AIMS Ireland
Association for Improvements in the Maternity Services - Ireland

info@aimsireland.com www.aimsireland.ie

Association for Improvements in the Maternity Services – Ireland

Submission to the Citizens' Assembly on the Eighth Amendment of the Constitution

15 December 2016

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Introduction

The Association for Improvements in the Maternity Services Ireland campaigns for the repeal of Article 40.3.3° of the Constitution. It is a core principle of our constitution that we support women's right to access evidence-based reproductive healthcare, and that this includes access to free, safe and legal termination of pregnancy services in Ireland, without restriction or legal sanction. This submission to the Citizens' Assembly is based upon that core belief and position.

About AIMS Ireland

The Association for the Improvements in Maternity Services Ireland (hereafter 'AIMS Ireland') is a consumer led voluntary organisation that was founded in 2007. Its mission is to promote normal birth by promoting best international practice guidelines and the use of evidence-based research in maternity care settings. AIMS Ireland lobbies on behalf of pregnant women and provides independent information and support to women. We maintain close links with other consumer advocacy organisations working in the area of maternity care, including Human Rights in Childbirth, AIMS UK, and Make Mothers Matter. We are also a member of the Coalition to Repeal the 8th Amendment. Our Chair, Dr. Krysia Lynch, sat on the National Maternity Strategy Steering Group and was involved in the creation of the Health Information and Quality Authority Standards for Maternity for Maternity Care in Ireland which will be launched by the Minister for Health Mr. Simon Harris on 21st December 2016.

AIMS Ireland's Position on Article 40.3.3° of the Constitution

The majority of women contacting AIMS Ireland are looking for support in relation to traumatic birth experiences, many of whom complain of feeling undermined or not listened to during pregnancy, labour, and birth. Recurring issues in these support queries, and in the What Matters to You surveys conducted by AIMS Ireland in 2009 and in 2014, are lack of informed consent and informed refusal. This direct consumer feedback, combined with our concern over the outcomes of the numerous legal actions concerning Article 40.3.3°, and the inclusion of Article 40.3.3° in the National Consent Policy as a barrier to fully informed decision-making in healthcare decisions during pregnancy, led us to adopt a formal position on the need to repeal the amendment. Accordingly, our position on the need to repeal Article 40.3.3° was adopted by our members in a unanimous vote at our Annual General Meeting in 2013.

It is AIMS Ireland's submission that the existing regulation – both in law and in policy – and the existing practice of maternity care in Ireland, and in particular the continued presence of Article 40.3.3° in the Constitution, falls short of meeting Ireland's international human rights obligations. A significant focus of the campaign for repeal of Article 40.3.3° has been on the lack of access to abortion services in Ireland. It is the view of AIMS Ireland that Ireland's legal regulation of maternity services, the tone of which is set by Article 40.3.3°, unacceptably infringes on the human rights not only of women seeking abortion services but also on the human rights of those women wishing to continue with a pregnancy, and on the human rights of women during labour and delivery. In particular, AIMS Ireland believes that the following represent specific areas wherein the State has failed to meet its international human rights obligations, and that each of these specific areas can be linked back to the presence in the Constitution of Article 40.3.3°:

1. The failure to legislate for equitable and easily accessible family planning services including termination of pregnancy services;

2. The continued criminalisation of the procurement of abortion services outside of the extremely restrictive and inherently discriminatory terms of the provisions of the Protection of Life During Pregnancy Act 2013;

3. The failure to ensure respect for women's rights to freedom from inhuman and degrading treatment and punishment; to bodily integrity; and to privacy in the context of maternity services, with particular reference to the National Consent Policy and to the lack of individualised care plans and risk assessment for women accessing maternity services; and

4. The failure to provide equitable access to choice in maternity care services, and in particular to ensure the removal of barriers to women's ability to access midwife led maternity care and home birth services.

The refusal of the State to date to hold a referendum on the question of repeal of Article 40.3.3° has inflicted unnecessary and indefensible suffering on thousands of women and their families, and so long as Article 40.3.3° remains in place that suffering is continuing and ongoing. It is our conservative estimate that in the region of 103,000 women are affected annually by Article 40.3.3° when all pregnancies are counted (including women who choose

to continue with the pregnancy and are affected in pregnancy, labour and delivery; women who choose to terminate the pregnancy by travelling abroad for a termination or by accessing abortifacient medication; and women who experience miscarriages, ectopic pregnancies, and stillbirths). It is AIMS Ireland's submission to the Citizens' Assembly that a referendum on repeal of Article 40.3.3° needs to be held as soon as possible.

The focus on this submission will be on two core areas: the effect of Article 40.3.3° on women's access to abortion services in Ireland, and the effect of Article 40.3.3° on women's human rights in continued pregnancy and during childbirth.

The Effect of Article 40.3.3° on Women's Access to Abortion Services

Article 40.3.3°

Article 40.3.3° of the Constitution of Ireland was inserted into the Constitution in 1986 following public plebiscite. It reads as follows:

> "The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right."

