct attack on her unborn child, are and always have been ethically and legally proper even though the loss of her child may follow as an unsought and unwelcome side effect. Irish medical practice has it that '... it is unethical always to withhold treatment beneficial to a pregnant woman, by reason of her pregnancy'.[135]

Thus, Irish law and the ethical guidelines of the Medical Council recognise the difference between induced abortion - the direct and intentional killing of the unborn - and damage to or even the death of unborn babies arising indirectly from medical treatment. This principle was not changed by the passage of the 1983 Amendment, any more than it would change if another prohibition on induced abortion were to be inserted in the Constitution.

In treating pregnant women, doctors know that all treatments have side effects. In selecting a treatment for any patient, the doctor must have regard - not alone to the desired effects - but also to the undesired side-effects. Pregnancy presents a near unique situation for any doctor, who is then required to deal with two patients simultaneously. Here the effects on the unborn child must also be taken into consideration. However, the fact that a woman is pregnant is not a ground for refusing her appropriate treatment. Although concerns for foetal well-being may alter therapeutic approaches, in serious or life-threatening conditions, therapy should not be modified in such a way as to compromise the goal of treatment.

Where, however, there are two treatments for any given condition in the mother - and both are of comparative therapeutic efficacy - there is an obligation to use that which is least harmful to both the mother and her unborn child. The function of medicine is to preserve life and relieve suffering. It is not the function of doctors to kill: an obvious point but one that would have been well remembered by the authors of this report.

In effect, Ireland without abortion is one of the safest countries for pregnant women. While not attempting to minimise in any way the death of any woman during pregnancy or childbirth, it is abundantly clear - and this is reflected in international reports - Ireland has one of the best

[135] Medical Council. Page 36.

records in the world,[136] which is reflected in our maternal mortality rates. The latest independent research states:

> The Republic of Ireland is unusual in the developed world in that termination of pregnancy is not available. This does not appear to have influenced these figures significantly, the maternal mortality rate due to obstetric causes being half that of the nearest European neighbour, i.e. England and Wales.[137]

This research is consonant with the major review of maternal deaths carried out in the National Maternity Hospital, Dublin in 1982, before the enactment of the Eighth Amendment. That study found that over a ten year period there were 21 maternal deaths and a total of 74,317 births. In each case the cause of death was analysed and the conclusion was that the availability of induced abortion would not, in any way, have reduced the number of maternal deaths over the study period.[138]

It might be thought that the rate of maternal death in Ireland is artificially low because of the number of Irish women who travel to Britain each year for abortions. This is not the case. Analysis of the British statistics is unequivocal. For whatever reason Irish women have recourse to abortion in England - which has one of the most liberal abortion regimes in Europe - a risk to the mother's life or health is not one of them. There is no evidence that women travel in order to obtain treatment for life-threatening conditions which could not be treated here in Ireland because of the non-availability of abortion. [139]

The Review Group's contention that a complete ban on abortion would prevent the mother being fully and properly treated for any condition which may arise while she is pregnant represents a major departure from the present legal and medical understanding of the matter, and is not supported by Irish maternal mortality statistics.

**The position of the Pro-Life Campaign is simple and clear. Irish medical practice has no difficulty in distinguishing between abortion and medical treatment for the mother. Irish obstetricians make the distinction every day in the hospitals. They do not carry out**

[136] 1994, 1995. *The Progress of Nations*. UNICEF, New York.
[137] *Maternal Mortality in the Irish Republic, 1989-1991.* Jenkins DM, Carr C, Stanley J, O'Dwyer T. Irish Medical Journal, July/ August 1996, Volume 89, Number 4.
[138] *Therapeutic Abortion: The Medical Argument.* Murphy J, O'Driscoll K. Irish Medical Journal, 75: 306-6, 1982.

**abortions, since they recognise that the Supreme Court was mistaken, legally and medically, in its holding in the X decision. The Irish electorate should be given the democratic choice, in a referendum, to restore full protection to the unborn, consistent with contemporary medical practice.**

**Option 'e', to 'regulate by legislation the application of Article 40.3.3', is the preferred option of the Constitutional Review Group.**

> Relying on legislation alone would avoid the uncertainties surrounding a referendum but the legislation would have to conform to the principles of the X case decision and be within the ambit of Article 40.3.3° generally.[140]

This statement forms the basis of the Group's recommendations and contains two points which cannot be left unchallenged.

