



**General Scheme of the Protection of Life During Pregnancy Bill
2013**

Submission by the Irish Family Planning Association

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Introduction

The Irish Family Planning Association (IFPA) is Ireland's leading sexual health charity. The organisation promotes the right of all people to sexual and reproductive health information and to dedicated, confidential and affordable healthcare services. The IFPA makes this submission based on its experience in providing information, counselling and medical health care to women and girls living in Ireland who are forced to travel abroad to access safe abortion services.

The IFPA makes this submission based on this experience as a medical and counselling services provider to assist the Oireachtas Health Committee in its discussion of the proposals contained in the General Scheme of the Protection of Life During Pregnancy Bill 2013 (Heads of Bill).

The IFPA has a particular standing in relation to the *A, B and C v Ireland* case (2010, Application 25579/05) at the European Court of Human Rights. The IFPA provided professional, specialist counselling and emotional support to the three applicants. The IFPA was not a formal applicant in *A, B and C v Ireland*, but assisted the applicants' legal team with respect to administration and coordination of the case.

The IFPA submission makes 12 recommendations (listed separately) for amendments to the Heads of Bill. These recommendations are intended to support the Committee process of amending the legislation so that it will provide sufficient legal certainty and safeguards to satisfy the Council of Europe.

The Committee of Ministers of the Council of Europe monitors the implementation of the A, B and C case through its enhanced supervision procedure. The Committee will assess whether the legislation meets Ireland's obligations under the European Convention on Human Rights.

The IFPA has analysed the Heads of Bill in relation to the judgment in *Attorney General v X* ([1992] 1 IR 1, "the X case"), the specific requirements of the *A, B and C v Ireland* judgment and other relevant case law under the European Convention on Human Rights.

The Supreme Court held in the X case that where a real and substantial risk to her life exists and can only be averted by the termination of her pregnancy, a pregnant woman is entitled to an abortion in Ireland. The Court did not consider that abortion can be permitted only where the risk is of immediate or inevitable death of the pregnant woman, as this would insufficiently vindicate her right to life. Nor is it necessary that risk to life is a virtual certainty.

According to the European Court of Human Rights, states must guarantee rights that are practical and effective, not merely theoretical and illusory (*Airey v Ireland* (1979, Application 6289/73)). In *A, B and C v Ireland* the European Court of Human Rights held that the failure to give effect to the right to a lawful abortion in Ireland where a pregnant woman's life is at risk is a violation of the European Convention on Human Rights.

The ruling of the European Court of Human Rights in *A, B and C v Ireland* requires:

1. Ireland must address striking discordance between the theoretical right to abortion where life is at risk and its practical application.
2. Legislative criteria or procedures must be put in place that allow for a practical assessment by doctors and women of a "real and substantial risk" to the life of the pregnant woman. The Court has stated (*Tysiack v Poland*, 2007, Application 5410/03) that where abortion is lawful, the State must not structure its legal framework in a way that would limit real possibilities to obtain it.

3. A framework must be established to examine and resolve differences of opinion between a woman and her doctor or between doctors.
4. The chilling effect of the severe criminal penalties for having or assisting an unlawful abortion, which can interfere with medical consultations between a woman and her doctor must be addressed. The Court stated in *Tysiac v Poland* that in order to fulfil the State's obligations under the Convention, the law must be formulated to alleviate the chilling effect.

The IFPA's submission is based on a consideration of these requirements. We have identified seven areas of particular concern and make recommendations for changes to the Heads of Bill in relation to each.

Outline of this submission

The submission is in three sections.

Section 1 outlines the IFPA's areas of particular concern and indicates the recommendations that relate to each.

Section 2 is a head-by-head analysis of the Heads of Bill, with the text of the amendments proposed to each head and the supporting evidence and argument for each.

Section 3 is an appendix listing all the recommendations.

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SECTION 1

AREAS OF PARTICULAR CONCERN

1. Definitions/interpretation

It is the view of the IFPA that the definition of “unborn” in Head 1 limits the scope of the government to introduce measures to allow terminations in cases of foetal abnormality incompatible with life. “Unborn” should be defined to mean a foetus which is capable of independent life. (Recommendation 1)

It is of great concern that the Supreme Court judgment in the X case is only partially reflected in the Heads of Bill, which refers to “real and substantial risk”, but omits, except in the explanatory notes, to specify that it is not necessary that medical practitioners are of the opinion that the risk is immediate or inevitable. (Recommendation 5)

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2. Referral pathways

As a primary health care provider, the IFPA’s particular concern is that women who fall within the criteria of the X case are assured of access to appropriate services. To ensure compliance with international human rights law and ensure that all women can exercise their right under the Constitution, the legislation must guarantee clear referral pathways for terminations that take place under Head 2. (See Recommendation 2)

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3. Timely access to a life-saving procedure

Delayed access to services and lack of public awareness are strongly associated with subsequent adverse health outcomes. Delays in decision-making could make the difference between a minor procedure and a more invasive procedure that would involve more risk for a woman whose health is already compromised.