Article 40.3.3° was then amended by public plebiscite in 1992 following two Supreme Court decisions which held that the Article prevented counselling agencies from assisting women to travel abroad to obtain abortion services, and from informing them of the methods of communication with clinics abroad who could provide them with abortion services (*Attorney General (SPUC) v Open Door Counselling* [1988] IR 592 IESC and *SPUC v Grogan* [1989] IR 753, Case C-159/ 90, [1991] E.C.R.4685). After a referendum on the questions of the provision of information and on the right to travel, Article 40.3.3° was amended to facilitate the provision of information about abortion services and clinics abroad that could provide those services, and the removal of any restrictions on the right to travel abroad to access abortion services.

The following year, in *X v Attorney General* [1992] IESC 1 the Supreme Court reaffirmed the right to travel abroad to avail of abortion services, but further ruled that Article 40.3.3° within its parameters permits of the provision of abortion services in Ireland:

> "…if it is established as a matter of probability that there is a real and substantial risk to the life, as distinct from the health, or the mother, which can only be avoided by the termination of her pregnancy, such termination is possible." (Finlay, C.J.)

The State, however, failed to legislate to provide for the availability of abortion services within the parameters of Article 40.3.3° as delineated in *X v AG*, and in the context of a criminal law regime which criminalised the procurement of or the performance of an abortion, health care providers were forced to operate in an unreasonable climate of uncertainty around the legality of the provision of Article 40.3.3° compliant abortions. The net effect was to render health care providers so fearful of the consequences of providing abortion services outside the bounds of Article 40.3.3° that in practice it remained impossible for Irish women to access even a legally permissible 'risk to life as distinct from health' abortion.

International Human Rights Jurisprudence Condemning Ireland's Abortion Laws

In 2010 the European Court of Human Rights in the decision in *A, B, and C v Ireland* (2011) 53 EHRR 13 ruled in favour of an Irish woman who argued that the failure of the State to provide legislative clarity around the judgment in *X v AG* had violated her right to privacy under Article 8 of the European Convention on Human Rights. The Strasbourg Court stated that the violation occurred because "there was nowhere C could go to secure a legally authoritative determination of what her rights were in her situation" and noted the "significant chilling" effect of Irish legislation on women's ability to access abortion services in Ireland.

In June 2016 the United Nations Human Rights Committee in the decision in *Mellett v Ireland* CCPR/C/116/D/2324/2013 held that Ireland's lack of legal clarity around the provision of abortion services had caused violations of Ms Mellett's rights under Article 7 (freedom from inhuman and degrading treatment or punishment); Article 17 (privacy and bodily integrity); Article 26 (freedom from discrimination); and Article 19 (the right to seek and receive information) of the International Covenant on Civil and Political Rights 1976. On November 30th 2016 it was reported that the government has offered Ms Mellett compensation in the sum of €30,000.00 for the trauma suffered by forcing her to travel to England for an abortion which

she could not lawfully receive here in Ireland owing to the lack of clarity in our laws. This is an acknowledgment in the clearest of terms that the presence of Article 40.3.3° in our Constitution creates an unworkable legal situation which infringes women's human rights and causes them direct harm.

The Protection of Life During Pregnancy Act 2013

Following the decision in *A, B, and C v Ireland* the Irish government passed the Protection of Life During Pregnancy Act 2013 ('the 2013 Act'). The aim of this legislation is to make provision for access to abortion in circumstances falling within the parameters laid down in *X v AG*. At the drafting stage of the legislation, AIMSI made substantial submissions to the Expert Group expressing grave reservations about certain aspects of the proposed regime. It is the submission of AIMSI that the 2013 Act is severely problematic and in gross violation of international human rights norms in the following respects:

1. The test for whether an abortion is permissible under sections 7, 8 and 9, including the test for determination of whether an abortion is necessary because the 'real and substantial risk to a woman's life' is a risk of suicide, requires assessment by three doctors and a potential assessment by a further three doctors. This is a gross infringement of a woman's privacy and dignity and furthermore it distances the medical professional and the government from the woman at the heart of the matter. It is highly likely that a distressed and possibly suicidal pregnant woman will prefer to seek anonymity and far less judgement by travelling to another jurisdiction for a pregnancy termination.

2. The formal medical review procedures are thorough but are not timely, forcing women who are seriously ill or suicidal to wait weeks for the outcome of the decision of the panel of medical professionals. This is an unconscionable failing to provide prompt and reasonable medical care to a woman in a desperate situation. Furthermore the lack of perinatal psychiatrists, and the geographical concentration in Dublin of the only perinatal psychiatrists renders the practical operation of the review panels problematic. Linked to the lack of experts in perinatal mental health, it is questionable whether a woman or pregnant person experiencing suicidal ideation is likely to disclose that fact to junior medical staff, and whether staff have the training or experience to address the needs of a woman in that situation should it be disclosed to them.

3. The provisions in section 22 criminalise the intentional destruction of unborn human life outside of the scope of the provisions of the Act and makes that offence punishable by a prison sentence of fourteen years. Women who do not have the means or the freedom to travel abroad, who access abortifacient medications to self-induce an abortion, have their vulnerability attenuated by the spectre of this prison sentence. In comparison with the punishments mandated by legislation for other violent crimes this is a disproportionate and discriminatory penalty.

