DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE AGUS LEANAÍ

JOINT COMMITTEE ON HEALTH AND CHILDREN

Dé Máirt, 8 Eanáir 2013

Tuesday, 8 January 2013

The Joint Committee met at 9.30 a.m.

MEMBERS PRESENT:

Deputy Catherine Byrne,	Senator Colm Burke,
Deputy Ciara Conway,	Senator John Crown,
Deputy Regina Doherty,	Senator Imelda Henry,
Deputy Robert Dowds,	Senator Marc MacSharry,
Deputy Peter Fitzpatrick,	Senator Jillian van Turnhout.
Deputy Seamus Healy,	
Deputy Billy Kelleher,	
Deputy Mattie McGrath,	
Deputy Eamonn Maloney,	
Deputy Mary Mitchell O'Connor,	
Deputy Denis Naughten,	
Deputy Caoimhghín Ó Caoláin,	

In attendance: Deputies Ciaran Cannon, Paudie Coffey, Joan Collins, Marcella Corcoran Kennedy, Joe Costello, Michael Creed, Bernard J. Durkan, Damien English, Frank Feighan, Terence Flanagan, Simon Harris, Kevin Humphreys, Finian McGrath, Joe McHugh, Tony McLoughlin, Derek Nolan, Seán Ó Fearghaíl, Aodhán Ó Ríordáin, Patrick O'Donovan, John O'Mahony, Willie Penrose, John Paul Phelan, Shane Ross, Billy Timmins and Peadar Tóibín, and Senators Ivana Bacik, Sean D. Barrett, Paul Bradford, Terry Brennan, Martin Conway, Fidelma Healy Eames, Terry Leyden, Labhrás Ó Murchú, Marie-Louise O'Donnell, Jim Walsh, Mary M. White and Katherine Zappone.

DEPUTY JERRY BUTTIMER IN THE CHAIR.

Implementation of Government Decision Following Expert Group Report into Matters Relating to A, B and C *v.* Ireland

Chairman: I welcome everyone to the meeting. I thank the Cathaoirleach, the Clerk of the Seanad and the Seanad Committee on Procedure and Privileges for facilitating our request to meet in the Seanad Chamber. This is the first in a series of hearings the joint committee will conduct in the next three days to discuss the implementation of the Government decision following the recent publication of the expert group report on matters relating to the case A, B and C *v*. Ireland. On Tuesday, 18 December 2012, the Government decided to accept the expert group's suggestion that the European Court of Human Rights judgment in the A, B and C *v.* Ireland case be addressed by the putting in place of legislation and regulations setting out the current constitutional position, as stated in Article 40.3.3° of the Constitution as interpreted by the Supreme Court.

Members of the committee and I are conscious of the complexity and sensitivity of this issue. For these same reasons, the Government decided that the process of drafting the heads of the Bill and draft regulations in line with its decision would not occur until after the Joint Committee on Health and Children had conducted hearings over three days this week. The Government has stated the aim of its action in this matter is to ensure clarity and legal certainty with regard to the process to be followed in the determination of whether a pregnancy is permissible in cases where there is a real and substantial risk to the life, as opposed to the health, of a woman, as a result of that pregnancy. In doing so we must ensure we take full account of Article 40.3.3° of the Constitution. The Government's decision is confined to the option to be pursued in order to bring regulations and rules to an area which is currently unregulated. As Chairman, it is my intention, with the co-operation of members and witnesses, to facilitate a discussion on current medical guidelines and legal practices with regard to legal and medical expertise, to ascertain the difficulties, if any, legal and medical, encountered by medical experts when making decisions and to provide a forum for the expression of views, recognising the broad range of views in this matter.

When the meetings have concluded, the committee should furnish a report to the Government summarising the oral and verbal contributions it has heard and received from various stakeholders. Over the course of the next three days the committee will hear a wide range of views from legal and medical experts, as well as from churches and advocacy groups, on what issues should be considered when implementing the Government's decision to accept the expert group's suggestions. I hope this will be a positive and constructive discussion giving each witness and committee member the opportunity to express his or her views. I hope we will respect and listen to each other. I intend to ensure the hearings will be conducted in a balanced, fair and calm manner, focusing on the issues which need to be considered in the drafting of the heads of the Bill. While we all recognise that many people have divergent and deeply held views on the issues involved, it is vital that the meetings are held in a manner that is respectful and tolerant.

In drawing up the panel of witnesses and speakers for the hearings members of the committee and Members of the Oireachtas who are not members of the committee suggested names as relevant panellists. These suggestions were considered and invitations were subsequently issued. In the selection of panellists and witnesses to appear before the committee, we have

done our best to ensure a fair and balanced expression of views, which will include contributions from experts, both academic and practising, in the legal and medical fields. In particular, it is of the utmost importance that the Government and Oireachtas are fully aware of the current medical guidelines and practice and how these guidelines have been implemented and operated over recent years.

In order to ensure that all attending and participating in these hearings have a full understanding of the matter at hand, my committee colleagues and I are strongly of the view that we should provide a background and context to the Government decision. For this reason, the hearings this morning will commence with a statement from the Department of Health. This will set out the background to the Government decision, including the judgment of the European Court of Human Rights in December 2010 which led to the establishment of the expert review group by the Minister, Deputy James Reilly, and the subsequent publication of its report. The committee recognises that the Department of Health has not yet developed policy detail on this particular matter. Our hearings this week will no doubt feed into that development and into the drafting of the heads of a Bill and draft regulations.

This morning's session will comprise statements by representatives of the Department of Health and the Medical Council. Later today we will hear from the Masters of the maternity hospitals and from the country's foremost practising academic psychiatrists. The insights provided by the witnesses appearing before us in the course of the week will frame the basis upon which the committee will proceed in its efforts to assist the Government in understanding and assessing the issues at hand. Tomorrow we will hear from legal experts on existing constitutional and legal provisions and there will be discussion on how to frame legislation as per the Government's decision. On Thursday the committee will receive the views of the churches and various advocacy groups on the decision being implemented by Government.

I ask my committee colleagues and other Oireachtas Members attending these discussions to bear in mind that our objective is to elicit as much information as possible from the witnesses appearing before us. I am conscious that these discussions are taking place in the eye of the nation and this is a very complex issue on which people hold strong and divergent view points. In that context, I hope we have a constructive, positive and comprehensive debate in the coming days which will allow us to make a thorough report to Government.

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In accordance with the format agreed at our meeting last night, we will begin with a presentation by the Department of Health, followed by a statement from the Irish Medical Council. After that we will have 80 minutes for discussion, comprising 60 minutes for questions by members and 20 minutes for non-members, with ten minutes at the end for summation. I remind all Members that they should put questions rather than making Second Stage speeches. The 80 minutes set aside for discussion allow time for responses from the delegates.

Deputy Terence Flanagan: I understand that of the large number of submissions made to the committee, not all submitting parties were selected to appear this week to deliver a presentation in person. Will the submissions by parties not attending the meetings this week be posted

on the committee's website?

Chairman: Yes, all the submissions will be posted to the website. Members can also collect hard copies of submissions in the ante-room.

Deputy Terence Flanagan: Has the committee signed off on the witnesses who were selected to come before it this week?

Chairman: Yes. The Chair was given plenary powers in advance of last night's meeting.

Senator Paul Bradford: I thank the Chairman for his inclusive introduction to the meeting. Will he give us some background as to how the various groups were selected to make oral presentations? My understanding is that interested parties, including some who will not appear before us this week, have by now-----

Chairman: I apologise for interrupting, Senator. To clarify, the committee has signed off on the witness list and we are moving on now to take opening statements.

Senator Paul Bradford: Will the Chairman indicate how that decision was arrived at?

Chairman: I cannot do so at this time. The matter has been agreed by the committee.

Senator Jim Walsh: Will the Chairman confirm that copies of the submissions being discussed today are available outside the Chamber?

Chairman: Yes. The other submissions will be made available on the day on which the parties concerned appear before the committee.

Department of Health and Medical Council

Chairman: I welcome Ms Geraldine Luddy from the Department of Health and Ms Caroline Spillane, chief executive officer, and Professor Kieran Murphy, president, of the Medical Council. Before we commence, I remind witnesses that they are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence in regard to a particular matter and they continue to do so, they are thereafter entitled only to a qualified privilege in respect of their evidence. Delegates are directed that only evidence connected with the subject matter of these proceedings is to be given. Witnesses are further asked to respect the parliamentary practice to the effect that where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice that they should not comment on, criticise or make charges against a person or persons outside the House or an official by name in such a way as to make him or her identifiable. I ask Ms Luddy to make her presentation.

Senator Jim Walsh: On a point of order, Ms Luddy's submission is not yet available.

Chairman: That is correct. We have not received it yet. No one has a copy of it. Will Senator Walsh resume his seat?

Senator Jim Walsh: In the interests of being constructive, I suggest that we begin with the submission from the IMO.

Chairman: I am going to begin with Ms Luddy.

Ms Geraldine Luddy: Good morning. I thank the Chairman and members for the invitation to attend these hearings in order to set out the context for the committee's deliberations and provide some background to the Government decision last December on the implementation of the judgment of the European Court of Human Rights in the A, B and C *v*. Ireland case. I am pleased to be here. I look forward to the debate that will take place and to the input of those who have been invited to come before the committee. We are confident that these hearings will assist us in examining the issues involved in the implementation of the judgment to which I refer and in formulating a legislative response that will stand up to public and parliamentary scrutiny.

As members are aware, last December, prior to the Dáil recess, the Government approved the implementation of the judgment of the European Court of Human Rights in the A, B and C *v*. Ireland case by way of legislation and regulation, within the parameters of Article 40.3.3° of the Constitution as interpreted by the Supreme Court in the X case. The Government also agreed to make appropriate amendments to the criminal law in this area, namely, the 1861 Act. This is in line with the recommendations which emerged on foot of a number of previous consultations on this subject in the past. As the expert group pointed out, the issue of how to provide for the X case has been considered by other eminent groups such as, for example, the Constitution Review Group in 1996, those who produced the Green Paper in 1999 and members' colleagues in the all-party Joint Oireachtas Committee on the Constitution in 2000. They all concluded that legislation, in some form, is the most appropriate way in which to regulate access to lawful abortion in Ireland.

Now that this decision has been taken, the Government will in the coming months be examining the procedural options for the operation of a scheme to guide clinical decision-making for doctors who find themselves dealing with pregnant women in very difficult circumstances whereby there is a real and substantial risk to their lives and where a lawful termination is one of the options to be considered. The committee's hearings will be a very important in the context of that process. These procedural options are complex, particularly in light of the technical, medical, legal, ethical and health service organisational implications.

The legislative provisions on termination of pregnancy in Ireland date back to 1861 and for the past 30 years have been fraught with much controversy. Abortion is currently a felony under the Offences Against the Person Act 1861 and a sentence of penal servitude for life can be imposed for the offence. In 1983 the first of Ireland's referendums on this subject was held and during the 1980s several landmark court cases were taken. The referendum to which I refer introduced a new section in Article 40.3 which was to guarantee the right to life of the unborn. This section became Article 40.3.3° of the Irish Constitution - or the eighth amendment thereto - and indicates that, "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."

In the Attorney General *v*. X in 1992, the Supreme Court considered the meaning of the eighth amendment in the circumstances that arose in this case. "X" was a 14 year old girl who became pregnant as a result of an alleged rape. The girl and her parents wished to travel abroad so that she could have an abortion. The issue of having scientific tests carried out on retrieved foetal tissue so as to determine paternity was raised with An Garda Síochána. The Director of Public Prosecutions was consulted and, in turn, informed the Attorney General. An injunction was obtained to restrain the girl from leaving the jurisdiction or from arranging or carrying out a termination of the pregnancy. The High Court granted an interim injunction and the case was

appealed to the Supreme Court. A majority of the Supreme Court rejected the view of the High Court that the risk that the mother would take her life, if not permitted to have an abortion, was of a lesser and different order of magnitude than the otherwise certain death of the unborn. On the other hand, the majority of the members of the Supreme Court held that if it was established as a matter of probability that there was a real and substantial risk to the life, as distinct from the health, of the mother and this real and substantial risk could only be averted by a termination of pregnancy, such a termination was lawful. The Supreme Court accepted the evidence that had been adduced in the High Court that the girl had threatened to commit suicide if compelled to carry her pregnancy to full term and deemed that this threat of suicide constituted a real and substantial risk to the life of the mother. On this basis the High Court injunction was lifted.