The Heads of Bill must also specify clear timeframes for access to the examination by two consultants which is required for certification that risk to a pregnant woman’s life exists. The Heads of Bill must also be amended to reduce the maximum time allowed for a review and decision by an appeal committee in cases where there is a difference of opinion between doctors or between a woman and her doctors. (See Recommendations 3, 8 and 9)

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4. Chilling effect

The IFPA is of the view that the language used in the Heads of Bill is not consistent with a guarantee of access to the exercise of a right. The term “lawful”, is more appropriate to give legal certainty to doctors and to reassure pregnant women that they are both protected by the law and guaranteed access to services. (See Recommendation 4)

The IFPA is of the view that the retention of severe criminal penalties for both women and their doctors is ineffective, disproportionate and inconsistent with the State’s obligations under the European Convention on Human Rights and international human rights law generally. The inclusion of the very heavy maximum penalty of fourteen years, which could apply to pregnant women and to doctors will not only maintain, but substantially reinforce, the chilling effect. (See Recommendation 12)

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5. Women’s wishes central to decision-making

The pregnant woman’s wishes and views must be central to any decision-making about a pregnancy that involves risk to her life. The IFPA is concerned that some provisions in the Heads of Bill appear to override a woman’s consent. For example, Head 2 requires that a woman’s general practitioner be consulted, but does not specify that such consultation can only be with the woman’s consent. Rather than impose a mandatory additional layer of consultation, the legislation must give the woman a more active role in the decision making process and allow her, if she so wishes, to nominate a qualified doctor to be consulted by the medical practitioners who are empowered to certify that a risk to her life exists. (See Recommendations 6 and 10)

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6. Provisions relating to risk to life because of threat of suicide

The Heads of Bill require that while two doctors can certify that a real and substantial risk exists in the case of physical threat to a pregnant woman’s life, in the case of mental health grounds, three doctors must make the decision. The IFPA believes that the higher number of doctors and the requirement of unanimity place unwarranted obstacles in the path of a woman seeking life-saving medical care.

The diagnosis of expressed suicide intent is a routine process for psychiatrists and the requirement of a second psychiatrist when this does not occur when a pregnancy is not involved has no justification. Imposing a different standard of decision-making in cases where the risk arises from threat of suicide risks stigmatising mental health conditions. (See Recommendation 7)

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7. Conscientious Objection

Conscientious objection has been used in many countries to frustrate, delay or refuse access to lawful abortion. The Heads of Bill place some necessary limits on its exercise. But they do not place sufficient duty on a doctor who refuses to perform a lawful termination to save a woman’s life to ensure that the procedure is carried out by another doctor. The IFPA is concerned that the provisions in this head do not provide adequate safeguards against refusal of care and do not sufficiently ensure women’s access to life-saving treatment. Subhead 4 does not place sufficient duty on a doctor who exercises conscientious objection to ensure timely referral so that a termination can take place. The IFPA is concerned at the change in language in subhead 4—the duty is to “ensure that another colleague takes over the care”, rather than ensuring that the procedure is carried out. (See Recommendation 11)

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SECTION 2

HEAD-BY-HEAD ANALYSIS OF THE HEADS OF BILL, TEXT OF THE AMENDMENTS PROPOSED TO EACH HEAD AND SUPPORTING EVIDENCE AND ARGUMENT

RECOMMENDATION 1

Head 1: Interpretation

The Heads of Bill unduly limit the scope of the Oireachtas to address the needs of women who have received a diagnosis of foetal abnormality incompatible with life outside the womb. The Oireachtas Health Committee must ensure that no definition in the legislation when enacted has the consequence of limiting the scope of the Oireachtas to introduce therapeutic abortion in cases of fatal foetal abnormality.

Recommendation

Delete the definition of “unborn” and replace with the following: “‘unborn’ means a foetus which has reached that stage of pregnancy at which, if born, it would be capable of independent life.”

Supporting evidence

The IFPA is of the view that the definition of “unborn” as “human life means following implantation until such time as it has completely proceeded in a living state from the body of the woman” is unduly restrictive and has the effect of affording equal protection to a non-viable foetus as to a woman.