These provisions exist in the 2013 Act directly and clearly in response to the need to ensure restrictions on access to terminations of pregnancy outside of the Article 40.3.3° 'risk to life as distinct from risk to health' criterion, and the provision of legal penalties for accessing or providing termination outside of that criterion.

Finally, as AIMS Ireland pointed out at the time in our submission to the Oireachtas Joint Committee on Health and Children on the Report of the Expert Group on the 2013 Act when it was in draft stage; because the wording of the Act explicitly refers only to women who are pregnant and whose pregnancy will kill them, trans men (who are also capable of pregnancy) who are in the same situation are not protected against death from pregnancy in Ireland. AIMS Ireland further remains concerned that there are no references to children or girls in the 2013 Act, meaning that Ms. X could conceivably still be denied abortion access in Ireland if she presented today as the 14-year-old survivor of rape that she was.

The truth of the matter is that women in need of an abortion who have the means to do so will continue to travel abroad to access these services rather than submit to the intrusive demands of the 2013 Act. In this respect the 2013 Act discriminates against women who do not have the financial means to travel, or for other reasons are prohibited from doing so (if for example she does not have free movement to travel owing to her status as an asylum seeker; or if disability or illness makes travel more difficult for her as it did for Michelle Harte, who was denied an abortion by Cork University Hospital despite suffering from terminal cancer and who was subsequently denied the continuation of her cancer treatment by the same hospital, forced to travel to the UK so weak she was in a wheelchair and subsequently died from her cancer; or if she does not have the means to seek out the necessary information to arrange and book an appointment at a foreign clinic or to arrange overseas travel). The data collection provisions under section 20 of the 2013 Act do not take into account these women who will continue to travel abroad to access abortion services, a number often quoted as upwards of

nine women per day (Cullen, Paul, "Number of women going to UK for abortion lowest since 1980", *The Irish Times*, May 16, 2016).

This is borne out by the experience of the woman known in media reports as "Miss Y." This woman arrived in Ireland as a teenager in 2014, seeking asylum. She shortly thereafter discovered she was pregnant, a result of rape in her country of origin. She immediately sought an abortion. She was unsuccessful in her attempt to procure an abortion in the United Kingdom as her status as an asylum seeker restricted her right to travel. She then sought to access an abortion under the terms of the 2013 Act. It was accepted by the medical experts that she was suicidal. However, when she went on hunger strike, rather than authorise and perform the abortion she sought, the HSE obtained an order from the High Court authorising her forced feeding and hydration. A caesarean section was then performed at 26 weeks' gestation, and a baby boy was delivered prematurely. Miss Y in May 2016 initiated legal proceedings against the State seeking damages for alleged trespass, assault and battery, alleged negligence; and alleged reckless and intentional infliction of emotional harm and suffering.

Irish women will continue to travel abroad to access abortion services simply because the pathways of care under the 2013 Act are too cumbersome and excessively stringent at a time when these women should be treated with compassion and support. The provisions of the 2013 Act are discriminatory and in violation of women's right to access healthcare.

Public Opinion on Access to Abortion Services in Ireland

Finally, public opinion on issues surrounding reproductive healthcare has changed significantly since 1983. Numerous opinion polls and research studies conducted in recent years have found a clear majority consensus in favour of access to abortion in Ireland. In October 2016, an Irish Times/Ipsos MRBI poll found 75% of respondents to be in favour of repealing Article 40.3.3° (Collins, Stephen, "'Irish Times' Poll: Majority want repeal of Eighth Amendment", *Irish Times*, Friday October 7, 2016). In July 2016, another Irish Times/Ipsos MRBI poll found that 67% of respondents supported repeal of Article 40.3.3° specifically to allow for abortion in cases of rape or fatal foetal anomaly (Leahy, Pat, "Majority support repeal of Eighth Amendment, poll shows", *Irish Times*, Friday July 8, 2016). In March 2016, Amnesty International Ireland commissioned a Red C poll which analysed in great detail Irish people's views on access to abortion and on the legal regime regulating abortion in Ireland:

- 87% of respondents wanted abortion access expanded;
- 71% of respondents believed that abortion should be decriminalised;
- 69% of respondents wanted the expansion of Ireland's abortion laws to be a priority for the new government (when 'don't knows' and those who were neutral are excluded);
- 73% of respondents believed that the new government should hold a referendum on repeal of the Eighth Amendment;
- 72% believed that the fact that women must travel for abortion services unfairly discriminates against those women who cannot afford or are unable to travel;
- 68% of respondents described Ireland's abortion laws as "cruel and inhumane" (when 'don't knows' and those who were neutral are excluded);
- 80% of respondents supported abortion at least in cases where a woman's life or health is at risk or where the pregnancy is a result of rape or incest; 38% favoured abortion access as women choose; and 7% supported abortion access only in cases of fatal foetal anomaly;
- Only 5% of respondents were opposed to abortion in all circumstances and of that group, 72% were not aware that the penalty for an unlawful abortion is up to 14 years imprisonment;
- 55% of respondents did not know that having an abortion in Ireland is a crime when a woman's life is not at risk; and
- 80% of respondents agreed that under international human rights law, women have a right to access abortion in Ireland in cases of rape or incest, where their health is at risk or in cases of fatal foetal anomaly. (Amnesty International / Red C, *Public Attitudes Towards Abortion in Ireland* (Dublin: Red C Research, 2016, available online at http://www.redcresearch.ie/wp-content/uploads/2016/03/157316-–-Amnesty-International-Feb-2016-040316-Press-Release.pdf).

