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ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Women's right to health and Ireland's abortion laws

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ABSTRACT

The provision of the Irish Constitution that guarantees "the unborn" a right to life equal to that of a pregnant woman has consequences for access to abortion and the care of women in pregnancy generally. Long-awaited legislation to give effect to the narrow constitutional right to abortion was enacted into law in 2013. In 2014, a guidance document for health professionals' implementation of the legislation was published. However, the legislation and guidance document fall far short of international human rights bodies' recommendations: they fail to deliver effective procedural rights to all of the women eligible for lawful abortion within the state and create new legal barriers to women's reproductive rights. At the same time, cases continue to highlight that the Irish Constitution imposes an unethical and rights-violating legal regime in non-abortion-related contexts. Recent developments suggest that both the failure to put guidelines in place and the development of guidelines that are not centered on women or based on rights further reduce women's access to rights and set unacceptable limitations on women's reproductive autonomy. Nevertheless, public and parliamentary scrutiny of cases involving Ireland's abortion laws is increasingly focusing on the need for reform.

1. Introduction

A constitution that gives the biological existence of a fetus pre-eminence over other aspects of life gives rise to complex legal and ethical questions that have serious implications for women and healthcare professionals, reproductive autonomy, and women's human rights to health and bodily integrity. WHO guidance on safe abortion [1] highlights human rights standards of access to information, respect for dignity, and sensitivity to women's needs and perspectives. These standards are central to reproductive autonomy, as is bodily integrity—an individual's interest in being secure from violations of the body by others, and being able to control or determine the actions of his/her own body [2]. Consideration of the law in Ireland in the context of reproductive autonomy illuminates how laws that aim to restrict access to abortion cause harms to women's bodily integrity, their dignity, and their lives, and can have implications for pregnant women in cases that do not involve abortion.

Article 40.3.3 of the Irish Constitution provides that the state recognizes 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." Inserted by referendum in 1983 with the intention of prohibiting abortion, the full implications of this provision are still unclear. A decision of the European Court of Human Rights—*A, B and C v Ireland* [3]—in 2010 led to the enactment of legislation to give effect to the limited right to abortion when a woman's life is at risk in 2013 [4] and the publication of guidelines for healthcare professionals in 2014 [5].

Although the legislation and guidelines could ensure access to lawful abortion for some women, regulation has put new barriers in the way of access to care for others. At the same time, the process of establishing procedural rights to lawful abortion in the wake of *A, B and C v Ireland* was a catalyst for the shift in parliamentary discussion of abortion away from a monolithic focus on the moral–legal aspects of abortion. The "frustratingly narrow" terms of the debate on the legislation in 2013 [6–8] ensured that women's reproductive rights could not emerge as a dominant narrative, but reproductive autonomy is beginning to enter the narrative frame in Irish political discourse to a degree unprecedented in debates on the various referenda on abortion held in Ireland since 1983 [9–11]. Furthermore, attention is increasingly being focused on the wider implications of Article 40.3.3 for pregnant women's health, autonomy, and dignity in both abortion and non-abortion contexts [12].

2. The legal and political imperative for legislation

In 1992—9 years after Article 40.3.3 was inserted in the Irish Constitution—a case involving a girl aged 14 years who was suicidal after becoming pregnant as a result of rape was taken to the Irish Supreme Court. In *Attorney General v X* (henceforth, the *X* case) [13], the Supreme Court held that a pregnant woman has a right to a termination of her pregnancy if there is "real and substantial" risk to her life, as distinct from her health, that can only be averted by a termination of the pregnancy. One of the Supreme Court judges in the *X* case described the state's failure to enact legislation "to regulate the manner in which the right to life of the unborn and the right to life of the mother

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could be reconciled" as "not just unfortunate", but "inexcusable": "What are the medical profession to do? They have no guidelines save what may be gleaned from the judgments in this case" [13].

Despite parliamentary reports in 1996, 1999, and 2000 on the implications of the *X* case and of Article 40.3.3 [14], this remained the situation until the European Court of Human Rights ruled in *A, B and C v Ireland* that failure to give legislative effect to the *X* case violated the European Convention on Human Rights. In 2012, the Irish Government established an expert group to advise on implementation of the ruling. The report of the expert group [15] was published only weeks after Savita Halappanavar died after being refused a termination despite "inevitable miscarriage in the early second trimester of a pregnancy" and prolonged rupture of membranes because a fetal heartbeat could be detected [16]. Her death galvanized public protest and international attention, and gave urgency to the political imperative created by *A, B and C v Ireland*. The expert group report [15] left no doubt that implementation of *A, B and C v Ireland* required that appropriate and accessible services be put in place. The group expressed doubt that any option short of legislation would give effect to the right to lawful abortion where there is risk to a woman's life [15].

Unlike the previous reports, the expert group report could not be shelved. In December 2012, the government announced that legislation would be enacted. Following two sets of parliamentary hearings [9,10], the Protection of Life During Pregnancy Act (hereafter, the Act) [4] was signed into law in July 2013, coming into force on January 1, 2014.