1. '...the uncertainties surrounding a referendum..'. Every popular vote is subject to uncertainties, because it is never clear which way the electorate will vote. Thus 'uncertainty' is an integral part of the democratic system; to suggest that such uncertainties should be avoided is tantamount to saying that, since the electorate cannot be trusted to vote in a predictable or reliable manner, it is better to leave major decisions to the Legislature.

2. '...the legislation would have to confirm to the principles of the X case decision...' This analysis is quite correct, and must mean that any legislation would have to permit the creation of a domestic abortion regime. Yet this was clearly not the intention of the people in 1983 and would be contrary to what the Review Group recognised to be 'strong opposition to any extensive legalisation of abortion in the State.'[141]

Despite the acknowledgement that 'legislation would have to conform to the principles of the X case decision'[142], the Review Group suggests that a time-limitation be imposed to prevent a viable foetus being aborted in circumstances permitted by the X case. This inconsistency in the Review Group's arguments is in itself a matter of concern; moreover the contention that the

[139] *Abortion Statistics, England and Wales, Series AB, 1974-1994.* Office of Population, Censuses and Surveys, HMSO, London.
[140] Review Group, Page 279
[141] Review Group, Page 277
[142] Review Group, Page 279

Legislature could limit the scope of a constitutional interpretation of the Supreme Court is simply a legal nonsense.

The Review Group notes that legislation could 'require written certification by appropriate medical specialists of "real and substantial risk to the life of the mother"'.[143] This is presumably an effort to reduce the number of abortions that would take place under the proposed legislation. Yet the foreign experience is that any abortion law, no matter how superficially restrictive in some areas is used to create a legal culture of abortion on demand. (And the Pro-Life Campaign notes again that legislation under the terms of the X decision would have to be broad, rather than restrictive, if it is to give scope to the decision).

The Review Group concludes:

> While in principle the major issues discussed above should be tackled by constitutional amendment, there is no consensus as to what that amendment should be and no certainty of success for any referendum proposal for substantive constitutional change in relation to this subsection.
>
> The Review Group, therefore, favours, as the only practical possibility at present, the introduction of legislation covering such matters as definitions, protection for appropriate medical intervention, certifications of 'real and substantial risk to the life of the mother' and a time-limit on lawful termination of pregnancy.[144]

The Pro-Life Campaign agrees that, in principle, the abortion issue should be tackled by constitutional amendment. It also agrees with the somewhat obvious observation that there is no consensus as to what the amendment should be and no certainty of success for any referendum. It would be a bizarre situation indeed if there were to be a total consensus on abortion, or indeed a certainty of success for any constitutional referendum. None of this means that a national abortion debate, taking place at the most fundamental level of the Constitution, is impractical. The strength of our democratic system lies in its ability to confront difficult issues and reach a mature decision which will, by virtue of having such a direct mandate from the people, be infinitely more acceptable than a judicial or legislative decision.

[143] Review Group, Page 279

**The Pro-Life Campaign, therefore, rejects the proposal of the Review Group to legislate to allow abortion and stands by the alternative approach of a referendum to allow the electorate to constitutionally prohibit abortion.**

## APPENDIX

***Comments upon the Review Group's proposals 'b', 'c' and 'd'.***

**b) redraft the constitutional provisions to restrict the application of the X case decision**

The Review Group notes the failure of this approach in 1992. The Pro-Life Campaign agrees with this analysis.

**c) amend Article 40.3.3° so as to legalise abortion in constitutionally defined circumstances**

The Review Group draws attention to the fact that there 'appears to be strong opposition to any extensive legalisation of abortion in the State.' The Pro-Life Campaign endorses this view. Concerning the Group's assertion that 'There might be some disposition to concede limited permissibility in extreme cases, such, perhaps, as those of rape, incest or other grave circumstances', the PLC draws attention to the 1995 survey by the Institute of Advertising Practitioners in Ireland which put opposition to abortion in all circumstances at 52% of the electorate.[145]

(Another poll, conducted by Irish Marketing Surveys for the Pro-Life Campaign in May, 1993 asked a representative sample of the electorate whether, their personal opinions on abortion aside, they felt that a constitutional referendum was the way to deal with the issue. 60% were in favour of a referendum, 28% opposed.)