The Effect of Article 40.3.3° on Women in Continued Pregnancy

Women Experiencing Miscarriage or a Pregnancy with a Diagnosis of Fatal Foetal Abnormality

As a result of Article 40.3.3° the right of a woman to health and the right of a miscarrying foetus operate as competing interests. Consequently, medical staff treating a woman experiencing a

miscarriage are forced to balance the necessity to treat a woman who may be at risk of infection or other complications, against the foetus's right to life. In practice, this has meant that for so long as a foetal heartbeat could be detected, no steps could be taken to accelerate the termination of the pregnancy, even where the mother's health was at risk, because the Supreme Court interpretation of Article 40.3.3° in *X v AG* was that termination of a pregnancy is only permissible where the mother's life was in immediate danger. It would not be unusual for a woman who is experiencing a miscarriage to be told at an ultrasound scan diagnosing the loss that the hospital are unable to provide any treatment until either the foetal heartbeat ceases, or she become seriously unwell. The cruelty of this position, for those women who would prefer to have an inevitable miscarriage medically managed, is unjustifiable.

The heartbreaking consequences of this cruel paradox were seen in the tragic death of Dr. Savita Halappanavar on 28th October 2012 who died as a result of mismanagement of sepsis arising out of a miscarriage which happened when she was 17 weeks pregnant. The medical staff treating Dr. Halappanavar could not, as a result of Article 40.3.3°, perform any treatment which would accelerate the loss of the pregnancy for so long as a foetal heartbeat could be detected, despite her requests for a termination once it had been determined that the pregnancy could not survive. By the time the foetal heartbeat had ceased, Dr. Halappanavar was suffering from the sepsis which would ultimately cause her death.

Article 40.3.3° is also arguably implicated in the death of Malak Thawley on 8th May 2016. Ms. Thawley suffered a vascular bleed after an artery was torn while she was undergoing surgery to remove an ectopic pregnancy diagnosed at 7 weeks gestation. Surgery was performed despite Ms. Thawley's requests for medical management of the ectopic pregnancy but such medical management could not happen within the confines of Article 40.3.3°. The internal hospital report into Ms. Thawley's death highlighted a number of failures in the management of the surgery; a surgery she arguably would not have been required to undergo but for the presence in our Constitution of Article 40.3.3°.

For women who receive the devastating diagnosis of a fatal foetal abnormality, the same situation prevails. For so long as the unborn child retains a heartbeat, no treatment can be undertaken which would cause or accelerate the termination of the pregnancy. For women who would not wish to continue with a pregnancy which they know will result in the birth of a child who has no hope of survival, and who will die shortly after birth and may suffer greatly during their short life, there is no treatment available in Ireland and they are forced to travel abroad. There has been extensive media coverage of the ordeals faced by parents in this

situation, including among them Ms. Amanda Mellett whose successful action taken to the United Nations Human Rights Committee has already been referenced above.

Finally, Article 40.3.3°was at the heart of the High Court decision in the case of P.P. v Health Service Executive [2014] IEHC 622. In that case a pregnant woman collapsed and suffered a severe cardiac arrest, and was placed on life support mechanisms. Five days later brain stem death was declared. However, at this juncture a foetal heartbeat could still be detected. The medical staff caring for the woman were thus compelled by compelled by Article 40.3.3° to continue life support so long as the foetus still had a heartbeat, even though the prospect of maintaining a viable pregnancy was not a real one. Ultimately, it was necessary to obtain a decision of the High Court permitting the withdrawal of life support even though this would result in the inevitable death of the unborn child. This appalling situation and the resulting trauma inflicted on the family of the woman are now the subject of litigation.

Respect for Informed Consent and Informed Refusal

Article 40.3.3° of the Constitution of Ireland in public discourse in Ireland is predominantly seen as an 'abortion amendment' and there is very little understanding of the implications of it for pregnancy and childbirth. In fact, Article 40.3.3° impacts on every aspect of women's interaction with maternity care in Ireland. From conception to delivery, Article 40.3.3° affects every decision a woman makes regarding her care during pregnancy. Many Irish women are unaware of this fact that their basic maternal and reproductive rights are subject to legal constraint, or of the impact Article 40.3.3° has on their right to choose the place and the circumstances in which they labour and give birth.

The National Consent Policy

The Health Service Executive National Consent Policy (Health Service Executive, *National Consent Policy QPSD-D-026-1.1 V 1.1*, May 2016) in Section 7.7.1 explicitly cites Article 40.3.3 as it circumscribes women's rights to self-determination, autonomy, bodily integrity, and privacy in its treatment of the right to refuse medical treatment during pregnancy:

"The consent of a pregnant woman is required for all health and social care interventions. However, because of the Constitutional provisions on the right to life of the "unborn" (Article 40.3.3 of the Constitution of Ireland 1937), there is significant legal uncertainty regarding the extent of a pregnant woman's right to refuse treatment in circumstances in which the refusal would put the life of a viable foetus at serious risk. In such circumstances, legal advice should be sought as to whether an application to the High Court is necessary.