The explanatory note states that the definition is based on the Supreme Court judgment in *Roche v Roche & Others*, which “deemed that embryos acquire legal protection under Article 40.3.3 of the Constitution only from the moment of implantation”. In *Roche v Roche* the protection to the unborn provided under the Constitution was deemed by the Supreme Court not to include an embryo that has not implanted in the womb. The IFPA is of the view that the restrictive definition in Head 1 is not in fact required by case law or necessary to vindicate the rights of the unborn under Article 40.3.3.

The Irish state has in fact argued to the contrary before the European Court of Human Rights in 2006 in *D v Ireland*. In that case, a woman who was pregnant with twins, one of which died within the womb and one was diagnosed with Edwards Syndrome, argued that Ireland's ban on abortion in the case of fatal foetal abnormalities violated the European Convention on Human Rights.

The State argued that there was “at least a ‘tenable’ argument” that the right to life is not actually engaged in the case of a foetus that has no prospect of life outside the womb and that such a foetus may not be considered ‘unborn’ for the purposes of Article 40.3.3.

The European Court of Human Rights accepted that there was a possibility that the Irish Supreme Court could rule that termination of pregnancy could take place lawfully in the State in these circumstances. The definition proposed in Head 1 would appear to close off this possibility.

Such an outcome of the legislation would be devastating to the clients of the IFPA and other women who have received a diagnosis of severe foetal abnormality. Many women in these

circumstances see no alternative but to avail of costly private treatment in the UK, and they express anger at the lack of appropriate, compassionate services within the State and what they experience as abandonment by the health service in Ireland.

The case law of the UN Human Rights Committee indicates that failure to provide for terminations of pregnancy in the case of severe foetal abnormality inconsistent with life outside the womb may give rise to liability under international human rights law. In the 2005 K.L. v Peru case, K.L. a 17-year-old, was pregnant with an anencephalic foetus and was denied an abortion. Although Peruvian abortion law permits abortion when the life or health of the mother is in danger, K.L. was denied an abortion and had to deliver the baby and breastfeed her for the four days she survived. K.L.'s pregnancy severely compromised her life by endangering her physical and psychological health during the second half of her pregnancy (when she desired but was denied an abortion). The United Nations Human Rights Committee found that this constituted cruel, inhuman and degrading treatment by state officials and was a clear violation of international standards prohibiting violence against women and was a violation of the International Covenant on Civil and Political Rights.

The UN Special Rapporteur on Torture and Cruel, Inhuman and Degrading Treatment in his April 2013 report highlighted that denial of abortion in certain circumstances may cross the threshold into cruel, inhuman and degrading treatment.

Further cases relating to the denial of abortion in cases of foetal abnormality may well come before the Irish courts and the international human rights monitoring committees.

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Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

Recommendations 2, 3, 4, 5 and 6 relate to Head 2

RECOMMENDATION 2

The Heads of Bill do not place sufficient emphasis on duty of care to ensure access to a lawful treatment and thereby fail to ensure legal certainty and the guarantee of practical and effective exercise of a constitutional right.

Head 2 should be amended to place a duty of care on the Health Service Executive to facilitate speedy access to appropriate services when a risk to a pregnant woman's life first presents and should include specific reference to minors, migrant women and women living in poverty. Consistently with Heads 15 and 16, which apply to the making of regulations of certification of opinion and notifications to the Minister respectively, a new head, "Regulations respecting the establishment of referral pathways" should be inserted. This Head should state that the Minister **shall** make regulations regarding timely and appropriate referral pathways from primary to tertiary care, including self-referral.

Supporting evidence

The IFPA knows from our services that women who are concerned about a possible risk to their life tend to present at a primary care setting before the risk becomes imminent. As a medical services provider, the IFPA's particular concern is that women who fall within the criteria of the X case have timely access to appropriate services.

The legislation must ensure that women in the situation of Applicant C in *A, B and C v Ireland* never again experience the violation of their rights that occurred in her case.

Applicant C was in remission from cancer when she became pregnant. Unaware that she was pregnant she underwent a series of check-ups contraindicated during pregnancy. Upon learning she was pregnant, she was unable to find a doctor willing to make a determination as to whether her life would be at risk if she continued with the pregnancy.

It is critical that women in the situation of Applicant C are guaranteed a referral pathway under the legislation.

The IFPA is also aware that most of the cases that have come before the courts in Ireland have involved minors in the care of the State (e.g. the X case (1992), the C case (1997) and the Miss D case (2007)). While the Heads of Bill define “woman” as a female person of any age, the IFPA is of the view that without specific reference to a duty of care to ensure that young women and girls, particularly those in the care of the State, are facilitated to access speedy care pathways, the legislation will fail to give sufficient legal clarity in regard to such cases and that further cases will come before the courts.