**d) revert, if possible, to the pre-1983 situation**

The Review Group comments that the experience since the 1983 Amendment was 'a lesson in

[144] Review Group, Page 279
[145] It might be expected that this figure would rise during a referendum campaign; the same survey indicated that opposition to divorce was 28%!

the wisdom of leaving well enough alone...'

This viewpoint is contested by the Pro-Life Campaign. That the Amendment was not upheld by the Supreme Court in the X decision can as easily be construed as a criticism of that decision rather than of the Amendment itself. And it is fair to say that without the constitutional protection for unborn life throughout the 1980's, the situation in Ireland might now be very different.

The Pro-Life Campaign would not recommend a return to the pre-1983 situation, because such would not provide adequate protection for unborn life.

# Appendix G : Effects of cancer treatment on unborn children

**CHEMOTHERAPY**

Chemotherapy is potentially curative in carcinoma of the breast and ovary, acute leukaemia, Hodgkin's lymphoma, and intermediate and high grade non-Hodgkin's lymphomas. Cytotoxic drugs produce their effects predominantly on rapidly dividing cells. Therefore, rapidly dividing foetal cells exposed to such agents may be associated with deleterious effects. The timing of the exposure is critical. Drugs administered in the first week after conception probably produce an "all or nothing" phenomenon (i.e. either a spontaneous miscarriage or normal development). During the first trimester when organogenesis occurs, drugs can produce congenital malformations of differing severities and/or spontaneous miscarriage. Each type of malformation can occur only at specific times.[146,147148] During the second and third trimesters, drugs do not cause significant malformations but they can impair foetal growth and functional development (neurological development in particular).[1,149] Finally towards the end of gestation, the foetus reacts like a newborn exposed to a noxious substance.

The teratogenic and mutagenic potential of chemotherapeutic agents has been clearly demonstrated in animals[150,151,152] but extrapolation from animal studies to humans is tenuous because of differences in species susceptibility.[1,153] Up to 600 factors have been catalogued as teratogenic in animal experiments[154]. However teratotoxic sequelae have been documented for only some of these factors. This is partly due to the fact that the therapeutic dose used in humans is lower than the minimal teratogenic dose applied in animals. In addition, the genotype of the organism also plays an important role. Thus the absence of teratogenesis in animals is no guarantee of safety in man (e.g. thalidomide) and conversely agents that produce defects in animals appear to be harmless in humans (e.g. aspirin).[3]

Studies have confirmed that the critical phase for teratogenesis embryonic organogenesis in the first trimester.[155,156,157] But the risk is significantly lower than is

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[146] Ebert U, Löffler H, Kirch W. Cytotoxic therapy and pregnancy. Pharmacol Ther 74 (2) 207-220 1997

[147]

[148] Beeley L: Adverse effects of drugs in the first trimester of pregnancy. Clin Obstet Gynecol 13:177-195, 1986.

[149] Doll DC, Ringenberg QS, Yarbro JW: Antineoplastic agents and pregnancy. Sem Oncol 16(5):337-346, 1989.

[150] Cahen RL: Experimental and clinical chemoteratogenesis. Adv Pharmacol 4:263-349, 1966.

[151] Chaube S, Murphy ML: The teratogenic effects of the recent drugs active in cancer chemotherapy. Adv Teratology 3:181-237, 1968.

[152] Sieber SM, Adamson RH: Toxicity of antineoplastic agents in man: Chromosomal aberrations, antifertility effects, congenital malformations and carcinogenic potential. Adv Cancer Res 22:57-155, 1975

[153] Brent RL: Evaluating the alleged teratogenicity of environmental agents. Clin Perinatol 13:609-613, 1986.

