Statement to the Joint Committee on the Eighth Amendment to the Constitution.

Chairman and Members. On behalf of the Institute of Obstetricians and Gynaecologists, thank-you for the invitation to present today.

My name is Meabh Ni Bhuinneain. I am a practicing consultant obstetrician & gynaecologist in Mayo University Hospital, Castlebar. I am the National Speciality Director for Basic Speciality Training in Obstetrics and Gynaecology in the Institute of Obstetricians and Gynaecologists of the Royal College of Physicians in Ireland. I am Dean for Medical Education at Mayo Medical Academy, Castlebar – a teaching academy of the School of Medicine, NUI Galway.

My clinical and teaching practice encompasses general obstetrics and gynaecology in the rural, non-tertiary setting in Ireland and global maternal/reproductive health and development.

As requested in the invitation to today's proceedings, my comments below refer to the issues that may arise if the recommendations of the Citizens' Assembly on the Eighth Amendment are adopted in part or in whole by Irish society.

My status is as a witness from a professional body whose membership replicates the diverse views of Irish society. The Institute does not have nor should it purport to have a common stance. These comments are my opinions except where otherwise noted, informed by views of members, who wished to contribute and who wished to be clear about the status of the presenters.

The complex and often conflicting elements that inform discussions on termination of pregnancy cannot be disaggregated, although required to be studied as separate entities for the sequential program of work that this committee is undertaking with diligence.

The work of this committee on the matter of the eighth amendment requires consideration of the guiding principles of ethics and human rights balanced by the right to national and individual self-determination.

Global maternal/reproductive health outcomes are one measure of effective civil society and government partnership. In high income settings sub-national adverse outcomes are often concealed if the metrics used are the rare frequency of mortality over the common frequency of physical and psychological morbidity. Globally, restrictive termination of pregnancy legislation contributes to maternal mortality and significant morbidity, disproportionately in vulnerable women and girls as supported by the witnesses from the W.H.O. last week.

While I speak as a health professional today, I wish to re-emphasise the inter-sectoral and social determinants on quality reproductive health outcome as included in the first two ancillary recommendations of the Citizens' Assembly. Outside the scope of today's meeting, the members of the Oireachtas may consider their ability to influence the wider

development of reproductive health care when deliberating over connected symbiotic interventions that are delivered in the sectors of Education, Social Welfare, Youth Development and Finance.

Women and Girls: If the introduction of woman-and-girl centred safe termination services is the desire of the Irish electorate, it should be considered as just one element of a comprehensive reproductive health program. Engagement with woman and girls, men and boys is required to develop formal and informal reproductive health education programs, to strengthen peer-education as a delivery method for life-skills learning, to develop responsive, acceptable, affordable, and locally accessible services while also facilitating bypassing of local services, especially in rural areas, where anonymity and distance from home is preferred. Delays and barriers in access to safe reproductive health services, including termination of pregnancy, are influenced by distance, institutional reception, cost and bypass behaviours.

Health care workers in women's health in Ireland are guided by the legislative framework of the country, the professional standards of the registration authorities, their professional bodies and their personal value systems whether conscious or unconscious.

Obstetricians & gynaecologists in Ireland to date, specialists or trainees, have not been systematically studied to explore their position on the specific items about which the members of the citizen's assembly were balloted. The process to secure professional readiness to respond to possible legislative change has not yet been determined. It is not known if the views of the women's health professionals will reflect the results of the citizens' assembly ballot.

Many clinical providers in women's health in Ireland have trained or completed part of their training in other countries where termination of pregnancy is lawful. Some of those providers would have already explored their personal ethical decision-making pathways. For some, new legislation would involve the unlearning of the restrictive practices provided in Ireland to date. However, for the majority of clinical providers in this country, the possible enactment of lawful termination of pregnancy in Ireland may lead to individual professional moral distress for first time. Training needs also include cultural & diversity competence, unconscious bias awareness and the development of a national framework for ethical decision-making.

Care, support and sensitive leadership within the professions to deliver a new service following ethical decision-making is required. Societal care, support and avoidance of alienation of health care workers during such transformative change is also required.

Health Systems: If in due course there is legislative change, then the new service would be commissioned and provided. Regulatory codes of practice would be revised and the professional bodies would revise their competence standards and training curricula and assessment tools. Quality assurance and suitable designation of centres that provide termination of pregnancy would be required – centres may include certain primary care services, family planning and sexual health clinics, infectious disease clinics, maternity units, and general hospitals with gynaecology departments.

The logistical challenges are those faced in the development of any new health service. The process would involve a multi-dimensional approach to include biomedical health system strengthening, informal health system strengthening, woman and family engagement in addition to the actual service development.

The skill-set for the medical and safe surgical procedures of termination of pregnancy already exists in obstetrics and gynaecology and women's health services in Ireland; some exist in the primary care setting as discussed by the ICGP witnesses on October 12th 2017 and some exist in the early pregnancy care units and the tertiary maternal-fetal medicine units. The training and service expansion needs are in the domains of professionalism, communication and inter-sectoral and inter-professional teamwork.

Conscientious objection would facilitated for all cadres of healthcare staff. This may result in logistical problems in the smaller rural centres and especially as there are already existing rota gaps, a mismatch in the urban-rural distribution of doctors, nurses and midwives and a dependency on agency workers. One third of obstetricians, gynaecologists and midwives in Ireland work in the smaller centres with significant dependence (>50%) on international medical graduates to provide specialist obstetrics and gynaecology services. There is the mixed challenge of providing continuity of services with unstable manpower in some disciplines and an overly stable workforce in other disciplines, where the introduction of change may be less common. Of importance for the smaller centres is agreed tertiary pathways for complex care with agreed automatic acceptance protocols for maternal transfer whether emergency or elective in nature.

Conscientious objection may also compound the problems of recruitment to the relevant disciplines, attrition of trainees and retention of older providers in the specialty during a period of transformative change. We do not yet know the unknowns in this subject.

There has been significant initiation of organisational development in women and infants programming in Ireland at national level in the past decade, sadly in many instances in response to unacceptable adverse outcome. Women's advocacy and advisory contributions, national governance, regulatory standards, guideline development and implementation, hospital groups structure, managed clinical networks, HSE clinical programs, primary care teams, the Framework for Improving Quality in our health service and the National Office of Clinical Audit have contributed to progressive system strengthening in both urban and rural women's healthcare provision.

All these developments provide a degree of organisational preparedness for the introduction of an expanded reproductive health service, if required to do so by the Irish people. However, by international and O.E.C.D. standards, the women's health service continues to be considerably under-resourced, fragmented and in public opinion, as surveyed in the preparation of the first National Maternity Strategy 2016, is not yet considered to be woman-and-family centred or woman-led.

My final comments reflect individual notes from Institute members:
In other jurisdictions, initial restrictive termination law has evolved into more liberal practice. In addition, members have noted that overly proscriptive categorisation of fetal anomaly may prevent the evolution of matching of options with health technology advancement. Therefore, they recommend that the detail is provided for by initial legislation and subsequent regulation rather than by constitutional amendment. Some gynaecologists have expressed potential personal moral distress at the dual challenge of providing extraordinary life-saving interventions for one fetus/infant at borderline viability while also providing fetocide for a potentially normal fetus at the same gestation. Those members who wished to contribute gave general support for the provision of termination for fatal fetal abnormalities. Some members view the current law as excessively restrictive for crisis pregnancy.

Ends.