The United Nations Committee on Torture in 2011 expressed its concern that “despite the already existing case law allowing for abortion, no legislation is in place and that this leads to serious consequences in individual cases, especially affecting minors, migrant women, and women living in poverty (arts. 2 and 16).”

The UN Special Rapporteur on Health, in his 2011 interim report, has criticised the criminalisation of reproductive health services as unduly shifting the burden of exercising the right to health from the State onto the woman—in this case a seriously ill / extremely distressed woman or girl.

Women faced with a possible risk to their life in pregnancy need information on their options and on relevant service provision. Information must include what services local health providers, including general practitioners, must offer and should be in a range of formats and provided in a range of settings.

To ensure compliance with international human rights law and ensure that all women can exercise their right under the Constitution, the legislation must guarantee clear referral pathways and timeframes for terminations that take place under Head 2.

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RECOMMENDATION 3

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

The Heads of Bill do not include sufficient safeguards to ensure that a woman will not experience undue delays in referral for examination by a medical practitioner at an appropriate location.

Recommendation 3

Head 2 should specify that referral to a *medical practitioner at an appropriate location* should be made within 2 days. The certifying consultants must examine the woman within 5 working days of such referral; the termination should be carried out within 5 days of a decision that as a matter of probability there is a real and substantial risk to the pregnant woman's life.

Supporting evidence

Delayed access to services and lack of public awareness are strongly associated with subsequent adverse health outcomes. Delays in decision-making could make the difference between a minor procedure that does not require a general anaesthetic and a more invasive procedure. This would involve more risk and more distress for a woman whose health is already compromised and who fears for her life.

However, the Heads of Bill do not stipulate a time-frame within which a termination must take place once a risk to a pregnant woman's life is certified under Head 2.

A woman who is concerned that pregnancy involves a risk to her life must not be subjected to additional stress or risk to her health or life because of delays while waiting for appointments with the two consultants who must certify that a real and substantial risk to her life exists.

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RECOMMENDATION 4

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

The language used in the Heads of Bill should reflect the aim of ensuring access to the right to a lawful medical treatment.

Recommendation 4

Where the phrase “it is not an offence” is used in Head 2, subhead (1) (and also in Head 3, subhead (1) and Head 4, subhead (1)), it should be deleted and replaced with “it shall be lawful”.

Supporting evidence

The ECtHR in *A, B and C v Ireland* considered it evident that the serious criminal penalties for having or assisting in an unlawful abortion would constitute a significant “chilling factor” for both women and their doctors, regardless of whether or not prosecutions have been pursued under that Act. The chilling effect has been described by the World Health Organisation as “suppression of actions because of fear of reprisals or penalties”.

We return to a consideration of the proposed new penalties in our analysis of Head 19.

In relation to Head 2, the IFPA is of the view that the language used in this head—“It is not an offence”—is not consistent with a guarantee of access to the exercise of a right. The term “lawful”, is more appropriate language to give legal certainty to doctors and to reassure pregnant women that they are both protected by the law and guaranteed access to services.

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RECOMMENDATION 5

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

In order to give sufficient clarity to women and their doctors: Head 2 must not only refer to “real and substantial risk to life”, but also include the full X case criteria.

Recommendation 5

All references to “real and substantial risk” should be qualified by the phrase “as a matter of probability”. Head 2 should be renamed: Risk of Loss of Life from Physical Illness, Not Being Immediate or Imminent, Not Being a Risk of Self Destruction.

Supporting evidence

Very few of the women who avail of our services do so because of risk to their lives but some women do. The women who come to the IFPA in life threatening circumstances tend to present at an early stage of pregnancy before the risk is imminent. They tend to be women who have had serious complications during previous pregnancies, or have underlying health conditions and have been advised not to become pregnant. These women have taken a decision to terminate the pregnancy rather than incur the risks their lives. They are not prepared to wait until the risk to their health deteriorates to an immediate risk to their life.

In this context, it is of great concern that the Supreme Court judgment in the X case is only partially reflected in the Heads of Bill, which refers to “real and substantial risk”, but omits, except in the explanatory notes, to specify that it is not necessary that medical practitioners are of the opinion that the risk is immediate or inevitable.

The consequences could be extremely serious for women. Without clear reference to the X case criteria, doctors may believe that they can act only in circumstances of imminent or immediate risk, and may thereby endanger the life or health of a woman who does in fact fall within the X case criteria.