The second referendum on abortion in Ireland was held on 25 November 1992. The electorate was asked to vote on three proposed amendments to the Constitution. The 12th amendment, which was designed to exclude the risk of suicide as a ground for lawful abortion, was defeated. However, the right to travel and the right to information were accepted and Article 40.3.3° of the Constitution was further amended to reflect the position.

Following the referendum, the issue of information on abortion was dealt with in legislation. The Regulation of Information (Services Outside the State For Termination of Pregnancies) Act 1995 makes it clear that in general, the provision of abortion information is unlawful in Ireland except in very restricted circumstances, and that has remained the position until now.

As members are aware, in December 2009 the European Court of Human Rights heard a case brought by three women in respect of the alleged breach of their rights under the European Convention on Human Rights in regard to abortion in Ireland. This is known as the A, B and C *v.* Ireland case. All of the applicants were women who unintentionally became pregnant and who travelled to the United Kingdom for abortions. The European Court of Human Rights accepted that Article 40.3.3° of the Irish Constitution, as interpreted by the Supreme Court, provides that it is lawful to terminate a pregnancy 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, of the mother which can only be avoided by a termination of the pregnancy. This has not been altered by that judgment.

The court found that in the case of Ms A and Ms B there was no violation of their rights and it dismissed their applications. It found that there had been a violation of the applicant's right to privacy and family life contrary to Article 8 of the convention in the case of the third applicant, Ms C. The court held that there was no accessible and effective procedure to enable her to establish whether she qualified for a lawful termination of pregnancy in accordance with Irish law. The court ruled that no criteria or procedures have been laid down in Irish law by which that risk is to be measured or determined, leading to uncertainty, and held that further legal clarity was required.

Following on from this judgment, the Government established an expert group in January 2012 to advise on the way this matter could be properly addressed. The group was made up of experts in the fields of obstetrics, psychiatry, general practice, law, regulation and public policy. It met nine times from January to October and submitted its report to the Minister for Health on 13 November.

I know that some of the Members of the Oireachtas present today have made statements in the Dáil or in the Seanad on the report and I hope that they have had time to peruse it carefully over the Christmas break. I will not revisit the report although I would like to say a few words

about one of its chapters, which I believe will be the focus of these hearings.

Chapter 6 illuminates possible avenues for the assessment of the entitlement to lawful termination of pregnancy in Ireland and for the delivery of this medical treatment. It discusses the possible qualifications of the doctors involved in this process, the number of doctors that would be responsible and the locations where the terminations might take place. It also provides a lengthy discussion on a formal framework to review the initial clinical decision, which is one of the main requirements emanating from the judgment.

It is important that I set out the nature of the decision reached by the Government last December. The Government decided that we will have primary legislation which will confer powers on the Minister to make regulations under a new Act. It also agreed that it will consider the matter further when the Department and the Minister have developed proposals based on policy options set out in the report. It is clear, therefore, that much work remains to be done by the Department on the policy requirements to be put into effect by a new legislative framework. This committee's deliberation will be welcome in the context of the work to be carried out. The Department will engage further with the Oireachtas when heads of a Bill have been developed.

I look forward to hearing the members' deliberations on this matter and to the assistance they will provide in the Department's policy work in this area.

Chairman: I thank Ms Luddy. I welcome Professor Kieran Murphy and Ms Caroline Spillane from the Medical Council. I invite Professor Murphy to make his presentation.

Professor Kieran Murphy: On behalf of the Medical Council, I welcome the opportunity to provide the Joint Committee on Health and Children with views that will be of assistance to it in formulating its report to the Government on issues that need to be addressed in the heads of a Bill and draft regulations.

I will say a few brief words about the role of the Medical Council. This is very relevant in the context of a discussion about the recent Government decision and the publication of the expert group report. The Medical Council is the statutory body responsible for the regulation of doctors in Ireland. Its purpose is to protect the public by promoting and ensuring the highest standards among doctors. From the day a student first enters medical school until the day he or she retires from practice, the Medical Council works to ensure medical education and training remains up to date and is benchmarked to the highest international standards. The Medical Council sets standards for all undergraduate education and postgraduate training of doctors and also requires that all doctors fulfil ongoing professional competence requirements to ensure they keep their knowledge and skills up to date throughout their professional lives.

In the interests of patient safety and the protection of the public, the council has been vested by the Oireachtas with sole responsibility to ensure that only those doctors with the necessary education, training and skills are registered to practise in Ireland. The council also specifies standards of practice for doctors in the areas of professional conduct and ethics.

I hope members have been furnished with copies of the Medical Council guidelines for their information. The Medical Council provides guidance to doctors on matters relating to conduct and ethics through its *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*, the seventh edition of which was published in 2009. It was developed following extensive consultation with doctors, the public, medical schools, postgraduate medical training bodies, Departments, employers and a range of other stakeholders.

In order to ensure the guide is as relevant as possible, taking on board the views of all those consulted, the council established an ethics working group to oversee the development of the guide. This multi-stakeholder working group, which included council members and non-members, including a number of medical and non-medical experts, was established to ensure that the guidance was both evidence based and developed in line with best practice.

The guide is a principle-based document which must be relevant to each of the 18,000 doctors registered to practise in Ireland, regardless of their discipline. It covers issues as diverse as consent, confidentiality, end-of-life care, advertising, clinical trials, prescribing practices and referral of patients. The council's guidance provides the principles which are the cornerstone of each doctor's practice. It has been designed to support doctors in decision making regarding conduct and ethics and to complement other external sources of clinical guidance, procedures and protocols devised by expert bodies and employers.

Paragraph 21 of the guide relates to abortion. Paragraph 21.1 states:

> Abortion is illegal in Ireland except where there is a real and substantial risk to the life (as distinct from the health) of the mother. Under current legal precedent, this exception includes where there is a clear and substantial risk to the life of the mother arising from a threat of suicide. You should undertake a full assessment of any such risk in light of the clinical research on this issue.

Paragraph 21.2 states:

> It is lawful to provide information in Ireland about abortions abroad, subject to strict conditions. It is not lawful to encourage or advocate an abortion in individual cases.

Paragraph 21.3 states "You have a duty to provide care, support and follow-up services for women who have an abortion abroad", while paragraph 21.4 states:

> In current obstetrical practice, rare complications can arise where therapeutic intervention (including termination of a pregnancy) is required at a stage when, due to extreme immaturity of the baby, there may be little or no hope of the baby surviving. In these exceptional circumstances, it may be necessary to intervene to terminate the pregnancy to protect the life of the mother, while making every effort to preserve the life of the baby.

All doctors are expected to adhere to the council's guide. However, it is important to note that Medical Council guidelines are not a legal code. In drafting its ethical guidance, the council seeks to incorporate and reference relevant legislation to ensure doctors are aware of the legal framework within which they operate.

I will now turn to the views of the council on the implementation of the recent Government decision. The Medical Council, having examined the report of the expert group, considered it appropriate to provide the Joint Committee on Health and Children with views regarding certain matters set out in chapters 6 and 7 of that report. The views of the council are set out in pages 3 to 6 of this submission. To assist the reader, the council deals with each question sequentially using the same reference numbering as appears in the report of the expert group. I refer to chapter 6 of the report of the expert group, on procedures for determining entitlement and access to termination of pregnancy. Paragraph 6.2 pertains to the test to be applied. In regard to the question of the test to be applied, the view of the Medical Council is that legislation or regulations or both should include a requirement that the treating doctors' opinions and rationale for decision-making must be documented, the diagnosis should be evidence-based and

made expeditiously or within a defined time limit and the diagnosis should be notified formally by the treating doctors to the woman. Paragraph 6.3 pertains to the qualifications of doctors involved in the process. In regard to the question of the qualifications of doctors, the view of the Medical Council is that clinical decision-makers must be registered in the specialist division of the register of medical practitioners. Moreover, registration in the specialist division requires that a doctor has undertaken medical education and training benchmarked to the highest international standards. For the patient, it provides assurance that the doctor possesses the necessary knowledge and skills to engage in clinical practice at the appropriate level to be able to make appropriate clinical decisions.

Paragraph 6.4 relates to the number and role of doctors. In regard to the question of the number and role of doctors, the view of the Medical Council is that legislation or regulations or both should set out criteria for the number and role of doctors to be involved. The council will engage actively with the Department of Health in the development of regulations in collaboration with other stakeholders. In addition, the legislation or regulations or both should include a requirement that doctors involved have sufficient knowledge and skills to facilitate appropriate clinical decision-making. Paragraph 6.5 pertains to emergencies. In regard to the question of emergencies, the view of the Medical Council is that special procedures do not need to be developed for emergency situations. Paragraph 6.6 relates to locations. On the question of locations, the view of the Medical Council is that the location of medical facilities is a matter for the Minister for Health to determine using criteria set out under licensing legislation.

Paragraph 6.7 concerns the formal review process. In regard to the question of the formal review process, review process requirements and attributes, section 6.7.3 of the report, composition of the review panel, section 6.7.4, and convenor, section 6.7.5, the view of the Medical Council is:

1. Legislation and/or regulations should set out a formal framework to provide the woman with a review mechanism which is: a. independent, b. accessible, c. transparent, d. competent, and e. timely.

2. The review panel should include doctors with sufficient knowledge and skills to facilitate appropriate clinical decision-making.

3. The review panel should have access to legal expertise on a formal basis.

Paragraph 6.8 deals with access to the courts. In regard to the question of access to the courts, the view of the Medical Council is that following a negative decision of the review panel, the woman has a constitutional right of access to the courts.

Paragraph 6.9 deals with conscientious objection. In regard to the question of conscientious objection, the view of the Medical Council is:

1. that legislation and/or regulations should set out clear criteria for enabling the exercise of an individual's right to conscientious objection. The Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* states in paragraph 10.1 that "As a doctor, you must not allow your personal moral standards to influence your treatment of patients". Paragraph 10.2 states that "If you have a conscientious objection to a course of action, you should explain this to the patient and make the names of other doctors available to them".

2. The right to conscientious objection must be balanced against the right of the pa-

tient - particularly in the case of a medical emergency. The Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* states in paragraph 10.3 that "Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances".

Paragraph 6.10 concerns monitoring. In regard to the question of a monitoring system, the view of the Medical Council is:

1. Legislation and/or regulations should set out criteria for independent monitoring cf the proposed structures.

2. Independently verified, anonymised data should be published on relevant matters - for example, numbers of women who seek terminations, numbers of women who receive terminations, medical reasons that gave rise to the treatment for clinical purposes.

Chapter 7 of the Report of the Expert Group deals with options for implementation, and paragraphs 7.2 to 7.4.3 implement the judgment in A, B and C *v.* Ireland of the European Court of Human Rights.

1. In regard to the question of options on how to implement the judgment in A, B and C *v.* Ireland of the European Court of Human Rights, the council's view is that it is in the public interest that doctors have legal clarity when making clinical decisions. Insofar as legislation, underpinned by regulations, will provide that clarification to doctors, the council supports its introduction. Paragraph 7.4.4 deals with new legislation or amendment of the 1861 Act.

2. The council is of the view that sections 58 and 59 of the 1861 Act should be repealed.

We are grateful for the opportunity to engage with the joint committee on this important issue and are willing to actively engage with the Department of Health if our input can support their processes for the development of legislation and regulations.