Relevant factors to be considered in this context may include whether the risk to life of the unborn is established with a reasonable degree of medical certainty, and whether the imposition of treatment would place a disproportionate burden or risk of harm on the pregnant woman."

At its most serious encroachment, this policy has the potential to result in the legally coerced performance of a medical treatment on a pregnant woman in the face of her informed refusal to consent, on the grounds that the refusal puts the life of a viable foetus at serious risk.

High Court Jurisprudence on Informed Consent and Refusal in Maternity Care

In 2013 a High Court application was brought by a maternity hospital in Ireland in respect of precisely this question. The woman who was the subject of the application wished to delay a caesarean section by two days. The hospital sought an order authorising the performance of the procedure on their recommended date, notwithstanding the woman's refusal. The Court ultimately was not to give judgment on the application, the woman choosing to consent to the earlier date for the caesarean section, but it is notable that media reports cite Senior Counsel for the hospital arguing during submissions that what was at issue was "how to balance the mother's right to refuse treatment with the right to life of the unborn" and that "in view of the "exceptional circumstances" of the case, it would not be a disproportionate response for the court to grant an order overriding A's right to refuse treatment". (Mac Cormaic, Ruadhan, "Waterford hospital sought court order to compel woman to have surgical delivery", *The Irish Times*, March 11, 2013).

In October 2016 another High Court application was brought in not dissimilar circumstances. In *HSE v B & Anor* [2016] IEHC 605 a maternity hospital sought orders to compel a pregnant woman to submit to a caesarean section delivery, and to indemnify the Health Service

Executive in sedating and restraining her in order to perform that procedure in the event that she did not so submit. The woman in question was full term and was seeking a trial of labour having had three previous caesarean deliveries. The High Court ultimately found:

a. That the woman was not suffering from such an impairment of capacity as to render her incapable of giving or refusing consent to medical treatment; and

b. That the degree of risk that would be involved in a trial of labour, to both the mother and the unborn child, were not of a sufficiently serious magnitude as to justify the making of the draconian orders that were sought.

This second limb of the judgment in *HSE v B* is necessitated by the presence in our Constitution of Article 40.3.3°. In another jurisdiction, without such constitutional protection for the right to life of the unborn, the mother's decisions regarding consent or refusal of medical treatment, once those decisions were made competently, would hold sway. This in fact accords with the earlier High Court decision in *North Western Health Board v HW and CW* [2001] 3 IR 622 which was cited in *HSE v B*, in which the competent decision of the parents of an infant to refuse a routine medical screening test was upheld. In *HSE v B* Twomey J reasoned that an unborn child at full gestation could be considered comparable to a newly born child, and that as such "the right of the Courts to intervene in a parent's decision in relation to an unborn child could not be any greater than the Court's right to intervene in relation to born children." (*HSE v B* [2016] IEHC 605, §15) This, however, opens up the spectre of the Courts being required to weigh up and assess the point on the scale at which the right of the Courts to intervene on behalf of an unborn child *does* become greater than any right to intervene on behalf of a born child. There is a significant question now to be considered as to where any such line is to be drawn, and as to the implications of this judgment in terms of its potential for policing women during pregnancy. For example, could this ruling be utilised to support the making of a care order under the Child Care Act, 1991 now justify the making of orders of mandamus compelling a woman to comply with health care decisions made regarding her pregnancy by maternity hospitals? Would it justify the making of orders even in the face of her otherwise competent refusal of a particular treatment? Furthermore, if a woman makes a competent choice to forego medical care during pregnancy, and perhaps during labour and delivery, or if she chooses to refuse the attend the particular model of care that is on offer to her in her locality, would that justify the making of High Court orders compelling her to submit to attendance at a maternity hospital for treatment and indemnifying the Health Service Executive in forcibly detaining and treating her? It is worth at this juncture bearing in

mind that the model of care most sought after by women in Ireland – midwifery led care – is not available nationwide. This was evidenced in AIMS Ireland's *What Matters to You?* survey in 2014 where only 5.5% of women reported access to midwife led care, despite 55.5% of women expressing a preference for it, and 90.3% of women expressing a desire for community based midwifery led care.