[154] Shepard TH. Catalog of Teratogenic Agents. 7th ed. Johns Hopkins Press, Baltimore. 1992

[155] Blatt J, Mulvihill JJ, Zieglewr JL et al: Pregnancy outcome following cancer chemotherapy. Am J Med 69:828-832, 1980.

generally appreciated because doses, dose frequency and duration of exposure are important variables. For an agent to be teratogenic, it appears necessary for the dose to lie within the narrow range between causing death of the foetus and causing no discernible effects. Synergistic teratogenesis may occur with combination chemotherapy.[158]

A large number of anti-neoplastic agents given alone or in combination may cause congenital malformations when given in early pregnancy.[3] An early review of 53 cases where antineoplastic drugs were administered during pregnancy reported a 7.5% rate of foetal malformation[159]. Another study found that 17% of foetuses exposed to chemotherapy developed congenital malformations[160]. The most recent review of 217 cases involving cytotoxic treatment during pregnancy between 1983-1995 found 9.2% of liveborn or stillborn infants had congenital abnormalities[1].

In a review of 56 pregnancies associated with haematological malignancies (27 treated before conception and 22 while pregnant) there was only 1 major malformation.[161] Furthermore an assessment of the rate of congenital malformation due to anti-cancer therapy should be tempered by the fact that the overall incidence of major congenital malformations is approximately 3% of all births[2,162] and the incidence of minor malformations is as high as 9% (depending on the definition of "minor" giving a total of 12% for all malformations).[3] Furthermore, the effects of radiation which is a well known teratogen in both humans and animals[163] are difficult to exclude from the data.[3]

If the effects of radiation and the folic acid antagonists are excluded the incidence of congenital malformation falls to 6% for single agents.[3] Fortunately, methotrexate, the principal folic acid antagonist used, is not part of any curative regimen for which a therapeutically equivalent substitute is lacking.[3] Similarly, there are reports of normal infants delivered following chemotherapy (including methotrexate[164]) during the first trimester.[17,165,166,167] Long term follow-up of these children has revealed

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[156] Barber HRK: Foetal and neonatal effects of cytotoxic agents. Obstet Gynecol 58:41S-47S, 1981 (suppl).
[157] Gilliland J, Weinstein L: The effects of cancer chemotherapeutic agents on the developing fetus. Obstet Gynecol Surv 38:6-13, 1983.
[158] Mulvihill JJ, McKeen EA, Rosner F et al: Pregnancy outcome in cancer patients. Cancer 60:1143-1150, 1987.
[159] Hicholson HO. Cytotoxic drugs in pregnancy. J.Obstet Gynecol. Br. Commonw. 75:307-12. 1968
[160] Doll DC, Ringenberg S, Yarbro DW. Management of cancer during pregnancy. Arch Intern Med 148: 2058-2064. 1988
[161] Znazu J, Julia A, Sierra J, Valentin MG, Coma A, Sanz MA, Batle J, Flores A. Pregnancy outcome in haematological malignancies. Cancer 63(3) 703-9. 1991
[162] Kalter H, Warkany J: Congenital malformations. N Engl J Med 308:424-431, 1983.
[163] Brent RL: The effects of embryonic and fetal exposure to x-rays, microwaves and ultrasound. Clin Perinatol 13:615-648, 1986.
[164] Aviles A, Diaz-Maqueo JC, Talavera A, Guzman R, Garcia EL: Growth and development of children of mothers treated with chemotherapy during pregnancy: Current status of 43 children. Am J Haematol 36:243-248, 1991.
[165] Aviles A, Niz J: Long-term follow-up of children born to mothers with acute leukaemia during pregnancy. Med Pediat Oncol 16:3-6, 1988.
[166] Caliguri MA, Mayer RJ: Pregnancy and leukaemai. Sem Oncol 16:388, 1989.

normal is the phase of growth and development.[17,18,20]

There is no evidence of an increased risk of teratogenesis associated with the administration of chemotherapy in the second and third trimesters.[14,168]