Chairman: We will now proceed to questions and answers beginning with members of the committee. I call Deputy Billy Kelleher.

Deputy Billy Kelleher: I welcome the witnesses. I will speak briefly, Chairman, because we want to accommodate as many members as possible. I would like to ask Professor Murphy whether a complaint about a doctor has ever been made to the Irish Medical Council by a colleague or another individual because he or she has refused to carry out a termination on foot of the X case, Article 40.3.3° or the Irish Medical Council's guidelines. I suppose my key question relates to whether a termination has ever been carried out in this country under these guidelines. Has a complaint ever been made to the Irish Medical Council about a doctor who has refused to carry out a termination under these guidelines?

On the broader issue, I would like to ask Professor Murphy about the view of the Irish Medical Council with regard to prescriptive legislation. Would the council be concerned that it could be overly prescriptive? In other words, is there a concern that the detail of the legislation could make it so prescriptive that it will be very difficult for a practising clinician to carry out his or her duties without having a barrister or lawyer tied to his or her hip? Such a view was expressed to us by some medical professionals in committee and privately. I have asked the two questions I have on that particular issue.

I would like to know whether difficulties existed prior to the A, B and C *v.* Ireland case. Had the Irish Medical Council and its members encountered difficulties with clinical decisions being arrived at? We do not yet have legal clarity or legal certainty. We must be reminded that legislation will be passed not by the Government but by the Houses of the Oireachtas. How has the Irish Medical Council been dealing with these issues in the absence of the clarity that is being sought by people now?

Chairman: In order to facilitate the recording of these proceedings, I ask members to stand when they are addressing the committee.

Deputy Caoimhghín Ó Caoláin: I join others in welcoming Professor Murphy and Ms Spillane from the Irish Medical Council. I note that section 21.1 of the council's guidelines for registered medical practitioners states:

> Abortion is illegal in Ireland except where there is a real and substantial risk to the life (as distinct from the health) of the mother. Under current legal precedent, this exception includes where there is a clear and substantial risk to the life of the mother arising from a threat of suicide. You should undertake a full assessment of any such risk in light of the clinical research on this issue.

That is the current situation as set out in the guidelines issued to the 18,000 registered members of the council. During Professor Murphy's contribution, he made the point that "clinical decision-makers must be registered in the specialist division of the register of medical practitioners". I presume that in many of the circumstances that present themselves, we are talking about obstetricians and gynaecologists. That must be one of the specialist divisions. Perhaps Professor Murphy can offer some clarification in that regard. I presume that psychiatry - Professor Murphy is a psychiatrist - is a specialist division within the register. Can he expand on that for us? A question arises immediately in that regard. Is the number of registered practitioners adequate? Are they present and available in all maternity settings in this jurisdiction 24 hours a day, seven days a week? It is critically important for us to be certain that sufficient qualified staff are available to carry out the various clinical decision-making responsibilities.

Deputy Mattie McGrath: I want to welcome the expert witnesses who are present this morning. I thank them for outlining their positions for us. Did the Department of Health issue any instructions or guidance, in any form whatsoever, to the expert group beyond its terms of reference?

Chairman: That is not relevant to the Irish Medical Council.

Deputy Mattie McGrath: The Department of Health is also represented here.

Chairman: The Deputy was present at last night's meeting, at which we agreed how we would structure today's meeting.

Deputy Mattie McGrath: It is not relevant to the Department of Health.

Chairman: No.

Deputy Mattie McGrath: We have received a submission from the Department of Health.

Chairman: As a member of the committee, the Deputy agreed at last night's meeting that we would allow the Department to make an opening statement outlining the parameters of where we are today, before coming back at a later stage following the publication of the heads

of the proposed Bill. We will come back at a further stage following the publication of the heads of the Bill.

Deputy Mattie McGrath: Are we not allowed to ask any questions?

Chairman: Not today. That was agreed to at our meeting last night which the Deputy attended.

Deputy Mattie McGrath: Of course I attended it; I am a member.

Chairman: The Deputy agreed with the decision made. The committee was unanimous on the matter.

Deputy Mattie McGrath: When will we get the opportunity to ask a question?

Chairman: I ask the Deputy to direct his questions to the Medical Council.

Deputy Mattie McGrath: I will desist for the moment.

Deputy Ciara Conway: I welcome the members of the Medical Council. As most of my questions have been asked, I will only ask one more.

Reference was made to conscientious objection in the context of the medical guidelines. I ask Professor Murphy to elaborate by providing real life examples to show how a conscientious objection might become manifest in day-to-day practice among members of the Medical Council.

Professor Kieran Murphy: The council is represented by me as its president and Ms Caroline Spillane as its CEO. We will share our responses to questions, if members so agree.

Chairman: I welcome Ms Spillane.

Professor Kieran Murphy: I will address some of the questions raised and Ms Spillane will follow on from me.

Deputy Kelleher asked whether the Medical Council had ever received a complaint about a termination of pregnancy. To the best of my knowledge, we have not received a complaint under this section of the guide. The guide is a high level and principle based document which covers a range of scenarios, including consent, capacity and abortion. We categorise complaints under a variety of sections. Ms Spillane will elaborate further on this issue.

Deputy Kelleher also asked whether the Medical Council was concerned that the legislation would be unduly prescriptive. It is clearly a matter for the Oireachtas to pass legislation. The purpose of the meeting is to allow members to inform themselves about the concerns and views of the various stakeholders in this debate which include the Medical Council but also the professionals, the advocacy groups and the legal groups. Only by listening to the views expressed by a range of stakeholders will the committee be enabled to formulate legislation that will protect the public, which is the Medical Council's primary responsibility. Like all aspects of our work, our submission is guided by the desire to ensure the public is protected in whatever happens in this debate. If the Oireachtas decides to pass legislation underpinned by regulations, the protection of the public should be paramount.

Deputy Kelleher also referred to different clinical situations. I suggest this question might be better raised with the obstetricians and psychiatrists who will be appearing before the com-

mittee later today.

Deputy Ó Caoláin asked about our guidelines. He has quoted the first section of the guidance on abortion. It is important to understand, as we mentioned in our submission, that the guidelines the council published are not a legal code. They are guidelines to assist doctors in their practice. It is also important to remember that all doctors work within an environment in which there are many different guidelines. For example, doctors work within areas where they are supported by practice guidelines - their training bodies will publish guidelines in the management of specific scenarios. It is important that members understand that Irish Medical Council guidelines are a further set of guidelines in a framework which comprises many different guidelines, which are all underpinned by and must be consistent with the law because first and foremost we are all bound by the law of the land. Consequently, any guidance offered by any other body, such as the Irish Medical Council, must be consistent with what is the current legislation.

Deputy Conway asked for a number of examples to illustrate conscientious objection. With respect, I suggest this question would be more appropriately asked of the psychiatrists and obstetricians who will be presenting later today because the views of psychiatry and obstetrics will inform her knowledge with regard to the scenarios these individuals will face with regard to this issue. I will now pass over to Ms Spillane who may wish to expand further on some of those replies.

Ms Caroline Spillane: Deputy Kelleher asked about the Irish Medical Council's complaints process. Our system for categorising complaints outlines the number of complaints the Irish Medical Council would receive in any 12-month period. For 2012 we received approximately 420 complaints. These are categorised into very broad areas, such as treatment or professional standards. Of course, many complaints concern a number of related issues and, as such, are not categorised in the narrow way suggested here. To the best of my knowledge and in agreement with the president, we have not received any complaints regarding this section of the guide to professional conduct and ethics. Hypothetically, if the council were to receive a complaint, the council has quite a sophisticated complaint management process that is defined through the Medical Practitioners Act, which would, in the first instance, necessitate the investigation of the complaint by the preliminary proceedings committee. If that committee felt there was a *prime facie* case, an inquiry may be held into that complaint.

Deputy Ó Caoláin asked about registration. Some 18,000 doctors are registered with the Irish Medical Council and they are registered in five different divisions of the medical register as follows: the supervised division; the trainee-specialist division; the general division; the specialist division - I will go on to talk about that; and a sub-division, which is the intern division of the trainee-specialist division. Of the 18,000 doctors registered, a minority would be in the specialist division. However, there are approximately 3,000 to 4,000 doctors who are currently registered with us in this division. It is difficult to be precise on numbers because the register is quite dynamic and changes literally on a day-to-day basis. We have conducted some surveys among registrants. For example, we know that most of the registrants who are registered with the Irish Medical Council practise full-time rather than in a part-time capacity. Within the specialist division, we have a sub-categorisation for some of the specialist areas that Deputy Ó Caoláin has mentioned. All of this information is available in the Medical Council's annual report and is also available on the Medical Council's website. Any member of the public can, of course, search the Medical Council's website for information and details about their doctor, and there is a facility on the website to search for a registrant. Approximately 250,000 people

used that facility in 2012, so we find it is a very valuable resource for members of the public and those in health professions who wish to understand the qualifications of the doctors operating in the health system.

The president has outlined in the submission made by the Medical Council that to be on the specialist division of the medical register requires that a doctor's education and training is benchmarked to the highest international standards, so the Medical Council can stand over the qualifications, education, training and competence of doctors who are on the specialist division of the medical register.

Senator Colm Burke: I thank Professor Murphy and Ms Spillane for the very comprehensive and concise submission. With regard to the issue of the expert group giving a number of different options for dealing with the issue of suicide, including an assessment by two psychiatrists and an obstetrician, given their experience in the Medical Council, what is the witnesses' view of the three options proposed and what is the most workable option, if that issue has been discussed?

A second issue arises. We will get a submission later today which sets out that the three Dublin hospitals have perinatal psychiatry specialists and they are the only three of the 19 maternity units in the country that have that specialist category. What is the witnesses' view, in a situation where there is a threat of suicide, as to whether the regulation should recommend that the patient would come under the remit of the specialists dealing with this issue in arriving at a decision?

Deputy Regina Doherty: I thank the witnesses for attending. With regard to the threat of suicide, how many terminations due to the threat of suicide have actually been carried out in Ireland since the X case judgment? The witnesses spoke earlier in regard to the need for a termination where the threat to the life of the woman could only be averted by a termination. When they talk about the risk assessment, can they describe the procedures that would lead up to the decision being made that it was the only course of action that could take place to save a woman's life? I would be grateful for that.

Deputy Denis Naughten: Some of the questions I wanted to ask have been put so I will not repeat them. I have two questions for the Medical Council. First, the guide of professional conduct and ethics that is currently in place is the seventh edition. Prior to the current edition and subsequent to the X case decision in 2002, were similar guidelines in place and have they been replicated in the seventh edition or have they changed, based on medical practice over that period? The witnesses might clarify that point.

The second question concerns the point made by the witnesses in their submission that they do not believe specific provision should be made for emergencies. Will they elaborate as to why this specific provision for emergencies should not be made? To relate back to a fundamental point raised by Deputy Ó Caoláin - I compliment Ms Spillane on her response as she did very well in avoiding the question - the question is whether we have enough obstetricians in the country, both in terms of numbers and geographic spread, to ensure whatever provision is made in legislation can be implemented on the ground in the 19 maternity hospitals we currently have. Following on from Deputy Ó Caoláin's question, is the council confident that sufficient specialist expertise would be available in each of the current 19 facilities in an emergency to make a determination on an individual case of the risks to an expectant mother?