3. The Protection of Life During Pregnancy Act

The Act sets out the procedures for establishing entitlement to a lawful abortion. Satisfaction that the government had finally taken this step was cautious from the outset because of concerns about the onerous nature of the Act's provisions [17]. It seemed to have been drafted with more apparent concern to appease conservative fears of "floodgates" being opened than to ensure realization of a constitutional right to access to care. Ignoring the recommendations of international human rights bodies [18–23] and of WHO [1], the Irish Government chose to enact legislation that fully secured the most restrictive possible approach to Article 40.3.3.

Decriminalization was definitively ruled out; the Act created a new criminal offence of intentional destruction of unborn human life, with a maximum 14-year sentence of imprisonment. Consideration of lawful abortion in cases of rape, risk to a woman's health, or fatal fetal anomalies was also ruled out, although persuasive arguments had been made that at least fatal anomalies could have been included in the legislation. In *D v Ireland* in 2006, the Irish authorities had argued before the European Court of Human Rights that abortion in such cases could be lawful within Article 40.3.3 [24]. The then Attorney General asserted that there was "at least a tenable argument" that the Irish courts would not apply the right to life of the unborn with "remorseless logic" when the condition of a fetus was incompatible with life [24,25]. (Notably, the current Attorney General has issued contrary advice [26].)

The Act includes separate provisions for the certification of cases of non-emergency physical threat to life (section 7), medical emergencies (section 8), and cases of risk to life from suicide (section 9). The terms "abortion" and "termination of pregnancy" are not used in the Act, which instead uses the formulation "a medical procedure in respect of a pregnant woman in accordance with this section in the course of which, or as a result of which, an unborn life is ended." Certification involves a two-part test based on the *X* case: first, doctors must make a determination that there is a "real and substantial" risk to the woman's life; and second, they must jointly certify "in good faith" that the relevant "medical procedure" is the only reasonable means of eliminating that risk.

Decision making is in the hands of medical specialists and is different under each section. One doctor can make the decision in emergency cases. A pregnant woman who asserts her right to abortion because of physical risk to life under section 7 must be examined by two medical practitioners (an obstetrician and a specialist in a relevant area). However, in response to the contentious discussions of the grounds based on suicide during the parliamentary hearings on the legislation [6,8], the drafters of the Act made the requirements for certification more onerous in cases of suicide risk than when there is physical risk to life. Section 9 provides that three specialists—two psychiatrists and an obstetrician—must jointly certify a woman's legal entitlement to the "medical procedure". If certification is refused under section 7 or section 9, the pregnant woman, or someone acting on her behalf, can seek a second opinion or initiate a formal review procedure. She will then be examined by a review panel of the same number and specializations as under sections 7 and 9, depending on the nature of the risk to life. A review procedure was a requirement of the *A, B and C v Ireland* judgment, but these provisions place significant burdens on women, particularly a pregnant woman who asserts suicide risk, and is, by definition, extremely vulnerable. If she is denied certification and seeks a review of the decision, she will be subjected to examinations by four psychiatrists and two obstetricians. The role of the four psychiatrists in this process is not to provide treatment, but only to examine the woman to determine whether she is at risk of suicide.

In drafting these provisions, recommendations of the expert group that the Act should reflect existing clinical practice when the risk to life involves risk of suicide were sidelined. The expert group's view was that that examination by two psychiatrists would put an extra burden on a woman and her treating doctor(s), and risked stigmatizing mental health conditions and making them a "separate case" [15]. The report also commented that, because the diagnosis of expressed suicide intent is a routine process for psychiatrists, it would be hard to justify requiring a second psychiatrist when this does not occur among patients who are not pregnant [15]. The apparent purpose of section 9 of the Act is to test women, rather than to fulfil the intent of *A, B and C v Ireland* to positively ensure pathways for accessing lawful abortion. Indeed, the Act reflects the same "perceptibly misogynistic" view that women would fake suicide intent, which had underlain previous attempts to exclude risk to suicide as a ground for abortion [6,7]. Views that women would fabricate suicidal ideation to obtain an abortion and that doctors would provide abortion under cover of the Act to women who were not genuinely suicidal were canvassed during the parliamentary hearings, as they had been during referendum campaigns in 1992 and 2002 [6,7]. Deference to such views has led to provisions that discriminate against women who are suicidal and has detrimental effects on women's health [17].

Within days of the Act coming into force, the representative body of doctors in Ireland had called on the Minister of Health to publish clinical guidelines based on the best international evidence to ensure that patients receive the most appropriate care [27].

4. Guidance document on the implementation of the Act

It was not until September 2014 that a guidance document [5] was issued by the Department of Health. The guidelines can, in theory, facilitate more informed and appropriate doctor–patient discussion of abortion and contribute to the normalization of abortion as medical treatment, albeit in a limited context. But medical practitioners hoping for authoritative principles to inform decision making in difficult cases and obviate the need for doctors to engage in ad hoc, bedside interpretations of the law were disappointed. The guidelines are entirely focused on procedure: there are forms and tables outlining the certification process and the test to be applied. Additionally, the document uses language that is almost identical to that of the Act and includes numerous repetitions of the language of Article 40.3.3. There is no reference to the WHO guidance on safe abortion or to international evidence or practice, and nothing about how, in clinical terms, a decision to certify or not is to be made.