In most cases the cancer and the pregnancy can be managed concurrently with a good outcome for the baby and without compromising the mother's prognosis.[169] When cure is a realistic goal, therapy should not be modified in such a way as to compromise its achievement. If there is no hope for cure or even significant palliation, the primary goal may become the protection of the foetus from the harmful effects of anticancer therapy and the delivery of a healthy infant. Therapy must be individualised for each patient.[3]

**SURGERY**

Excluding caeserean sections, approximately 50,000 pregnant women per year in the United States will undergo a surgical procedure[170]. Surgery *per se* does not cause problems in pregnant patients. Anaesthetics given to a pregnant woman who requires surgery can be used safely and have not been shown to be teratogenic.[171,172]

**RADIOTHERAPY**

The most common tumours requiring radiotherapy are lymphomas, leukaemias and tumours of the breast, uterine cervix and thyroid. With the exception of cancer of the cervix there is no direct radiation to the foetus, instead the foetus is excluded from the radiation field and is exposed only to radiation leaking from the accelerator, collimator dispersion generated from apparatuses other than the accelerator and dispersion radiation from the mother. The most important factor is the distance of the foetus from the field edge which is the limit of the direct beam. It is possible to estimate the foetal dose as a function of the stage of pregnancy.[173] Covering the mother's abdomen with a lead shield (approx 4.5 cm thick) was effective in further reducing the radiation to the foetus.[174,175]

To optimise the efficacy of radiotherapy for cancer patients who are pregnant, the

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[167] Reynoso EE, Shepherd FA, Messner HA et al: Acute leukaemia during pregnancy: The Toronto Leukaemia Study Group experience with long-term follow-up of children exposed in utero to chemotherapeutic agents. J Clin Oncol 5: 1089-2106, 1987.

[168] Grendys EC Jr, Barnes WA. Ovarian cancer in pregnancy. Surg clin North Am 75(1) 1-14. 1995

[169] Antonelli NM, Dotters DJ, Katz VL, Juller JA. Cancer and pregnancy: a review of the literature Part I. Obstet Gynecol surv 51(2) 125-34. 1996

[170] Barron W, The pregnant surgical patient: Medical evaluation and management. Ann Intern Med 101:683-691 1984

[171] Pedersen H, Finster M. Anaesthesia risks in the pregnant surgical patient. Anaesthesiology 51. 439-51. 1979

[172] Nunn FJ. Faulty cell replication, abortion, congenital abnormalities. In Cottrel JE, editor International Anesthesiology Clinics. Vol 19 82-3 1981.

[173] Van der Giessen PH. Measurment of the peripheral dose for the tangential breast treatment technique with Co-60 gamma radiation and high energy X-rays. Radiotherapy and Oncology 42: 257-264. 1997

[174] Stovall M, Blackwell CR, Cundiff J, et al. Fetal dose from radiotherapy with photon beams. Report of AAPM Radiation Therapy Committee Task Group No. 36. Am Assoc Phus Med. 22: 63-82. 1995

[175] Woo SY, Fuller LM, Cundiff JH, et al. Radiotherapy during pregnancy for clinical stages IA-IIA Hodgkin's diesase. Int J Radiation Oncology Biol Pyhs. 23: 407-412. 1992

following facts must be considered: the potential effects of the therapy on the foetus and neonate, the stage and prognosis of the mother's disease, and the possible risks to the mother of restricting or delaying treatment. Malformation and mental retardation are the most serious consequences of foetal exposure to radiation. The risk is negligible if foetal exposure does not exceed 0.1Gy.[176] With higher doses the sensitivity to radiation is high from 2-8 weeks after conception for malformations and from 8-15 weeks for mental retardation.