Professor Kieran Murphy: I will deal with Senator Burke's questions first. Senator Burke

asked if the council had a view on the roles and number of doctors who should be involved in a decision. I refer members of the committee to our submission at paragraph 6.4 of page 4 where it is set out that, in regard to the number and role doctors, the view of the Irish Medical Council is that legislation and-or regulation should set out criteria in that regard. It further sets out that the council will actively engage with the Department on the development of regulations in collaboration with other stakeholders and submits that legislation and-or regulations should include a requirement that relevant doctors have sufficient knowledge and skills to facilitate appropriate clinical decision making. The primary role of the council is to protect the public, which is done by ensuring doctors have the necessary knowledge and skills to practice safely. As Ms Spillane outlined, our specialist division is one we see as providing a hallmark of quality. A doctor registered in the specialist division has a standard of training which is benchmarked with the best in the world. It is the council's view that a doctor who makes these decisions should be in a specialist division of the register. It assures the public that decisions are being made by the most appropriately qualified individuals. Senator Burke asked about the number of perinatal psychiatrists, from three of whom the committee will hear later a joint submission. It is a matter for the HSE and employers to determine whether there is sufficient capacity in the health service to meet needs. I am sure the committee will ask the perinatal psychiatrists whether they feel that capacity is sufficient.

I was asked in the context of suicide how many terminations had been carried out since the X case. The council does not have this information. It is important for the committee to be aware that the council is made aware of situations only where a complaint is made. Approximately 420 complaints were received by the council last year. If the council receives a complaint on any matter, well established robust procedures are followed to ensure it is thoroughly investigated. A committee of the council has a significant range of powers to permit it to adequately investigate any complaint and each one is taken seriously. A decision is made on the basis of that committee's deliberations as to how a complaint should be addressed. In certain circumstances, a complaint proceeds to an inquiry. Members of the joint committee will have seen that since the advent of the Medical Practitioners Act inquiries are held in public. While inquiries have been always held, they were conducted in private in the past. Following the commencement of the legislation in 2008, an inquiry is held in public unless there is a particular sensitive reason it should be held in private.

I was asked if there were similar guidelines in place prior to the X case. It is important to understand that each medical council has a five-year term and publishes its own guidance, which usually constitutes a refinement of the existing guidance. Each council publishes its own guidance. It is usually a refinement of the existing guidance so the council would see each edition of the ethical guide as a further refining of guidance that the council offers. It is important for Members to be aware that because medicine is constantly changing we need to ensure that the guidance that we provide to doctors takes note of the fact that medicine is continually evolving. The reason that the council publishes editions of guidance is to reflect this fact. We of course had guidelines which pre-existed the X case but the current guidelines that the Medical Council has produced, which Members can see in paragraph 21 of our submission, reflect the current legal framework.

Ms Caroline Spillane: In response to the question about the number of specialists available, the role of the Medical Council is to ensure that doctors on the specialist division of the register have the necessary knowledge and skills to be able to operate at that very high level. We benchmark this to the best international standards. It is the concern of the council to ensure in the public interest that doctors on the specialist division of the register have the necessary

knowledge, skills and competence to operate at that level. If a doctor has the necessary qualifications to enter the specialist division the Medical Council will register that doctor. There is also a role for the employer to ensure that there is an adequate number of doctors in whatever speciality and for the various training bodies to ensure that their training programmes take into consideration future needs for specialists in various areas. The Medical Council has a role in accreditation of post-graduate training and the council ensures that the future needs of the health service are adequately addressed through the number of doctors being trained in various specialties.

Deputy Denis Naughten: Why does the Medical Council not believe that there should be specific provision for emergencies? Could the witnesses please elaborate on that point that Deputy Ó Caoláin asked earlier?

I asked whether the guideline has changed. The sixth edition would have been published after the X case. Has the definition in the guideline changed between the sixth and seventh editions? I am not sure whether the fifth edition was published before or after the X case but it would have been impossible for the council to predict the X case so I want to know whether the guideline has changed since then.

Professor Kieran Murphy: In answer to the question about emergencies, in our submission, paragraph 6.5 we say: "In regard to the question of emergencies, the view of the Medical Council is: 1. Special procedures do not need to be developed for emergency situations." I am not sure that we need to expand on that. The council position is that we do not believe that it is necessary for special procedures to be-----

Chairman: For the benefit of Members will Professor Murphy please outline why that is the case?

Professor Kieran Murphy: We feel that the principles underlying a decision are similar whether the situation is an emergency or not. We believe that the same procedures should apply in all situations.

With regard to the second question about the guidance, it is important for members to understand that the ethical guide is a dynamic document. It is continually being refined. Since the publication of the ethical guide in 2009, the seventh edition, the council issued further guidance earlier last year on the interaction between doctors and industry which many Members will have seen. As medicine constantly evolves the guidance that the Medical Council offers doctors changes. With regard to the specific point on abortion, as I mentioned earlier, all doctors work within the law of the land. The Supreme Court judgment changed the law of the land and the guidance the Medical Council offers to doctors, to which they are required to adhere, reflects the current legal position.

Deputy Robert Dowds: I thank the witnesses for addressing the meeting. In Professor Murphy's submission he stated sections 58 and 59 of the 1861 Act should be repealed. Will he please clarify what these sections state? My other questions relate to situations in which termination of pregnancy would be necessary to save the life of a woman. To what extent are doctors in a legal quandary at present because of the lack of clarity in legislation? Where it is in the interest of a woman's health that a pregnancy is terminated, am I right to think that medical professionals cannot take any action?

Deputy Seamus Healy: I thank the Medical Council representatives for coming before the

committee. With respect, we must ask the invitees again about emergencies and locations as I do not think they have adequately responded to the questions from members on these. On page 4 of the submission in paragraphs 6.5 and 6.6, the Medical Council has put forward a particular point of view. Its response in respect of emergencies is not adequate and it has not responded with regard to location. In its submission it states the location of medical facilities is a matter for the Minister for Health to determine under criteria set out under licensing regulations. This is not good enough. We need to know specifically from the Medical Council its view on locations, and what we have seen is not adequate. Will the Medical Council expand on and clarify these areas in particular? If time is available I also ask the witnesses to clarify and expand on the question of conscientious objection.

Deputy Catherine Byrne: I thank Ms Luddy and Professor Murphy for coming before the committee this morning. I also have a question on emergencies, but as it has already been asked, I will not go back over it. In his submission, Professor Murphy stated paragraph 21 of the Medical Council's guide relates to abortion. With regard to paragraph 21.4 of the guide, will the witnesses expand on the meaning of the phrase "extreme immaturity of the baby"? How is this explained?

Deputy Peter Fitzpatrick: My question is directed to Professor Kieran Murphy. With regard to procedures to determine the entitlement and access to termination of pregnancy, the same questions have been asked repeatedly. Will Professor Murphy elaborate on the suggestion that the opinions and decisions of treating doctors should be documented? He also stated diagnosis should be evidence-based within a defined time limit. Questions on these have been asked day after day and I ask him to define them. He also stated the diagnosis should be notified by the treating doctor to the woman. People think this automatically happens. It is explained to a certain extent in the documentation but I ask Professor Murphy to elaborate.

Senator John Crown: I thank my colleagues from the Medical Council for coming before the committee. First, will Professor Murphy provide a "Yes" or "No" to the question of whether he believes that the current situation, in which our practices are guided by the Constitution as determined by the will of the people in referenda and by the courts as opposed to through legislation, provides an adequate framework for doctors to practice. Is there a problem that needs to be fixed and-----

Deputy Mary Mitchell O'Connor: Could the Senator speak into the microphone, please?

Senator John Crown: If the Chairman does not mind, I will sit down. Obviously, the microphones were designed for shorter parliamentarians.

Chairman: The Senator should not be long-winded.

Senator John Crown: Indeed. Is the current situation adequately regulated? Is there a clear and present need for legislation? The argument that we do not need legislation has been advanced.

My second point is more contentious and I will understand if Professor Murphy's answer is somewhat nuanced. Over the years, those of us in our profession who have watched Medical Council elections have been aware of rumours of serious attempts at entryism by people wishing to advance particular agendas in terms of medical ethics. In light of the issues that have arisen in respect of emergencies and the number of doctors, was the decision not to make a specific determination a unanimous or a consensual position? Does the lack of a recommendation on

emergencies and the number of doctors reflect the council's belief that such a recommendation was unnecessary or the fact that the council could not reach agreement on the matter? Looking at it from the outside, one would suspect that the latter may have been the case.

I have a technical question on behalf of those of us who find ourselves in this situation. My understanding of the interpretation of the 1992 referendum allowing freedom of information is somewhat different from that being outlined today. If I answer "Yes" when someone asks me whether her health will be enhanced if she has her pregnancy terminated, will I be in breach of Medical Council guidelines?

Professor Kieran Murphy: Quite a number of questions have been asked. I will deal with Deputy Dowds's first. He sought clarification on sections 58 and 59 of the 1861 Act. I do not have that information off pat, but I will cite the sections. Section 58 reads:

> Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable to be kept in penal servitude for life.

Section 59 reads:

> Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanor.

I hope this answers the Deputy's question on sections 58 and 59.

As to the question on the health of the woman, the council was asked to comment on the expert group's report, which was clearly concerned with options for the Government in implementing the judgment of the European Court of Human Rights, which related to the life of the woman rather than the health. Consequently, the council has not taken a view on the health of the woman.

I regret Deputy Healy's opinion that we have not answered adequately in terms of emergencies and locations. I will restate the council's position. As outlined in paragraph 6.5 of our submission, we believe that special procedures "do not need to be developed for emergency situations". The principles that apply to clinical decision making should apply irrespective of whether a case is an emergency.

Similarly, with regard to paragraph 6.6 - locations, the council believes that the location of medical facilities is not a matter for the council. Rather, it is a matter for the Minister for Health to determine using criteria set out under licensing legislation.

Deputy Catherine Byrne asked about paragraph 21.4 of the guide, which deals with extreme immaturity. The council statement in regard to "extreme immaturity of the baby" is clear. It refers to where there is little chance that a baby will survive. Obviously, where a baby is delivered over 28 weeks, the likelihood of it surviving is high. However, if delivered at less than 20 weeks, this is inconsistent with survival. I suggest that this is an issue that should be teased out more with obstetricians when they make their submissions later this morning.

With regard to Deputy Fitzpatrick's question in relation to "evidence based", the Deputy will note the final sentence of paragraph 21.1 which states that the medical council provides in its guidance that a full assessment of any risk in the light of the clinical research on an issue should be taken. This reflects the fact that, as I mentioned earlier, medicine is continuously evolving and doctors are encouraged to utilise new research to inform their decision making. Members of the Oireachtas will be aware that there is now a legal requirement on all doctors to maintain their professional competence. This is done by their ensuring they remain up to date in their practice. The purpose of this is to ensure that the public is protected because their doctors are up to date and have informed themselves about new research in their particular area.

On the issue raised by Deputy Crown in regard to clarity for doctors, I believe this issue should also be teased out with the obstetricians and psychiatrists when they make their presentations to the committee later this morning. The council's view is that it is in the public interest that doctors have legal clarity when making clinical decisions. In so far as legislation underpinned by regulation will provide this clarification to doctors, the council supports its introduction. It is important that members are aware that the guidelines issued by the council are not a legal code. They follow on from legislation and reflect the current legal framework.

Ms Caroline Spillane: I take this opportunity to reiterate how the council developed the guide. This is probably the most important document that the council will produce in its lifetime. The guide was produced by the Essex working group, which comprised council and non-council members and was chaired by a non-medical member of the council. The Essex working group took an evidence-based approach to the development of the guide. Its development was underpinned by widespread consultation. The group would have consulted patients, members of the public, patient safety representatives, medical schools, postgraduate training bodies, doctors and doctor representative bodies. Everybody was involved in the consultation process. This council has prided itself on the fact that it consults very widely on key pieces of guidance and documentation for doctors. The Essex working group has as its reference the law of this jurisdiction, but its work is very much in line with the approach that would be taken by other medical regulatory bodies internationally.

Senator John Crown: My questions have not been addressed. I specifically asked Professor Kieran Murphy if he believed the situation at present provides clarity or does it need to be addressed. Second, Professor Murphy said that the council exists to protect the public. It does, and in the interests of public protection he must answer my second question, which I believe he skipped. Did the council deliver any watered down set of recommendations, specifically on the issue of emergencies and on the number of doctors, because consensus could not be reached within the council on these issues, or did the council believe that such recommendations were not necessary and that the public interest would not be served by the Medical Council expressing an opinion on them?