Jurisprudence of this flavour has no place in a modern democratic society that claims to respect human rights, including autonomy and self-determination in healthcare, but this is the line of reasoning our courts are forced to adopt given the continued presence of Article 40.3.3° in our Constitution. Indeed Twomey J in *HSE v B* expressed as much when he stated:

> 20. This Court wishes to emphasise that it cannot see why she would choose to increase the risk of injury or death to herself or her child. This Court also wishes to emphasise that the doctors and nurses who gave evidence cannot be criticised for their concern for the health and life not only of the unborn child, in light of the constitutional protection granted to the unborn in Article 40.3.3°, but also their concern for the health and life of Ms. B, such that they sought court intervention in order to protect both lives. They must also be commended for the efforts they have made to try and persuade Ms. B to re-consider her decision. (*HSE v B* [2016] IEHC 605, §20)

At this point AIMS Ireland would like to highlight that there was no negative outcome for either Ms. B or her baby from 'allowing' her bodily autonomy, as is the case for the vast majority of those who give birth in the manner in which they choose. In fact, she requested a caesarean section after going into labour herself, at the point of feeling she needed one, and we would also like it to be noted that the HSE argued in court that she and her baby would both definitely die if she were allowed to even go into labour at all which is patently untrue. This was not a case of Ms. B wanting to avoid a caesarean section at all costs to her baby and herself, but rather of her believing that the final say on what happens to her body should be hers and not the HSE's. That such a belief should be a matter of sufficient controversy in Irish law that it could have resulted in High Court litigation of this nature is abhorrent.

The Effect in Practice of Article 40.3.3° on the Culture around Consent to Treatment and Refusal of Treatment in Maternity Services

HSE v B is clear proof that the HSE coercively use the existence of Article 40.3.3° against pregnant women. It is of great concern to AIMS Ireland that the HSE sought to resist the reporting of the judgment in that case, which we would argue signals a continued desire to use Article 40.3.3° as a tool of coercion in this way, both in hospital wards and in the courts.

Reports of coercion of this nature, or of threats of coercion, are regrettably commonly made to AIMS Ireland by women receiving care in the maternity services in Ireland. We have had reports from women area threatened with the use of the Gardaí to compel their compliance with medical instruction, in particular in relation to inductions. The presence of Article 40.3.3° in the National Consent Policy as a limit on women's capacity to give or refuse consent to medical treatment in pregnancy has resulted in an endemic culture in our maternity services of coercion to secure compliance with a particular model of care or a particular treatment plan. Article 40.3.3° is the locus of this restriction of women's human rights in Ireland and without it the scope to utilise the law in this fashion to coerce women would be greatly diminished if not eliminated. By contrast, in the United Kingdom, a pregnant woman who is competent and not suffering from a serious mental illness may refuse a medical treatment even where that refusal may expose her or the foetus to harm, and any overriding of that refusal even by means of judicial authority is a violation of her right to autonomy (*St George's Healthcare NHS Trust v S; R v Collins and others, ex parte S* [1998] 3 All ER 673). In the Irish legal system, operating as it must within the confines of Article 40.3.3°, and necessarily therefore in Irish maternity services policy and practice, decisions around consent to treatment and refusal of treatment are framed in terms of degrees of risk, and as a consequence all questions of women's rights are erased.

Furthermore, however, Article 40.3.3° and the National Consent Policy are products of and perpetuate a national history and culture that subordinates women and their human rights most particularly in the area of maternity services. The appalling human rights abuses perpetrated against women in Mother and Baby Homes and the Magdalene Laundries, and the inadequacy of the Symphysiotomy Redress Scheme, are examples of the continued influence of this cultural perception of women and of their rights. It is worth noting that at the time of the public plebiscite in 1983 on the insertion of Article 40.3.3° Mother and Baby Homes and Magdalene Laundries were still in operation. The *Walsh Report on Symphiosotomy in Ireland 1944-1984* (Dublin: Department of Health, 2014, available online at http://health.gov.ie/wp-content/uploads/2014/07/Final-Final-walsh-Report-on-Symphysiotomy1.pdf) found that symphiosotomies were still being performed in Ireland up until 1992 notwithstanding the availability of caesarean section as an alternative. The social climate within which the Eighth Amendment to the Constitution was passed was significantly different to the present day. The opinion polls cited earlier in this document reflect only the contemporary public opinion on access to abortion services, but it is submitted that if public views on that topic have changed so dramatically it is surely not a stretch to conclude that a similar change has almost certainly occurred in relation to attitudes to women's rights to make decisions pertaining to their healthcare during pregnancy, labour, and delivery.

In that regard, in 2008 AIMS Ireland conducted a research study on *Availability of Information and Consent in the Irish Maternity Services* which found that 75% of respondents in the self-selecting survey felt that consent is an issue of concern in the Irish maternity system, and almost 60% said they were not given the option to refuse a procedure, test or treatment. Many women provided qualitative data in the form of comments on the procedures they were subjected to, with no consent given by them, while under the care of their maternity provider. The most frequently reported procedures that were performed without informed consent were artifical rupture of membranes ('ARM'), episiotomy, the use of syntocinon, and membrane sweeps. In *Hamilton v HSE* [2014] IEHC 393 the High Court heard a case brought by a woman who argued that her membranes were artificially ruptured during labour without her consent. It was her argument that she had consented to the performance of a vaginal examination, but not to ARM. On the evidence before it the Court refused to believe that she consented to the one, but not the other:

Since, on the evidence, this was a routine procedure that Ms Kelliher was carrying out for the purpose of diagnosis to see if her fear of foetal distress was justified or not, it does seem strange that she would not have mentioned to the patient what she was going to do and have obtained her consent. The very fact that it was so routine suggests that the midwife would have done so. I am satisfied that the probability is that Midwife Kelliher obtained the plaintiff's consent and informed her about the ARM that she was going to perform. (§ 16)

As is noted above, the results of AIMS Ireland's 2008 research study into the performance of procedures such as ARM is that 60% of women experience these procedures being performed on them without their consent. In AIMS Ireland's *What Matters To You?* survey in 2014 only 48.9% of women responding felt they had been given the opportunity to make an informed refusal of a test, procedure, or treatment.