It has been well established that planned delay in therapy for patients with early squamous cell carcinoma of the cervix can improve neonatal outcome without compromising maternal outcome.[177] In cases of advanced disease, primary radiation therapy is the main treatment modality. Radiation for cancer of the cervix in the first and second trimester will result in a spontaneous abortion. Options should be fully discussed with the mother who may decide to forego treatment for the sake of her foetus if maternal outcome is likely to be poor regardless of treatment. For patients in the third trimester the baby can be delivered by ceasarian section or vaginally prior to treatment. There is no difference in outcome in pregnant and non-pregnant patients.[178]

[176] Nakagawa K, Yukimasa A, Kusama T, Ban N, Nakagawa S, Sasake Y. Radiotherapy during pregnancy: effects on fetuses and neonates. Clin Therap 19(4) 770-777. 1997

[177] Soronsky J, Squatrito R, Ndubisi BU, Anderson B, Podczaski ES, Mayr N, et al. Stage I squamous cell cervical carcinoma in pregnancy: planned delay in therapy awaiting fetal maturity. Gynecol Oncol. 59:207-10. 1995

[178] Sood AK, Sorosky JI, Mayr N, Krogman S, Anderson B, Buller RE, Hussey DH. Radiotherapeutic management of cervical carcinoma that complicates pregnancy. Cancer 80(6) 1073-1078. 1997

# Appendix H: Abortion Sequelae: G*eneral and Psychological*

**GENERAL**

Notwithstanding some high profile cases of abortion survivals the mortality rate for the unborn child in abortion is effectively 100%.

While the introduction of so-called 'lunch-time' or 'quickie' abortion would seem to emphasise the safety of the procedure for the mother yet there is significant maternal morbidity and even mortality. The report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1991-1993 reports 5 deaths directly related to abortion, a further 2 deaths due to suicide within 42 days of the abortion and another 2 deaths in women known to be substance abusers who died of injecting substance abuse overdose within 1 year of an abortion.[179] The report for the following three years 1994-1996 reports a total of 12 deaths related to abortion: 1 direct, 1 suicide; 2 deaths from thrombosis/thromboembolism; 1 death from myocardial infarction; 1 death from a ruptured ectopic pregnancy after an induced abortion had supposedly been performed; and finally 6 deaths occurred in a women who had so called medically indicated induced abortion for cardiac conditions such as primary pulmonary hypertension and Eisenmenger's.

A survey of abortion mortality in the United States from 1972-1987 found 240 maternal deaths: the main causes of death were sepsis, haemorrhage and anaesthetic complications.[180]

A study of maternal mortality in Finland found the suicide rate following abortion was much higher than that associated with birth. The mean annual suicide rate was 11.3 per 100,000; the rate associated with birth was 5.9; the rate associated with induced abortion was 34.7.[181]

Abortion begets abortion. A study of 2,925 women in Norway showed that the incidence of repeat induced abortion doubled from the second to the third abortion, indicating that the moral threshold for choosing an abortion after recognition of an unplanned pregnancy is the first induced abortion.[182] In a review of women having abortions in 1987, 59% were under 25 years of age and 42% had had a previous abortion.[183] In another review of 2,001 women seeking abortion in Wichita, Kansas in 1991-1992, 34% had had a previous abortion.[184] In a study of 163 women seeking abortions who attended Irish Family Planning Association clinics in a 1 year period 10 of the women had had an abortion in the past with 4 of these having had 2 previous abortions. One teenager had 2 abortions during the study period of 1 year and

[179] Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1991-1993.
[180] Lawson HW, et al. Abortion Mortality, United States, 1972 through 1987 Am J Obstet Gynecol 1994: 171(5)
[181] Gissler M, Hemminki E, Lonnqvist J. Suicides after pregnancy in Finland 1987-94: register linkage study. BMJ 313(7070) 1431-4, 1996
[182] Skjeldestad FE, The incidence of repeat induced abortion - a prospective cohort study. Acta Obstetricia et Gynecologica Scandinavica 73(9) 706-10, 1994
[183] Henshaw S K, Koonin LM, Smith J C. Characteristics of U.S. women having abortions, 1987. Family Planning Perspectives 23(2) 75-81, 1991
[184] Westfall J M, Kallail K J. Repeat abortion and use of primary care health services. Family Planning Perspectives 27 (4) 162-5, 1995

returned for a third abortion one month after the study ended.[185]

Incidence of postabortal upper genital tract infections varies across populations. Incidence rates range at 5-20%. Infecting organisms include Chlamydia Trachomatis, Neisseria gonorrhoea, Mycoplasma hominis, Ureaplasma urealyticum, Group B streptococci and Human Papillomavirus. Long term sequelae of postabortal infection include chronic pelvic pain, ectopic pregnancy, dyspareunia and infertility.[186,187]