Deputy Billy Kelleher: With regard to conscientious objection in the event of legislation being passed, terminations being provided and clarity being brought to bear, should that be made public? In other words, if a person has a conscientious objection to carrying out a termination, when would there be an obligation on the clinician to inform peers or the administration of that location? Would it be at the start of his or her contract or in the event of an individual procedure being required? Should there be such an obligation and should it also be published that these people have a conscientious objection to a particular procedure for the termination of pregnancy?

Professor Kieran Murphy: I regret that Senator Crown feels that my previous answer was

less than expansive. Clearly, the Government has decided to introduce legislation, underpinned by regulations. In so far as the introduction of legislation and regulations provides clarity for doctors to ensure that they can best protect patients, the council clearly welcomes that approach.

On the Senator's second question about consensus or otherwise, the council speaks with a collective voice. The council comprises 25 members. There is a lay majority of members of the council. Members of the committee might not be aware of this but our council is the only regulatory authority in the world that has a lay majority. Of the 25 members of the council, 12 are medical members and 13 are lay members, so there is a lay majority. As with every group in society, each group attracts the variety of opinion that is consistent with our society. Like in this committee, the Medical Council comprises many different views. Nevertheless, the council has agreed on a consensus view, which is the submission it has made to the committee today.

On Deputy Kelleher's question about conscientious objection, I refer him to our current guidance on the issue in paragraph 6.9. Our current guidance, at 10.1, is that as a doctor one must not allow one's personal moral standards to influence one's treatment of patients. Paragraph 10.2 states that if one has a conscientious objection to a course of action, one should explain this to the patient and make the names of other doctors available to the patient. Paragraph 10.3 states that conscientious objection does not absolve one from responsibility to a patient in emergency situations.

We heard Ms Luddy acknowledge earlier this morning that a great deal of work must be done on policy before work is done on refining regulations. The council is very keen to engage actively with the Department to ensure that these issues are teased out and refined in the regulations that are produced.

Chairman: I call on Deputy Mitchell O'Connor and Deputy Ó Caoláin.

Deputy Mary Mitchell O'Connor: I refer the witness to 6.2 on page 3. It states that in regard to the question of the test to be applied, the view of the Medical Council is that the diagnosis should be evidence based and made expeditiously or within a defined time limit. Can I ask what evidence-based diagnosis is being talked about in that paragraph? Deputy Regina Doherty asked in a different way about the sort of risk assessment or what happens when a doctor is going to make a decision.

Deputy Caoimhghín Ó Caoláin: Accepting that all cases are unique, the formal review process recommendations set out in paragraph 6.7 of the submission this morning include independence, accessibility, transparency, competency and timeliness. I would like to ask Professor Murphy about the issue of timeliness. How long is reasonable for the establishment of a formal review process and the issuance of its decision? Given that no distinction has been drawn between an emergency and all of the other situations, how does one understand emergency? Is this understood to be an immediate situation? There is a distinction drawn between emergency and other situations in section 6.9.2 when conscientious objection is mentioned. A distinction is drawn at that point. Could we have an understanding of timeframes for all of these?

Professor Kieran Murphy: To deal firstly with Deputy Mitchell O'Connor and the question that she raised about to what is evidence based, it is important for committee members to understand that, increasingly, the practise of medicine is evidence based. What does that mean? It means that to make a decision, a doctor must weigh up the available evidence. He or she must ensure the treatment option he or she is providing for his or her patient is based on the best available evidence. Consistent with that council approach in its guidance to doctors, all

decisions should be made using an appropriate evidence base. That means being familiar with the literature in this area to ensure doctors are guided to act in the best interests of their patients.

The role of the Medical Council is to ensure doctors act in the best interests of their patients. It might be helpful if members could look at the introduction to the ethical guide. It states in the first paragraph that the patient-doctor relationship is a privileged one that depends on the patient's trust in the doctor's professionalism. The role of the Medical Council is to safeguard the public by ensuring the quality of the doctor's competence, behaviours and relationships that underlie this professionalism is maintained in the patient-doctor relationship. Of particular relevance to the current discussion is the second paragraph on page 7 of the guide, which states that doctors must always be guided by their primary responsibility to act in the best interests of their patients, without being influenced by any personal consideration. They should act independently in the service of their patients and have a responsibility to advocate with the relevant authorities for appropriate health care resources and facilities. It is very important that doctors understand they need at all times to act with the patients as their primary interest. Every action that doctors take has to be guided by that principle. As part of that process, the council reminds doctors that any decisions they take need to be guided by what the evidence is that supports their decision.

With regard to Deputy Ó Caoláin, who referred to the formal review process, clearly, as Ms Luddy indicated earlier this morning, a lot more work needs to be done to tease out the individual detail that will be contained within the regulations. Clearly the process we are undertaking today and for the next two days will inform the debate. It is important that the Members of the Oireachtas seek information from the obstetricians and psychiatrists who are faced in clinical practice with these scenarios. The purpose of the Medical Council document is to set out the principles which need to be safeguarded so that it can be assured that the protection of the public is maintained. I think this clearly will evolve with the development of regulations. As I mentioned earlier, we are very keen to work with the Department and other stakeholders to ensure that those principles on which the Medical Council has set its position are maintained in the development of these regulations.

Senator Colm Burke: Options were set out in the expert group report and Professor Murphy referred to paragraph 6.4 of that report. I know he does not want to come down on one side or the other on these options. Does Professor Murphy believe that all three options are workable?

Professor Kieran Murphy: As Senator Burke mentioned paragraph 6.4 of the export group report, the Medical Council has set its position which is as follows:

1. Legislation and/or regulations should set out criteria for the number and role of doctors to be involved. The Council will actively engage with the Department of Health in the development of regulations in collaboration with other stakeholders.

2. The Legislation and/or regulations should include a requirement that doctors involved have sufficient knowledge and skills to facilitate appropriate clinical decision-making.

The Medical Council's primary concern, as I mentioned earlier, relates to protecting the public. The Medical Council believes it can best do that by ensuring the education and training of a doctor is of an appropriate standard that is benchmarked favourably internationally. How we do this, as Ms Spillane said earlier, is by ensuring that entry onto the specialist division of our register is that hallmark of quality. For the council, that is the standard by which it can be

reassured that members of the public are protected.

Chairman: As the committee members have utilised their 60 minutes, I will now call on other Members. Deputy Terence Flanagan has indicated and I call him to ask questions.

Deputy Terence Flanagan: Paragraph 21.1 relates to abortion being illegal in Ireland, with the exception of circumstances "where there is clear and substantial risk to the life of the mother arising from a threat of suicide." Obviously these guidelines are directed towards doctors. It further states: "You should undertake a full assessment of any such risk in light of the clinical research on this issue." What is the current clinical research that supports the idea that abortion is an appropriate treatment for suicide?

Paragraph 21.4 refers to the rare complications that may arise where there may be little or no hope of the baby surviving and "it may be necessary to intervene to terminate the pregnancy to protect the life of the mother, while making every effort to preserve the life of the baby". What is unclear in relation to that paragraph? What level of correspondence has the Medical Council received from doctors on the lack of clarity in respect of the guidelines?. Have any deaths occurred due to the lack of clarity in the guidelines? Does the Medical Council wish to see the Offences Against the Person Act 1861 repealed? Is there a requirement to make provision in legislation for a duty of care to the unborn child? If so, how does Professor Murphy believe that should be achieved?

Chairman: I call Deputy Billy Timmins who has two minutes.

Deputy Billy Timmins: I have two brief questions for the witnesses from the Medical Council. However first I wish to state that it is extraordinary that the Department of Health has been excused by the joint committee from undergoing questions in this period.

Chairman: We explained earlier, in the Deputy's absence, that the Department is not running away but will come back at a future date. The legislation has not been drafted. At our meeting last night it was agreed unanimously that we will wait until the publication of the Bill. That was made quite clear.

Deputy Billy Timmins: I have no wish to go into conflict with you but I was here when you made that point. I was not absent.

Chairman: Sorry about that.

Deputy Billy Timmins: It is important to note that the purpose of the committee is not alone to inform ourselves but also to inform the wider public on the issue. There is a broad view among the public that the expert group report was dealing with the issue in its broad concept in line with the commitment in the programme for Government. However, this was not the case because the interpretation of the terms of reference were limited to advising the Government on how to give effect to the existing constitutional provisions. Thus, when the Government drew up the terms of reference in November 2011, whether unwittingly or otherwise, the decision was made to legislate for the X case at that time. I would like to have got clarification on that from the Department of Health and I would also like to have got clarification on the position of the report into the sad and tragic death of Savita Halappanavar.

Chairman: That particular point is not part of our remit today.

Deputy Billy Timmins: The majority of representations I received on this issue dealt with that case but we do not know where it stands at the moment.

Chairman: As you know, Deputy, your last comment is not part of our remit.

Deputy Billy Timmins: I am aware that it is not part of our remit, regrettably. The issue of capacity was raised by the Medical Council. What is the waiting time for a pregnant person to see a perinatal psychiatrist in the country at the moment? It is important to clarify that. I thank the Chairman for bearing with me. Has the Medical Council received any complaints from medical practitioners with respect to the guidelines as they currently exist? Has there been a request from the Medical Council to any Government since 1992 to have the guidelines legislated for?

Senator Jim Walsh: Can the Medical Council identify any deficiencies it has recognised in the current guidelines which need to be addressed? Under the guidelines the Medical Council recognises the distinction between abortion, to which Professor Murphy has referred, and a termination of pregnancy arising from the course of therapeutic intervention in which every effort is made to preserve the life of the baby. How does the Medical Council define this distinction?

The Medical Council stated that diagnosis should be evidence-based. The expert group report recognises the difficulties in predicting suicide in particular. What is the evidence base for suicide as a grounds for termination in the view of the council? Does the Medical Council believe that there are two patients in a pregnancy? Does it believe that the two-patient approach which we have had traditionally has served us well and has had a good record? Do we have a duty of care to both the mother and the child?

Professor Kieran Murphy: The first question related to paragraph 21.1 of our submission, the final sentence of which is: "You should undertake a full assessment of any such risk in the light of the clinical research on this issue." As I noted earlier, medicine is continuously evolving and it is a principle of the council that doctors must ensure that they remain up to date. Within their particular field it is important that doctors' knowledge and skills remain current. This was one of the prime reasons for the introduction of mandatory professional competence and there is a requirement now for all doctors to ensure that their practice, knowledge and skills remain current and up to date. This is to ensure that the protection of the public is maintained.

There was a question about current research. Clearly, this relates to doctors' need to be informed of all research in their area to ensure they are enabled to make the correct and appropriate decision and to ensure they serve the interests of their patients. I noted earlier that doctors should be guided by their primary responsibility to act in the best interests of the patient.

I regret that the Deputy believes paragraph 21.4 of our submission is unclear. As Ms Spillane outlined earlier and as we outlined in our submission, the guide the Medical Council produced in 2009 was developed following extensive consultation with doctors, the public, medical schools, postgraduate medical training bodies, Departments, employers and a range of other stakeholders. In order to ensure the guide was as relevant as possible, the council established an ethics working group to oversee the development of the guide. This multi-stakeholder working group, which included council members and non-council members, including a number of medical and non-medical experts, was established to ensure that the guidance was both evidence-based and developed in line with best practice.

Also, which I did not say before, the council was exercised to ensure that members of the public could also have access to the guide. We obtained a plain English mark from the National Adult Literacy Agency. The mark can be seen on the inside cover of the guide. The mark reflects the desire of the council that patients and members of the public should be able to under-

stand the standards the council expects of doctors. Members of the public need to understand the standards doctors are judged by and are obliged to adhere to.

We have tried extremely hard to ensure maximum levels of consultation in the development of our guidance. We worked hard to ensure that the language of the guide is as accessible as possible to all members of society, both doctors and members of the public.