This is a real concern, as the case of Michelle Harte, which was reported in 2010 in The Irish Times, illustrates. Ms Harte had cancer and in the opinion of her doctors required a termination of pregnancy to avert the risk to her life. However, she was refused treatment by a hospital ethics committee on the grounds that the threat to life was not imminent. Ms Harte was obliged to travel to the UK for a termination at a time when she was seriously ill.

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RECOMMENDATION 6

Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction (and Head 4)

The Heads of Bill create an unnecessary additional obstacle to access to appropriate care and could render the legislation impractical and ineffective. The legislation must give the woman a more active role in the decision making process.

Recommendation 6

Head 2, subhead 3 (a) and Head 4, subhead 2 (a) which require mandatory consultation with a woman’s general practitioner must be **deleted and replaced with** a provision that a qualified doctor of the pregnant woman’s choosing may, with the pregnant woman’s consent, consult with the doctors who are empowered to certify that a risk to her life exists.

Supporting evidence

Head 2, subhead 3 (a) and also Head 4, subhead 2 (a) require that a woman’s general practitioners “*shall*” be consulted by the medical practitioners who are empowered to certify that a real and substantial risk to her life exists.

The pregnant woman’s wishes and views must be central to any decision-making about a pregnancy that involves risk to her life. This requirement overrides a woman’s consent, which is not required for such consultation, and is an invasion of her privacy.

The IFPA is of the view that this proposal has implications for the effectiveness of the proposed legislation. It unnecessarily involves a **third** doctor in the decision-making process in relation to physical threat to life and a **fourth** doctor in the case of threat on mental health grounds. Such mandatory consultation has no precedent in medical practice or law and could cause additional delays in a woman’s access to a lawful termination.

Moreover, this requirement does not reflect reality—many women who experience crisis pregnancy do not consult their GPs; nor is it the case that there is always a GP who can provide additional insight into a woman’s medical history.

Rather than impose a mandatory additional layer of consultation, the legislation must give the woman a more active role in the decision making process and allow her, if she so wishes, to nominate a qualified doctor to be consulted by the medical practitioners who are empowered to certify that a risk to her life exists.

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RECOMMENDATION 7

Head 4 - Risk of Loss of Life from Self Destruction

The provisions of Head 4 place unjustifiable obstacles in the path of a woman in a situation where risk to her life arises because of threat of suicide.

Recommendation 7

Head 4 should be **amended** so that the number of doctors required to certify a risk to a pregnant woman's life should be the same as in Head 2. Recommendation 5 in relation to the requirement to consult a general practitioner also applies to Head 4.

Supporting evidence

In relation to the question of suicide, it is impossible to estimate the number of IFPA clients who fall within the provisions of Head 4. Not all women who attend for crisis pregnancy counselling choose to disclose all their reasons for considering abortion. In the past year, however, two clients have reported suicidal thoughts or have threatened suicide and one client followed through on those threats. Both clients were attending psychiatric services. This small, but significant number of clients in this situation is consistent with the findings of the Irish Contraception and Crisis Pregnancy Survey 2010 (ICCP-2010): among the findings of this study of 3,002 adults aged 18 to 25 was that 26 women (less than 1%) reported that they had experience of suicidal ideation.

The expert group gave a great deal of consideration to the appropriate legislative and health service response to risk to a woman's life by threat of suicide. The expert group report is absolutely clear that termination of pregnancy is a lawful medical treatment regardless of whether the risk to the woman's life arises on physical or mental health grounds.

The Heads of Bill require that while two doctors can certify that a real and substantial risk exists in the case of physical threat to life, in the case of mental health grounds, three doctors must make the decision. The IFPA believes that the higher number of doctors and the requirement of unanimity place unwarranted obstacles in the path of a woman seeking life-saving medical care.

The diagnosis of expressed suicide intent is a routine process for psychiatrists and the requirement of a second psychiatrist when this does not occur when a pregnancy is not involved has no justification. Nor is there any justification for the mandatory involvement of an obstetrician in the determination of a question outside their field of clinical expertise.

The IFPA is of the view that this proposal would put an extra burden on a woman and her doctor(s) and could cause unnecessary delays in access to treatment, in particular because of the requirement in Head 4, subhead 2(a) that a general practitioner also be consulted.

Imposing a different standard of decision-making in cases where the risk arises from threat of suicide risks stigmatising mental health conditions. Moreover, the provisions of Head 4 also have the potential to reinforce the chilling effect, which was highlighted by the European Court of Human Rights in *A, B and C v Ireland*.

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RECOMMENDATION 8

Head 6- Formal Medical Review Procedures

The timeframe specified in Head 6 in relation to formal medical review procedures is too lengthy and could unduly delay a woman's access to a lawful termination.