The themes of AIMS Ireland's research in 2008 and 2014 were borne out in the public consultations carried out as part of the creation of the National Maternity Strategy (Institute of Public Health in Ireland, *Consultation on the development of a National Maternity Strategy: A report prepared for the Department of Health by the Institute of Public Health in Ireland*, Dublin: 2016). In that report, a significant cohort of respondents stated that their highest priority for care during labour was the need to ensure respect for women's views and wishes, and to ensure that women are listened to and their decisions and choices respected:

> The issue of respect and listening to views, wishes and needs of women was the top priority for 7.8% (n=104) of respondents. Informed choice and decision making in regard to medical interventions and care plans (3.8%, n=50) and adherence to birth/care plans (3.1%, n=41) was also raised by a number of respondents. (Institute of Public Health in Ireland, *Consultation on the development of a National Maternity Strategy: A report prepared for the Department of Health by the Institute of Public Health in Ireland*, Dublin: 2016, at page 56).

The reasoning that because a procedure is 'routine' then consent must have been obtained is indicative of the chasm that exists between perceptions of maternity care and what is appropriate behaviour around consent and refusal of treatment, and the reality of women's lived experiences and their narrative of the violations of their rights that they endure. It is difficult to imagine a similar scenario where men would find themselves subjected to interventions or surgical procedures without their consent. This is where maternity care and services are unique, in that women are the sole patients of this service. The AIMSI research highlights the need for consent policies in maternity services that respect and vindicate women's human rights, as well as the need to tackle the issue of inequality between men and women in relation to the legal right to the highest attainable standard of physical and mental health. The introduction of such consent policies remains impossible so long as Article 40.3.3° remains in the text of the Constitution.

Article 40.3.3° and The Assisted Decision Making (Capacity) Act 2015

Finally, it is worth noting the provisions of the Assisted Decision Making (Capacity) Act 2015 (hereafter 'the 2015 Act') in respect of Advance Care Directives. Section 85 of the 2015 Act provides for advance healthcare directives that will specify the manner in which a person wishes to be treated should they become incapacitated and incapable of making decisions regarding their consent to or refusal of medical treatment. Section 85(6)(a) provides that where a pregnant woman lacks capacity, and she has in place an advance healthcare directive but the directive does not address whether she would wish to refuse a particular treatment during pregnancy, and it is considered by the healthcare professional concerned that complying with the refusal of treatment would have a deleterious effect on the unborn, there shall be a presumption that treatment shall be provided or continued. Section 85(6)(b) provides that where a pregnant woman's advance healthcare directive does address the refusal of a particular treatment during pregnancy, and it is considered by the healthcare professional concerned that complying with the refusal of treatment would have a deleterious effect on the

unborn, then an application must be made to the High Court to determine whether or not the refusal of treatment should apply. The High Court in determining any such application must have regard to the potential impact of the refusal of treatment on the unborn; the invasiveness and duration of the treatment and the risk of harm to the woman; and any other matter which it considers relevant. This analysis will without doubt revert the High Court back to the decision in *HSE v B*, and the Sisyphean task of weighing the degree of risk to the unborn should the treatment not be administered, against the relative rights to life and health of both the unborn and the mother, utilising as a yardstick the degree of similarity of the unborn to a born child, on behalf of whom the mother would have the right to make all decision regarding the acceptance or refusal of medical treatment.

It should be noted here again that the test required of healthcare professionals involves a balancing of perceived risks to the woman and the foetus, rather than a balancing of their respective rights. As noted above, this approach is mandated by the influence of Article 40.3.3° and rooted in an overriding culture of paternalism with respect to women's decisions made during pregnancy. However, the 2015 Act represents an even further encroachment upon women's rights to autonomy, self-determination and privacy and bodily integrity. The language of 'deleterious effect on the unborn' represents a significant dilution of the magnitude of risk as set out in the National Consent Policy which specifies 'serious risk to a viable foetus.' Additionally, the use of the term 'unborn' rather than 'viable foetus' further expands the reach of the 2015 Act back into even the earliest weeks of pregnancy. In the case of *PP v HSE* [2014] IEHC 622, already mentioned above, the High Court was asked to authorise the switching off of life supportive mechanisms for a pregnant woman who had been declared brain dead at 15 weeks' pregnant. The woman's healthcare providers had felt compelled by Article 40.3.3° to continue life support because the foetus still had a heartbeat, even though the prospect of maintaining a viable pregnancy was not a real one. Under the 2015 Act, even had PP adopted an advance healthcare directive prior to her death, and that advance healthcare directive had specified that life support were not to be continued in the event of her being declared brain dead, even should she be pregnant, the High Court application would still have been required. This level of legal scrutiny and oversight over the decisions made by women in respect of their care during pregnancy is something that would be unimaginable in respect of any medical treatment to be received by a man and it is an unreasonable and unjustifiable discrimination against women and an infringement of women's human rights.