Chairman: Professor Murphy, you might address Deputy Flanagan's question.

Professor Kieran Murphy: Which question was that?

Deputy Terence Flanagan: What correspondence has the Medical Council received from doctors regarding their difficulty in understanding the guidelines?

Professor Kieran Murphy: As part of the consultation process for the development of the Medical Council's guidance, we consulted widely with a range of stakeholders, including members of the public and of the profession, medical schools, postgraduate training bodies and advocacy groups. The council decided, based on consultation, the appropriate guidance it would publish for doctors.

The question about capacity relates to the capacity of the health care system to manage rather than the capacity of the individual patient to give consent, which is clearly dealt with separately in the guide. It is a matter for the employer to determine the capacity within the health care system. This is a question that should be posed to the obstetricians and psychiatrists when they make their submissions later this morning.

The third set of questions referred to what was termed deficiencies in the current guidelines. I have tried to outline the extraordinary lengths to which the council has gone in consulting about the guidance it gives to doctors. The guide was issued following an extensive period of consultation.

The issue of evidence-based guidance reflects earlier questions and also reflects our earlier replies. Like the guide, medicine is continuously evolving and changing. The guidance the Medical Council gives to doctors needs to reflect the evolution of medicine. Ms Spillane may wish to add something further.

Ms Caroline Spillane: Deputy Flanagan asked about the number of deaths resulting from lack of clarity in the legislation. The council can only take action on complaints it receives.

These complaints can be made by patients and members of the public and also by colleagues of doctors and other health care providers. Last year we received approximately 420 complaints. As I outlined, complaints are categorised in our annual report in quite a bit of detail. We produce statistical reports, but these do not isolate abortion as a category. However, from recollection, we have not received any complaint in that area of the guide. A provision in the guide states that if a doctor feels another colleague has acted outside the provisions of the guide, a complaint could be made to the Medical Council. Hypothetically, if a complaint were to be made, our preliminary proceedings committee which is made up of Medical Council and non-Medical Council members, doctors and lay members has powers to investigate complaints comprehensively. If it forms an opinion that there is a case to be heard, a hearing could take place on that basis. The vast majority of the council's fitness to practise inquiries are now held in public. This has been very informative for members of the profession in understanding how breaches of the guide can potentially lead to a complaint being made. It has also had the ef-

fect of informing the public about the expectations they can have regarding the standard of care doctors should provide for them.

Senator Jim Walsh: I agree that the medical guidelines are very clear, but none of my three questions was answered. The first concerns the distinction as Ms Spillane sees it between an abortion and the termination of a pregnancy by therapeutic intervention. What is the evidence base for suicide being used as a ground for termination? We are talking about today, not in 20 years' time as medicine has evolved. Is there merit in preserving the two patient system? That only requires a "Yes" or "No" answer.

Senator Labhrás Ó Murchú: I, too, welcome the representatives of the Irish Medical Council and thank them for their submission. As clarity is central to our deliberations, I would like to revisit that issue. I have a question for Professor Murphy who I understand is on record as saying the guidelines were awarded a stamp of approval by the National Adult Literacy Agency for the use of plain English. In view of this, when did the change occur? Does he still believe the guidelines are written in plain English? It is important that we establish at what stage we changed our views on the guidelines. Did it come from the council? Professor Murphy mentioned consultation, but he did not exactly reply to the question of how much correspondence he had received from practitioners on the lack of clarity in the guidelines. He must have some details, as distinct from the broader consultations to which he has referred.

I do not think Ms Spillane has provided a specific answer to the question of the knowledge she possesses of how many deaths have occurred owing to a lack of clarity. I would like to tease out that issue a little more with her. We should clarify it for ourselves.

Senator Paul Bradford: My question is a variation of the previous question. As we are asking the Medical Council to assist us in solving a problem, we need to recognise its scale. I ask Professor Murphy to indicate the levels of complaints made to the Medical Council arising from the current constitutional position and medical practice that in some way the health and lives of mothers are at risk. How many such complaints have been brought to the attention of the Medical Council?

Chairman: I ask Deputy Flanagan to be brief as this is his third time to contribute.

Deputy Terence Flanagan: I asked a number of questions which do not seem to have been answered correctly. What clinical research supports the view that abortion is an appropriate treatment for suicide ideation? This is a crucial question.

Deputy Eamonn Maloney: I did not intend to ask questions at this point, but I am slightly concerned at the direction the discussion is takng. From my knowledge of the judgment of the European Court of Human Rights, the reason this discussion is taking place, there is no reference in it to what the Irish Medical Council did or did not do. There is, however, a substantial reference to what politicians did not do, not for 20 but for 30 years. I dislike the way the discussion is tilting towards a focus on certain people. In fairness to him, Professor Murphy has made it clear ten or more times that what he is talking about is based on regulations. He is perfectly right to make the point that he is not a legislator. We should not forget our own shortcomings. Asking certain people for their opinion on the case A, B and C *v.* Ireland is all very well but, with respect to the delegates from the council, at the end of the day it is this Parliament which must decide on the implications of the ruling by the European Court of Human Rights and the report of the expert review group. It is regrettable that this matter has not been addressed 30 years after the constitutional amendment was made.

Chairman: I ask Professor Murphy to be brief in responding as the allocated time is up.

Professor Kieran Murphy: Senator Labhrás Ó Murchú asked about the background to the plain English issue in the context of the ethics guide. Following a period of extensive consultation with all stakeholders, the council produced its draft guidance. This was submitted to the National Adult Literacy Agency, not in order that that body might change its substance but rather to ensure the principles underlying the guidance were sufficiently clear to a lay audience. We had considerable interaction with NALA in this regard which resulted in a further refining of the language used in the guide. The final version was published only after the language was agreed to with the agency. The guide members have before them is the final version which was published in 2009. As I mentioned, it is, by necessity, a dynamic document which must reflect the fact that medicine changes. Last year, for example, we published supplementary guidance for the profession on the relationship between doctors and industry. The next council will, in turn, publish a revision of the current ethical guide.

Senator Paul Bradford asked whether there had been complaints regarding the existing guidelines on abortion. The council receives complaints where a doctor is deemed to be in breach of the guide. As I mentioned in my opening statement, to the best of my knowledge, we have not received any complaint that a doctor was in breach of the current council guidelines on abortion.

Regarding the evidence base for suicide, the principles underlying the council's guidance are that doctors need to be most informed when they are making clinical decisions. These decisions must be guided by the available evidence. Consequently, it is imperative from the council's point of view, in order to fulfil its mandate to protect the public, that all doctors are guided by the best available evidence internationally to take appropriate clinical decisions that will ensure patients are protected. I have already covered that last point in the context of referring to the research and evidence for any intervention.

As I stated, the council's very strong view is that any clinical decision that is taken needs to be guided by the best available evidence. It is probably worthwhile reiterating that doctors have guidance from lots of different sources. The Medical Council's guidelines form one set of guidance available to doctors. For example, within psychiatry and the new clinical care programmes in the HSE, specific guidelines are being developed by those programmes in order to manage a range of clinical scenarios such as self-harm. The doctor is expected to adhere to all the guidance, including that issued by the Medical Council, the practice guidelines published by the employer, namely, the HSE, through the clinical care programmes and the guidelines produced by each training college or royal college for each specialty. It is important for members to understand the Medical Council's guidelines are not the only point of reference through which doctors work. Doctors are guided by a range of different practice guidelines and protocols of which the Medical Council's guidelines are just one component.

Chairman: As it is now 11.26 a.m. and as we have exhausted the time available to non-members of the committee, I ask Professor Murphy to make a final summation if he so wishes.

Professor Kieran Murphy: The Medical Council is very grateful for being given the opportunity to make a submission to the committee. This is a very challenging issue for everybody. The council will work very actively with the Department of Health and other stakeholders in order to ensure that the public is protected with regard to any action that is taken. I thank the committee very much.

Chairman: I thank Professor Murphy and Ms Spillane for coming before us. I also thank Ms Luddy from the Department of Health. We will suspend proceedings until 11.45 a.m.

Sitting suspended at 11.27 a.m. and resumed at 11.47 a.m.

Kerry General Hospital, National Maternity Hospital and Rotunda Hospital

Chairman: I remind members and witnesses to ensure their mobile telephones are switched off for the duration of the hearing. We are starting promptly and on time, as we do every week. This is the second session in a series of hearings that the joint committee will be conducting over the next three days to discuss the implementation of the Government's decision following the recent publication of the expert group's report on matters relating to case A, B and C *v*. Ireland. I welcome Dr. Rhona Mahony, master of the National Maternity Hospital, Dr. Sam Coulter Smith, master of the Rotunda Hospital, and Dr. Mary McCaffrey from Kerry General Hospital, Tralee.

I remind witnesses that they are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence in regard to a particular matter and they continue to do so, they are thereafter entitled only to a qualified privilege in respect of their evidence. Delegates are directed that only evidence connected with the subject matter of these proceedings is to be given. Witnesses are further asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice or ruling of the Chair that they should not comment on, criticise or make charges against a person or persons outside the House or an official by name in such a way as to make him or her identifiable.

I ask Dr. Rhona Mahony to make her opening remarks. She is very welcome.

Dr. Rhona Mahony: I am very pleased to accept the invitation to attend today. I wish the committee every success in addressing what is a most important and complex issue. I hope I will be of some assistance. We are all present with the primary objective of preserving life. I am the master of the National Maternity Hospital in Dublin. I am a practising obstetrician and am also a specialist in foetal and maternal medicine. This means I have cared for women whose pregnancies have been complicated either by maternal or foetal disease.

The National Maternity Hospital is one of the busiest hospitals in Europe and delivers over 9,000 babies annually, or one in eight babies born in the State. Our hospital is a tertiary referral centre, which means we look after some of the most complicated pregnancies in Ireland. In addition to looking after our hospital population, we look after women referred to us from other obstetric units around the country. These women require additional expertise in dealing with the variety of complications that may arise either *de novo* or as a result of pre-existing maternal disease.

The primary reason for my presence today is to help members understand why we, as doctors, need enhanced legal protection in dealing with clinical cases where a pregnant woman may die and where treatment to save her life may include termination of pregnancy.

I wish to make one thing clear today: if there is any chance that a baby will survive at the threshold of viability, every effort will be made to save that baby. That must not be at issue today. We regularly look after babies at the threshold of viability with excellent results by international standards. Our neonatal intensive care facility is a national resource that cares for babies born as early as 23 weeks' gestation and who weigh as little as 500g, or even less in some cases.

At present in Ireland, doctors practice medicine relating to pregnancy with a degree of legal uncertainty. It was as far back as 1861 that the Offences against the Person Act, specifically sections 58 and 59, decreed that abortion was a criminal offence in Ireland, punishable by a life of penal servitude for both the woman and her doctor or anyone who assists her in procuring an abortion. This law remains today. It was to be more than 130 years before the Supreme Court judged that termination of pregnancy was admissible in the very rare circumstance of a real and substantial risk to the life, as opposed to the health, of a mother. As everyone present is aware, the risk to life in this case was the risk of this young girl taking her own life because of her distress at being pregnant. Twenty years later, the anticipated legislation that might have come from this judgment has not been enacted and, therefore, there is a degree of legal uncertainty in how we interpret the Supreme Court judgment and whether the Offences against the Person Act in fact is precedent. It remains law.