Recommendation 8

The legislation should provide that once an application for an appeal is made, a decision should be given within no more than 3 days. The review committee must be required to notify to the woman not only the outcome of the review, but also the reasons for the decision.

Supporting evidence

The judgment in *A, B and C v Ireland* requires a framework to examine and resolve differences of opinion between a woman and her doctor or between doctors.

The IFPA is of the view that the appeals procedure provided in the Heads of Bill is cumbersome, complex and that the maximum timeframe permitted could unduly delay women's access to the most appropriate and timely treatment.

This is of particular concern given the lack of timeframes and referral pathways already discussed under the recommendations relating to Head 2. Under the proposals as outlined, a woman may find herself in a situation where having already experienced delay in accessing an initial assessment, she is not informed of the result of a review of a decision in her case until the pregnancy has advanced beyond a point where the least invasive termination procedure is no longer an option.

A woman who has been refused a termination under the procedures proposed in Head 2 or Head 4 may be deterred from risking further delay, so that the provision as it is currently proposed may in practice act as a deterrent, rather than as a mechanism to facilitate access to the exercise of a right.

Best international practice in relation to appeals procedures is that a decision is made within 3 days of the receipt of an application.

The expert group gave considerable attention to the requirements for the composition of a review panel and committee. The expert group report outlines the attributes of an appeal process, including that it must be independent, competent and give written decisions in a timely manner, and that the procedures must include the possibility for the woman's voice to be heard.

The Heads of Bill as currently proposed require that the woman be notified of the outcome of the review, but omit to require that she be informed at the same time of the reasons for the decision.

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RECOMMENDATION 9

Head 8 - Review in case of risk of loss of life through self-destruction

The review process where risk to a woman's life arises because of threat of suicide is more onerous than in the case of physical threat to life.

Recommendation 9

The number of doctors required to review a refusal to certify a risk to a woman's life should be the same whether the risk arises from mental or physical health. The legislation should provide that once an application for an appeal is made, a decision should be given within no more than 3 days. The review committee must be required to notify to the woman not only the outcome of the review, but also the reasons for the decision.

Supporting evidence

The Heads of Bill require that, in the case of risk to a woman's life when the risk arises because of mental health grounds, a review committee of three must be convened, rather than the two doctors involved in reviewing a case where the risk arises on physical health grounds. These doctors must be unanimous in their decision.

The IFPA is of the view that the appeals procedure proposed in the Heads of Bill is cumbersome, complex and that maximum timeframe specified could unduly delay women's access to the most appropriate and timely treatment.

The IFPA is of the view that there is no justification for the higher number of medical specialists. Moreover, the imposition of a more burdensome process in this case than in the case of physical threat risks the stigmatisation of mental health issues and appears to be informed by a distrust of women's veracity in such circumstances.

Further, the inclusion of two psychiatrists in the decision does not reflect the reality recognised by the Government's expert group that the diagnosis of expressed suicide intent is a routine process for psychiatrists and the requirement of a second psychiatrist when this does not occur when a pregnancy is not involved is not justified.

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RECOMMENDATION 10

Head 9 - General Provisions for Committee

The general provisions are insufficiently clear and do not include sufficient safeguards for a woman who makes an application for a review of a decision under Head 2 or Head 4.

Recommendation 10

The legislation must require that a woman who makes an application for a review of a decision under Head 2 or Head 4 is furnished with copies of any direction under this head and guaranteed access to any “document or thing” sought by the review committee by way of direction.

Supporting evidence

Head 9 subhead 1 authorises the review committee to “direct in writing any relevant medical practitioner to produce to the committee any document or thing in his or her possession or control that is specified in the direction”.

The IFPA is concerned that this proposal is not reflective of fair procedures. The wording is unclear and places no restriction on the documents or things that may be requested, and this may amount to a breach of the woman’s right to privacy and confidentiality.

The Heads of Bill must be amended to clarify that all directions by the review committee and all documents or other things produced to the committee will also be made available to the pregnant woman.

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RECOMMENDATION 11

Head 12 - Conscientious Objection

Conscientious objection has been used in many countries to frustrate, delay or refuse access to lawful abortion; in the case of life-saving treatment it is especially important that women are not refused care because of the exercise of conscientious objection.

Recommendation 11

Head 12 must be amended to ensure that doctors who have an objection to abortion must be under a duty of care to ensure that the woman is referred to another doctor who does not have such an objection.

Supporting evidence

In many countries where abortion is legal, the exercise of conscientious objection has frustrated and delayed women’s access to lawful abortion, or women have been refused care. Because the issue in question is refusal of care where there is a risk to a woman’s life, the legislation must provide adequate safeguards against refusal of care.