Expert Evidence

AIMS Ireland wishes to call on the Assembly in its deliberations to consider the positions in other developed nations in respect of access to reproductive healthcare including access to abortion services, and with regard to women's rights to respect for autonomy and self-determination in healthcare, particularly around informed consent and informed refusal for medical treatments during pregnancy, labour, and delivery.

In particular, AIMS Ireland calls on the Assembly to call and to hear evidence from medical, legal, and human rights experts not only from Ireland but also from other democratic nations who subscribe to the same body of United Nations and European Convention on Human Rights jurisprudence as Ireland.

Most strongly of all, AIMS Ireland urges the Assembly to call and to hear the evidence of women and other pregnant people who are affected by the operation of Article 40.3.3° in practice: those who have been forced to travel to avail of abortion services; women who have been forced to obtain abortifacient medications illegally because they were unable or unwilling to travel; women who have been through the process of seeking to access an abortion under the Protection of Life During Pregnancy Act 2013, or who have been unable or unwilling to secure an abortion under that Act and have then been forced to travel; and women who have experienced the operation of Article 40.3.3° in their interactions with our maternity services in continued pregnancy, labour, and delivery. Where at all possible, given the legal climate in Ireland surrounding abortion and choice in pregnancy and childbirth, we would urge the Assembly to facilitate these women to give their evidence with measures provided to protect their anonymity. People who have been forced to endure this suffering are the true experts on the impact of Article 40.3.3° on the daily lives of the citizens of Ireland.

Consequences of a Repeal of Article 40.3.3°

In the event of a vote to repeal of Article 40.3.3° of the Constitution, there would be no overnight liberalisation of Ireland's legal regime governing both abortion and maternity care more generally, and accordingly it would not be necessary to replace Article 40.3.3° with some alternative wording.

Access to abortion services would continue to be governed by the Protection of Life During Pregnancy Act 2013, and abortion would only be permissible within the circumstances defined in its provisions. The performance or procurement of a termination of pregnancy outside of the parameters of the 2013 Act would remain a criminal offence punishable in accordance with the penalties set out in the Act. Any decision to liberalise Ireland's abortion laws; whether to widen access to abortion beyond the current 'risk to life as distinct from health' grounds, or to remove the penalties for performing or for accessing an abortion, would require legislative amendment. To secure any such amendment would involve the usual parliamentary process with consultation papers, public consultation, and parliamentary debate. The same position would apply to any proposed amendments to the Assisted Decision Making (Capacity) Act 2015 (hereafter 'the 2015 Act') in respect of Advance Care Directives.

One area in which a significant change would occur, which we posit would be a positive development, would be in respect of the National Consent Policy. It would no longer be necessary to include the caveat, in those sections of the National Consent Policy dealing with consent to or refusal of obstetric treatment, that the principles of autonomy and self-determination that apply to consent to treatment in all other areas of medical law are in this instance subject to oversight by the High Court owing to a lack of clarity in our law regarding the balancing of rights, risks, and interests. Without Article 40.3.3° that lack of clarity would evaporate, and it is our submission that following the precedent set in *HSE v B* that the legal position in respect of consent to or refusal of obstetric treatment would in its most general terms follow the usual principles regarding consent to treatment, and in respect of the interests of the unborn then the guiding principle would be that of *North Western Health Board v HW and CW* and that the mother's right to make decisions on behalf of and for her child would apply as equally to an unborn child as to a born child.

Conclusion

AIMS Ireland calls on the Citizens' Assembly to recommend the holding of a referendum on a complete repeal of Article 40.3.3° of the Constitution.

There has been a significant and compelling decline in support for the restrictive legal regime surrounding access to abortion services, consent to and refusal of consent to obstetric treatments, and maternity care in general that is necessitated by the provisions of Article 40.3.3°, and this has been evidenced in numerous opinion polls.

The jurisprudence that has developed in the Irish courts in interpreting Article 40.3.3° is of a nature and character that has no place in a modern democratic society which has made commitments to the European Convention on Human Rights and the United Nations Covenants on human rights. The Irish legal regime governing access to abortion services has been evaluated by both the European Court of Human Rights and the United Nations Human Rights Committee and found to be in breach of these international human rights norms. The case law on consent to and refusal of medical treatment in the context of obstetric treatment is repugnant to the human rights principles of autonomy, self-determination, and privacy. It is only a matter of time before a case is brought before either the European Court of Human Rights or the Human Rights Committee on these points.

The Citizens' Assembly has the opportunity to act now to call for a public decision on the continued presence of Article 40.3.3° in the Constitution. The implications of any potential repeal are a matter for a later date, what is urgent is the need to allow the people of Ireland to make a decision on the type of legal regime we want to have in the future governing maternity care and access to abortion services. No Irish citizen of child-bearing age has had a say on Article 40.3.3°. In a society which is markedly different today to that at the time of the passing of the Eighth Amendment, we submit that it is time they did. A 21st century maternity service should be bound by human rights, the concept of bodily autonomy and should include access to timely abortion services.