In the meantime, it is quite interesting. We have passed a variety of referendums which allow women access to information on termination of pregnancy outside this jurisdiction. We have had a referendum that allowed women to travel to alternative jurisdictions for termination of pregnancy, despite the fact that such a thing remains a criminal offence within this country. We have twice held referendums to remove suicide ideation as an indication for termination of pregnancy but I believe we have not yet managed to address the legal uncertainty surrounding termination of pregnancy in the very narrow, rare confines and context in which we believe there is a genuine risk to the life of a woman - that is, where a woman may die as a complication of her pregnancy but could be saved by termination of the pregnancy. Consequently, in very rare circumstances, doctors are faced with the task of making highly complex clinical decisions based on medical probability but without the luxury of medical certainty. It is imperative that we have the flexibility to make decisions based on medical fact. It is imperative that we have legal protection to do this. The State demands of us that we save life wherever we can and we must do this; it is our job. If a woman is critically ill and it is obvious she is likely to die, that she would be saved by intervening and treating her and that this treatment involves interrupting or terminating the pregnancy, we will not hesitate to do so. Moreover, society and women may be absolutely reassured that we will not hesitate to so do. The difficulty arises when the risk to life is not immediate. For example, a woman who has a serious underlying medical disorder may be sitting in front of one now but the additional burden of the physiology of pregnancy on organs that are already burdened and challenged may pose a highly significant and substantial risk to her life. Doctors must have the flexibility to make appropriate clinical judgment, not based on ideology or philosophy, but based on medical circumstances. This is what the State demands of us.

One must acknowledge that sometimes, tragically, women die during pregnancy. In fact, approximately eight women out of every 100,000 maternities in Ireland die during pregnancy. In some of these cases, they may die either because of direct pregnancy complications or from completely incidental causes such as a road traffic accident. Alternatively, they may die of indirect causes - for example, a woman may have a serious underlying morbidity to which the addition of pregnancy may so challenge her that she may die. This country recently produced a

triennial report into maternal deaths in Ireland from 2009 to 2011. If one looks back at maternal deaths, one can see there were six deaths arising directly from pregnancy complications but double that number, 13 deaths, arising in women who had pre-existing medical disease. Five of these women had pre-existing cardiovascular disease, two died by suicide and two of influenza, and there were a variety of other medical causes, including liver disease and lung disease. Interestingly, however, it is my experience that in many cases, women with serious underlying medical disease will choose to continue their pregnancy in the knowledge that they may die. In other words, women will risk their own lives to reproduce. However, some women faced with a significant risk of their own mortality will not wish to continue their pregnancy. This brings one to the highly difficult issue of defining what is a substantial risk to life during pregnancy. Is it a 10%, a 50%, an 80% or a 1% risk of dying? The interpretation of risk is not the same for all people. A woman herself will have a view as to what is an acceptable risk of her dying during pregnancy. Her opinion deserves to be afforded consideration. Clinical flexibility, supported by law, is required. Doctors must be able to make sound common-sense medical decisions based on medical conditions and circumstances and not ever on ideology or philosophy. They must be protected by law in doing this if they are to be able to carry out their jobs to the best of their ability. Members should make no mistake: what doctors wish to do is to preserve life. This is all about preserving life.

In recent months, we have listened to a wide variety of opinion. Some of this opinion has been extreme and absolute, at times unhelpful and, I would argue, at times even misleading. This forum hopefully will provide an opportunity for informed and mature debate. I believe the outcome of the joint committee's important work will underpin society's wish to protect life as far as possible. Perhaps the most controversial issue, which I now raise, is that of death during pregnancy as a result of suicide. Attempts have been made to confuse the risk of death from suicide by quoting figures from the United Kingdom relating to death from all mental disorders and not specifically the tiny number of women, who are under specific discussion here, who present wishing to take their lives during pregnancy. I am not a psychiatrist. I absolutely appreciate that members will be addressed later by specialists in the area of psychiatry and of course I defer to them. However, as a woman, I am offended by some of the pejorative and judgmental views to the effect that women will manipulate doctors to obtain termination of pregnancy on the basis of fabricated ideas of suicide ideation or intent. There also appears to be an assumption that psychiatrists are unable to assess the issue of suicide ideation, which is something they do every day in their clinical practice. I do not believe we have the right to dismiss absolutely the risk of a woman taking her life during pregnancy. It is known that women occasionally, albeit rarely, take their own lives during pregnancy. Women who are so distressed that they will consider taking their own lives must be listened to and believed and need appropriate medical care. That will not necessarily include termination of pregnancy but in a tiny percentage of cases, it just might.

Finally, one should remember the women and children who have brought us here today, and yes, I use the word "children". Let no one in this room forget the circumstances of the X case. This is the story of a 14-year-old child who was raped, who found herself pregnant and who was so distressed by her circumstances that at the age of 14, she wished to take her own life. Let no one forget her because she is real.

Chairman: I thank Dr. Mahony. I now invite Dr. Sam Coulter Smith to make his opening presentation.

Dr. Sam Coulter Smith: I wish to echo Dr. Mahony's thanks to members for the invitation

to speak to the joint committee today. I hope we can be of some assistance to the joint committee's work. My name is Sam Coulter Smith and I am master of the Rotunda Hospital, where I am in the fifth year of a seven-year term. The Rotunda Hospital is the oldest maternity hospital in the country and one of the oldest such hospitals in the world. Many of the comments that Dr. Mahony has made concerning the National Maternity Hospital are also applicable to the Rotunda, so I will not repeat all of that. It is important to recognise, however, that in the Rotunda we look after about 10,500 maternity patients annually.

Chairman: For the information of members who may be wondering, there is no script for this presentation.

Dr. Sam Coulter Smith: This accounts for about 12% of births nationally. We are a tertiary referral centre for both sick mothers and sick babies. We jointly manage maternal morbidity cases with our colleagues from the general hospitals - in our case, mostly the Mater hospital and Beaumont Hospital, but other hospitals as well.

I will provide some figures to put things into context. Of the women we look after, we see about 40 very significantly sick mothers with life-threatening issues annually. As I said, we jointly manage these cases with our colleagues, mostly in the Mater. It is important to recognise that we only have access to intensive care facilities in the Mater Hospital, which is about 400 yards away. That is not appropriate in this day and age. On average, we have approximately five or six cases a year in which interruption of the pregnancy is required to save the mother's life. There are a range of conditions and timescales in this sort of situation. One example is the case of maternal collapse when some sort of immediate intervention is required. Where the mother's life is at risk from something like cancer or significant cardiac abnormalities such as maternal cardiac disease, the risk obviously is not quite so acute but it is definitely there. Then there are situations in which the mother's life is at risk because of complications of pregnancy, such as infection. In that situation, where there is no prospect of the baby's survival, then obviously intervention has to be made.

Dr. Mahony has already alluded to the number of maternal deaths in the country. Most of the big maternity hospitals expect to have somewhere between zero and three maternal deaths a year. That would equate approximately to between nine and 11 cases in 100,000. The causes of death include epilepsy, thromboembolism, breast cancer, uterine rupture, haemorrhage and accidental death.

I would now like to turn my attention, if I may, to the issue of maternal mental health. Nationally we have three specialists who sub-specialise in the area of mental health in pregnancy. All of these specialists are in Dublin. Mental health issues complicate somewhere between 10% and 15% of pregnancies. They are therefore one of the commonest complications of pregnancy, yet they are one of the most under-resourced complications. Life-threatening mental health issues are rare. The incidence of suicide in pregnancy is of the order of one in 500,000. That is based on UK figures. We cannot be sure of the numbers who will feel they are at significant risk of suicide, as many of the patients who currently have suicidal ideation may not interact with our maternity services or our mental health services. They may, in fact, travel to the UK without accessing any of the services in this country. It is important to realise that it is very rare for a woman to claim that she is suicidal in pregnancy and wants a termination of pregnancy.

There are a number of issues that I would like to highlight. The first, on what might seem a small point but is hugely important, is the terminology we use when we talk about this subject. Some people will use the term "abortion", while some will use "termination of pregnancy". It

is of enormous psychological importance to a woman who is having her pregnancy interrupted for a life-saving procedure whether we call that an abortion or a termination of pregnancy.

There is the potential for a significant impact on existing services. Our maternity services in this country at the moment are all demand-led and are barely coping with the existing demand on them. We do not know what the demand will be down the line. We do not have the infrastructure, staff or resources - from an obstetric or a mental health point of view - to deal with this new component of service that we may be asked to provide.

The legislation and regulation are important. I welcome the Cabinet's decision on legislation and regulation. The legislation needs to be short and it needs to take into account future developments within medical practice. There needs to be a degree of flexibility within that legislation to deal with the wide variety of clinical scenarios that we face. In terms of regulation, there needs to be a suitable number of qualified doctors involved in a decision to terminate a pregnancy. Those doctors should be on the specialist register. There should be the opinions of at least two senior obstetricians, plus the opinion of whatever specialist is involved. If it is a mental health issue, then obviously a psychiatrist has to be involved. If it is a cardiac issue, then a cardiologist needs to be involved and others as well.

As regards where these procedures should occur, it will depend on the clinical scenario. However, most institutions that provide maternity services should have the ability to provide this service, bearing in mind that some of the smaller hospitals will not have the appropriate mix of specialties to deal with it, and a referral path needs to be made for that situation. There also needs to be an appropriate appeals system with appropriate access to legal opinion and access to the courts where necessary.

Turning briefly to the area of conscientious objection, it is important to realise that we are talking about situations in which a mother's life is at risk. She is at risk of death and in that case, obviously, conscientious objection becomes a lesser issue. I will leave it there but the committee can come back to any of the other issues.

Chairman: Thank you, Dr. Coulter Smith. I now want to welcome Dr. Mary McCaffrey from Kerry General Hospital, Tralee, and Dr. John Monaghan from Portiuncula Hospital.

Dr. Mary McCaffrey: I wish to thank the Chairman and other members of the Joint Committee on Health and Children for the invitation to speak here today. I understand that the purpose of the invitation was to gain some insight into how proposed legislation might affect smaller maternity units.

Of the 19 maternity units in Ireland, 12 are manned, or personed, by three consultant obstetrician gynaecologists, supported by junior staff and midwives. There are 12 units of that size in the country and approximately one third of all babies born in Ireland every year are delivered in units of that size.

In putting this presentation together I really am only a conduit for the views of a large number of consultants around the country, as I have consulted with many colleagues in similarly sized units. We have calculated that the people involved in this process have, together, around 280 years of obstetric experience under our belts. We have therefore managed quite a large number of patients, albeit in small units.

It is important for us that the legislation that is finally passed is workable and practical, that it will work equally in all maternity units in the country, that it will work for all medical practi-

tioners, that all medical practitioners who practice in this country as obstetrician gynaecologists will feel well protected under the legislation, and, most importantly, that all patients - regardless of where they deliver their babies or are cared for from a maternity point of view - are treated equally, and that the system will work for them.

I believe it is important for people to understand the day-to-day workings of a three-person maternity unit. On each weekday, there are three consultant obstetrician gynaecologists in the maternity unit. There will be one on-call consultant obstetrician who will look after all emergency procedures, theatre and labour ward. His or her two colleagues will be carrying out theatre lists, operating, doing outpatient procedures or whatever, so they will be within the hospital during normal working days. Out of hours - say, after 5 o'clock from Monday to Friday - the on-call obstetrician is the only person available on-site at the hospital until 9 o'clock the following morning. At weekends, from 5 o'clock on Friday - in some situations, from 1 o'clock on Friday - until 9 o'clock on Monday morning, that one on-call obstetrician is the only on-call emergency consultant available in that hospital. Obviously, he or she has a team of support staff, but he or she is the only senior obstetrician in the hospital. That is an important point to make in terms of staffing levels. Therefore, there are times when there is no immediate access to a second person on call in a maternity unit. Most people are acutely aware of that. If the on-call obstetrician needs to collaborate with a colleague, he or she endeavours to contact him or her by telephone or whatever.

The other point to make is that when consultants are on annual leave, locum consultants, who are temporary consultants, agency staff or whoever, are brought in to cover, and these are not part of the regular staff in the unit. In general, however, most consultant obstetricians in smaller units endeavour to employ a small core number of persons who are familiar with the unit. In general, we use the same people all the time; they are persons who we consider to be trained to the same level as ourselves. That is how staffing levels work in the smaller maternity units in the country.