There are some necessary limits on refusal to care in the current proposals. However, subhead 4 does not place sufficient duty on a doctor who exercises conscientious objection to ensure timely referral and ensure access to a lawful termination.

Further, this language raises concerns about women being sent from doctor to doctor, a process which is likely to increase the delay in accessing a termination and exacerbate the stigma and stress that were recognised by the ECtHR as part of the experience of women in Ireland who seek to terminate pregnancies.

The IFPA is concerned at the language in subhead 4—the duty is to “ensure that another colleague takes over the care”. Current medical guidelines stipulate that doctors have a duty of care to ensure after-care to women who have abortions.

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RECOMMENDATION 12

Head 19 - Offence

The IFPA is of the view that the retention of severe criminal penalties for both women and their doctors is ineffective, disproportionate and inconsistent with the State’s obligations under the European Convention on Human Rights, and international human rights law generally. The inclusion of the very heavy maximum penalty of fourteen years will not only maintain, but substantially reinforce, the chilling effect. The Oireachtas Health Committee must take into consideration the impact and appropriateness of criminal sanctions in relation to women and revisit the inclusion of pregnant women among those to whom criminal liability may apply.

Recommendation 12

Delete Head 19 from the Heads of Bill.

Supporting evidence

The European Court of Human Rights considered that the existence of criminal penalties for having or assisting in an unlawful abortion constitutes a significant “chilling factor” for both women and their doctors.

The IFPA is concerned that the Heads of Bill do not adequately address the chilling effect highlighted by the European Court of Human Rights, and may, in fact, substantially reinforce it.

The IFPA is of the opinion that the public interest to protect women’s health and ensure that vulnerable people are not exploited is not served by the prosecution of pregnant women. Nor is the constitutional protection of the unborn sufficient justification.

The UN Special Rapporteur on the Right to Health has stated, in his 2011 interim report, that the application of criminal and other legal restrictions on abortion is often ineffective and disproportionate. The extremely high maximum sentence proposed in Head 19, which would apply to anyone who induced an abortion, including a pregnant woman who self-induces an abortion using medication, is neither proportionate nor effective.

The current criminal law does not deter the more than 4,000 women who travel to the UK for abortions each year. Nor does the criminal law deter many other women from resorting to the importation of medication which may then be used incorrectly and without medical supervision or prescription of antibiotics, as is protocol when this medication is used in countries where it is lawful.

The law does, however, deter some women in such circumstances from seeking medical advice in cases of any post-abortion complications that arise. Delay in seeking medical advice may result in risk to women's health, or in certain circumstances, her life.

The UN Committee Against Torture in its 2011 report on Ireland noted that "the risk of criminal prosecution and imprisonment facing both the women concerned and their physicians, the Committee expresses concern that this may raise issues that constitute a breach of the Convention Against Torture".

The word "destroy" is potentially open to being interpreted to include actions affecting the development of the foetus in the womb, and as such could lead to the mistaken assumption that the Heads of Bill intend to criminalise certain conduct by a woman during pregnancy.

The UN Special Rapporteur on the Right to Health states in his 2011 interim report that criminal and other legal restrictions on conduct during pregnancy violate women's right to bodily integrity.

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SECTION 3

APPENDIX: LIST OF IFPA RECOMMENDATIONS

RECOMMENDATION 1: Head 1 – Interpretation

The Heads of Bill unduly limit the scope of the Oireachtas to address the needs of women who have received a diagnosis of foetal abnormality incompatible with life outside the womb.

Recommendation

The Oireachtas Health Committee must revisit the definition of “unborn” and ensure that no definition in the legislation when enacted has the consequence of limiting the scope of the Oireachtas to introduce therapeutic abortion in cases of fatal foetal abnormality.

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RECOMMENDATION 2: Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

The Heads of Bill do not place sufficient emphasis on duty of care to ensure access to a lawful treatment and thereby fail to ensure legal certainty and the guarantee of practical and effective exercise of a constitutional right.

Recommendation

Head 2 should be amended to place a duty of care on the Health Service Executive to facilitate speedy access to appropriate services when a risk to life first presents and should include specific reference to minors, migrant women and women living in poverty. Consistently with Heads 15 and 16, which apply to the making of regulations of certification of opinion and notifications to the Minister respectively, a new head, “Regulations respecting the establishment of referral pathways” should be inserted. This Head should state that the Minister shall make regulations regarding timely and appropriate referral pathways from primary to tertiary care, including self-referral.

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RECOMMENDATION 3: Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

The Heads of Bill do not include sufficient safeguards to ensure that a woman will not experience undue delays in referral for examination by a medical practitioner at an appropriate location.