A number of studies have suggested that induced abortion may be a risk factor for developing Breast Cancer. One study suggested that women age 45 or younger who have had induced abortions have a relative risk of 1.5 (50% increased risk) for breast cancer compared to women who had been pregnant but never had an induced abortion. The highest risk was for women who had an abortion younger than age 18 or older than 30.[188] The meta-analysis of 28 papers concludes that even one abortion significantly increases the risk and that overall the relative risk of breast cancer for women who have had an abortion is 1.3.[189]

**PSYCHOLOGICAL**

Short-lived adverse psychological sequelae following induced abortion occur in up to 50% of women studied. Psychiatric disturbance is marked, severe or persistent in 10 - 32%.[190,191,192]

Both women and men are severely impacted by post-abortion syndrome (PAS), according to diagnostic features developed by Rue et al[193] based on DSM-111 criteria for post-traumatic stress disorder. Certain factors predispose particular individuals to its development. Individuals at greatest risk include:

- a woman who is advised or coerced into having an abortion for medical reasons - either illness in the mother or deformity in the foetus;[13,194,195,196]
- a woman who has a previous psychiatric history;[13]
- a woman who has current or past interpersonal relationship difficulties and a premorbid personality vulnerable to trauma;[15]

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[185] Irish Medical Times page 5, April 18, 1997

[186] Sawaya G.F., Grady D., Kerlikowska K., Antibiotics at the time of Induced Abortion: the case for universal prophylaxis based on meta-analysis. Obstet Gynecol 87(5) 884-90, 1996

[187] Stray-Pedersen B, et al; Induced abortion: micrological screening and medical complications. Infection 19(5) 305-8, 1991

[188] Daling JR, Malone KE, Voigt LF, White E, Weiss NS, J Natl Cancer Inst (2)1994

[189] Journal of Epidemiology and Community Health 50: 481-96,1996

[190] Dagg: The psychological sequelae of induced abortion. Am J Psychiatr 148: 578-585, 1991.

[191] Ashton JR: Psychological outcome of induced abortion, Br J Obstet Gyn 87: 1115-22, 1980.

[192] Wallerstein JS et al, Psychosocial Sequelae of Therapeutic Abortion in Young Unmarried Women, Archives of General Psychiatry, 27: 832, 1972

[193] Rue V et al: The psychological aftermath of abortion: A White paper presented to C. Everett Koop, Surgeon General USA: A review of 225 articles, 1987.

[194] Blumberg et al: The psychological sequelae of abortion performed for a genetic indication. Am J Obsstet Gynecol 122-799, 1975

[195] Bracken et al: The decision to abort and psychological Sequelae. J Nerv Mental Dis 158: 154-162, 1974

[196] Iles S, Gath D, Psychiatric outcome of termination of pregnancy for foetal abnormality. Psychological Medicine 23, 407-413, 1993

- a woman who intends to have further children at some stage;[197]
- teenagers;[13]
- those with a history of previous abortions;[13]
- women who have second trimester abortions.[198,199]

Previous induced abortion has been shown to be associated with clinically significant neurotic disturbances and affective disorders in subsequent pregnancy and it is postulated that this phenomenon may reflect a reactivation of mourning which was previously suppressed.[200,201]

[197] Greenglass E: Therapeutic abortion, fertility plans and psychological sequelae. Am J Ortho Psychiatr 1:119-126, 1977.
[198] Zolese, Blacker: The psychological complications of induced abortion. B J Psychiatr 160:742-749, 1992.
[199] Kaltreider et al: The impact of mid-trimeter abortion techniques on patients and staff. Am J Obstet Gynceol 135:235-238, 1979.
[200] Kumar R., Robson K., Previous induced abortion and ante-natal depression in primiparae: preliminary report of a survey of mental health in pregnancy. Psychological Medicine 8(4): 711-5, 1978
[201] Kitamura et al. Psychological and social correlates of the onset of affective disorders among pregnant women. Psychological Medicine. 23: 967-975, 1993

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