Recommendation

Head 2 should specify that referral to a medical practitioner at an appropriate location should be made within 2 days. The certifying consultants must examine the woman within 5 working days of such referral; the termination should be carried out within 5 days of a decision that as a matter of probability there is a real and substantial risk to life.

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RECOMMENDATION 4: Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

The language used in the Heads of Bill should reflect the aim of ensuring access to the right to a lawful medical treatment.

Recommendation

Where the phrase “it is not an offence” is used in Head 2, subhead (1) (and also in Head 3, subhead (1), Head 4, subhead (1)), it should be deleted and replaced with “it shall be lawful”.

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RECOMMENDATION 5: Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction

In order to give sufficient clarity to women and their doctors: Head 2 must not only refer to “real and substantial risk to life”, but also include the full X case criteria.

Recommendation

All references to “real and substantial risk” should be qualified by the phrase “as a matter of probability”. Head 2 should be renamed: Risk of Loss of Life from Physical Illness, Not Being Immediate or Imminent, Not Being a Risk of Self Destruction.

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RECOMMENDATION 6: Head 2 - Risk of Loss of Life from Physical Illness, Not Being a Risk of Self Destruction (and Head 4)

The Heads of Bill create an unnecessary additional obstacle to access to appropriate care and could render the legislation impractical and ineffective. The legislation must give the woman a more active role in the decision making process.

Recommendation

Head 2, subhead 3 (a) and Head 4, subhead 2 (a) which require mandatory consultation with a woman’s general practitioner must be deleted and replaced with a provision that a qualified doctor of the pregnant woman’s choosing may, with the pregnant woman’s consent, consult with the doctors who are empowered to certify that a risk to life exists.

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RECOMMENDATION 7: Head 4 - Risk of Loss of Life from Self Destruction

The provisions of Head 4 place unjustifiable obstacles in the path of a woman in a situation where risk to life arises because of threat of suicide.

Recommendation

Head 4 should be amended so that the number of doctors required to certify a risk to life should be the same as in Head 2. Recommendation 5 in relation to the requirement to consult a general practitioner also applies to Head 4.

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RECOMMENDATION 8: Head 6 - Formal Medical Review Procedures

The timeframe specified in Head 6 in relation to formal medical review procedures is too lengthy and could unduly delay a woman's access to a lawful termination.

Recommendation

The legislation should provide that once an application for an appeal is made, a decision should be given within no more than 3 days. The review committee must be required to notify to the woman not only the outcome of the review, but also the reasons for the decision.

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RECOMMENDATION 9: Head 8 - Review in case of risk of loss of life through self-destruction

The review process where risk to life arises because of threat of suicide is more onerous than in the case of physical threat to life.

Recommendation

The number of doctors required to review a refusal to certify a risk to life should be the same whether the risk arises from mental or physical health. The legislation should provide that once an application for an appeal is made, a decision should be given within no more than 3 days. The review committee must be required to notify to the woman not only the outcome of the review, but also the reasons for the decision.

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RECOMMENDATION 10: Head 9 - General Provisions for Committee

The general provisions are insufficiently clear and do not include sufficient safeguards for a woman who makes an application for a review of a decision under Head 2 or Head 4.

Recommendation

The legislation must require that a woman who makes an application for a review of a decision under Head 2 or Head 4 is furnished with copies of any direction under this head and guaranteed access to any "document or thing" sought by the review committee by way of direction.

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RECOMMENDATION 11: Head 12 - Conscientious Objection

Conscientious objection has been used in many countries to frustrate, delay or refuse access to lawful abortion; in the case of life-saving treatment it is especially important that women are not refused care because of the exercise of conscientious objection.

Recommendation

Head 12 must be amended to ensure that doctors who have an objection to abortion must be under a duty of care to ensure that the woman is referred to another doctor who does not have such an objection.

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RECOMMENDATION 12: Head 19 - Offence

The IFPA is of the view that the retention of severe criminal penalties for both women and their doctors is ineffective, disproportionate and inconsistent with the State's obligations under the European Convention on Human Rights, and international human rights law generally. The inclusion of the very heavy maximum penalty of fourteen years will not only maintain, but substantially reinforce, the chilling effect. The Oireachtas Health Committee must take into consideration the impact and appropriateness of criminal sanctions in relation to women and revisit the inclusion of pregnant women among those to whom criminal liability may apply.

The IFPA is of the view that the phrase "destroying unborn human life" is open to interpretations which could have implications beyond the aim of the Heads of Bill.

Recommendation

Delete Head 19 from the Heads of Bill.

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