We then looked at the decision-making process for the various categories of patient and how we felt they pertained to our practice on a day-to-day basis. I reiterate that I am acting as a conduit for the views of a large number of people and I am trying to put these views together in the most objective fashion for the committee.

We looked, first of all, at women presenting with serious medical conditions, where the pregnancy itself puts the woman's life at risk. The most obvious example is serious heart disease. We felt that, in general, such women would already be under the care of a specialist cardiologist or physician in another hospital or in a tertiary referral centre in Dublin, Cork, Galway or wherever. It was the unanimous view of everybody I spoke to that these patients were best managed in that tertiary referral unit and that we would not be involved as decision-making signatories because we would not have the expertise, as obstetricians in a smaller unit, to decide whether or not a particular woman's pregnancy was compatible with life. Such women will already be travelling to a centre such as the Coombe Women's and Infants' University Hospital. That hospital has a medical clinic with three consultants who specialise. They may be going to Dr. Rhona Mahony's clinic or to Dr. Coulter Smith. However, we felt that in general these were not a group of people with which we would be involved in the smaller hospitals. Even if they presented on our doorstep for whatever reason - for example, in an emergency while on a weekend holiday - it would be inappropriate for any procedure to be performed on them because we would not have the backup of a cardiac anaesthetist or whatever. They would be stabilised and transported back to the place that would best serve their needs.

The second group of women we looked at was the group of women presenting with suicidal ideation or intent. Although we have discussed this among the group, I personally have no knowledge of ever having cared for a woman who wanted to end her life specifically because of a pregnancy, and in my pursuit of information over the past week or so, I have been unable to identify any other consultant who did know of such a woman, which backs up the information we already have - i.e., that this is an extremely rare situation. The consensus among my colleagues was that, as obstetricians in a medium-sized maternity unit, we did not feel we had the expertise to be involved in a diagnosis of suicidal ideation or intent, that we did not have the expertise to decide that a woman's pregnancy should continue, and that such diagnosis should be performed and carried out within the psychiatric services, with signatories from within those services.

We are then down to the issue of whether, if two psychiatrists, or whatever number of signatories are finally decided, say that this woman should have the foetus delivered early in the interest of her health, this should happen in the smaller maternity unit. A number of issues came up in this regard. We felt that if one looked at it in terms of medical services, we had the facilities to do so; however, there were a significant number of reasons people felt it should not happen in a smaller maternity unit. Many members of the committee will be aware, as they represent small rural areas, of how difficult it can be to remain anonymous in such an area. We felt that stigmatisation of women might occur and that anonymity would be extremely difficult to maintain. Some colleagues had issues regarding the skills base, because it was a procedure they had never been involved in and did not wish to be involved in in the future.

Although it is not an issue for this committee today, I must take the opportunity of saying that in the smaller maternity hospitals the gynaecology services and women's health are becoming the Cinderella services of the health services in general. There are a significant number of maternity units in the-----

Chairman: That is a matter for another day.

Dr. Mary McCaffrey: I am merely saying we do not have the gynaecology wards to put these women in. A pregnant woman, who is already fragile because of her condition, would be put into a ward with pregnant women who are having babies and we did not feel that this was appropriate in a number of units.

We then looked at obstetric emergencies. The consensus of the group was that this is something we carry out on a day-to-day basis in our practice. We are talking about women with severe infections, severe sepsis, severe haemorrhage, a condition called fulminant pre-eclampsia, or HELLP syndrome. We manage these on a regular basis as obstetricians in smaller maternity units, and we decide on some occasions that we will transfer them to bigger hospitals. In many circumstances it is inappropriate for a pregnant woman to be sent 70 or 80 miles in an ambulance and in those circumstances, we ourselves stabilise and manage the women. This is regular practice, and we felt this practice should continue. We felt that most people, as best practice, consult with other colleagues in managing complex cases and that such practice would continue. We were not really convinced that a formalised signatory process was necessarily appropriate.

Another issue is that of babies who may be born on the cusp of viability. This issue of what is extreme immaturity has come up already today; one is looking at babies who are born at 23 or 24 weeks, and a woman's dates might be wrong. Such women would be better served in a maternity unit of larger size. If it was unsafe to transfer a woman, we would utilise the services

of the neonatal transport team, which already exists and serves rural areas very effectively.

Lastly, I want to deal with the issue of conscientious objection. One of my colleagues is aware of a situation in the United Kingdom in which nine out of ten anaesthetists - the people who put patients to sleep - would not anaesthetise for terminations of pregnancy. The conscientious objection clause is very important in the hearts of many people here, and the current Medical Council guidelines facilitate that.

There was concern about one sentence in paragraph 6.9 of the expert report, which states: "Most jurisdictions accept that an individual's right to conscientious objection is not absolute and ... has limitations." All of my peers accept that they will always do what is best for a patient in an emergency situation, but people have the right to conscientious objection and that must be respected. I have worked in the United Kingdom. Everyone I have spoken to has worked in other jurisdictions where termination of pregnancy is performed and everyone's right to conscientious objection has been respected elsewhere. It is important to us that this will also be the case under future legislation here in Ireland and that nobody is discriminated against in his or her job or future job prospects. I thank the committee for taking time to listen.

Chairman: I thank Dr. Mahony, Dr. Coulter Smith and Dr. McCaffrey for their presentations. We will now have 60 minutes of questions from members. I call Deputy Kelleher.

Deputy Billy Kelleher: I welcome the witnesses.

At the outset, I wish to make some observations and pose questions. Dr. Coulter Smith pointed out that he is concerned about the increased demand on maternity services. He earlier stated that they are demand-led and that he was concerned that legislation would result in additional pressure on maternity services. My question is in the context of the quoted figure of between nine and 11 maternal deaths per 100,000 per year. Where does Dr. Coulter Smith see the increase in pressure on the maternity services in the event of legislation and regulation to facilitate terminations, in view of the fact that these are very extreme cases and that they would be within the parameters of Article 40.3.3° and the X case? I am a little confused on that issue. On the issue of suicide ideation and suicidal tendencies, it has been argued that they would apply in very limited circumstances and that some consultants never encountered a case in which suicide was contemplated because of pregnancy. Other people take different views but it is important to have regard for the witnesses' opinions as eminent obstetricians.

The issue of conscientious objection has been raised on several occasions. Should the conscientious objection of an obstetrician or gynaecologist to carrying out a termination be made public before an individual decides to employ his or her services? This is an important matter to clarify because people may have different views on whether a patient should be informed at the point of deciding to use a particular consultant or hospital. In the event of legislation being passed, should those with a conscientious objection be obliged to inform their employers when taking up positions? If, as the Medical Council has stated, patients come first, should they not be entitled to such information?

Deputy Caoimhghín Ó Caoláin: I join my colleagues in welcoming the witnesses and thank them for their contributions. Dr. Mahony stated that it is important for medical practitioners and women to be afforded the legal protection required to allow appropriate flexibility in making professional clinical decisions based on medical probability of risk to life. I take that to mean that such provisions would include all situations in which certainty indeed existed. I accept that probability would be the criterion on which the decision would be made. The expert

group indicated that the State is obliged to provide precision as to the criteria by which a doctor should assess that risk. I take it Dr. Mahony believes that greater precision is achievable. To what extent is precision possible given the complexities that regulation and legislation can present?

If a probability has been professionally asserted that a woman's life is at risk, how would the witnesses envisage the independent review system functioning? Surely it would need specific timeframes for its functionality. There is a lack of clarity on that matter. We raised this issue with the representatives from the Medical Council and I am anxious to hear the witnesses' views or ideas on this aspect of the expert group's recommendations.

We know that sections 58 and 59 of the 1861 Act remain in force in terms of absolute prohibition and associated criminal offences. In the witnesses' respective experiences, has the continued existence of this prohibition impaired or impacted on the decision making of fellow professionals?

Deputy Mattie McGrath: I welcome the witnesses and thank them for their enlightened contributions. If legislation is introduced for termination of pregnancy in line with the X case, including where the risk to the mother's life comes from her own threat of suicide, will it increase the number of abortions or change medical practice in any way?

Abortion has never been considered an appropriate treatment for suicide ideation and has never been carried out by doctors in Ireland on this basis. Do the witnesses think obstetric or gynaecological professionals would be happy to carry out terminations which are prescribed by psychiatrists?

A symposium on maternal health care held in Dublin in 2012 concluded that abortion is never medically necessary to save the life of a mother. Is that conclusion incorrect?

Deputy Ciara Conway: I thank the witnesses for their contributions. Some of issues I wish to raise follow from Deputy Mattie McGrath's questions on how substantial risks of mortality are to be assessed. There has been considerable discussion about suicidal thoughts and self-harming but what if a mother has a long-established mental health problem? We know about the proliferation of mental health difficulties throughout the country and the number of people who are, for example, on severe medication regimes for bipolar disorders or schizophrenia. From my limited experience of this area as a social worker, I understand women are often encouraged to discontinue their medication while they are pregnant. Does that increase the substantial risk to the life of the mother? Senator Crown previously outlined the example of a woman who is diagnosed with cancer and cannot receive the treatment she needs to save her life because she is pregnant. I ask for further elaboration on the real life choices that women may face. They are difficult choices and I ask those who work on the front line how we can make this clear for women and practitioners.

Deputy Kelleher raised the issue of conscientious objection. In the not so distant past a young girl who became pregnant was forbidden from attending a certain school in this country because of its ethos. What impact does the ethos of our hospitals have on the kind of health care required to save the lives of women?

Dr. Rhona Mahony: Deputy Kelleher expressed concern that legislating for the termination of pregnancy in order to save a woman's life could have a major impact in terms of numbers. I do not believe that will be the case. We are speaking about a tiny proportion of women who

we believe will die if their pregnancies are not terminated. This is an extremely rare scenario. Nobody is proposing to open the floodgates or create a situation in which we will be performing multiple terminations of pregnancies. The risk of death in pregnancy is extraordinarily rare but it does exist. I do not believe this particular issue gives rise to concerns about numbers.

In regard to conscientious objection, we are discussing women who might die. I am a doctor. I do not conscientiously object in my duty to save life. We are not dealing with broad issues surrounding termination of pregnancy. We are addressing cases in which we believe a woman is going to die during pregnancy and where the risk of death can be ameliorated by ending her pregnancy. I refer to serious medical disorders which we believe will result in death.

On the issue of suicide, nobody is suggesting that termination of pregnancy is a cure for mental anguish or the disorders associated with suicide ideation. However, in very rare cases women commit suicide. There have been two deaths relating to suicide between 2009 and 2011. A woman wishing to take her life in pregnancy is rare. It can be assessed by our psychiatric friends. It involves women being listened to, believed and treated in the totality of the condition. Nobody suggests that the termination of pregnancy is a cure for suicide, but it may be appropriate in certain very rare circumstances as part of a general treatment plan.

The next issue that Deputy Ó Caoláin raised was the idea of probability versus certainty. Doctors always deal with probability. We rarely have the certainty that death is inevitable until it has happened. So we deal all the time with probability. We are asking to have the flexibility and the legal protection to make sound sensible medical decisions based on medical probability. We do not have the luxury of certainty or of being able to look into the future and say: "Yes, that woman will definitely die." We do not have that certainty but we need to have flexibility where we believe there really is a risk that a woman might die. We come across women who have serious underlying medical disorders and who die. We see this in the triennial report into death. We treat women who wish to continue their pregnancy and for whom the treatment during pregnancy is terribly challenging. We need flexibility and legal protection. This is about saving life where possible. Society may be reassured that our aim is to preserve life where possible.

The question about timeframes relates to emergencies. In an emergency case where a woman is definitely dying, there is no hesitation, but obviously in most units in the country we have a number of consultant obstetricians. For example, in a hospital such as the National Maternity Hospital we always have a consultant obstetrician who is first on call. They are on the specialist register. There is always a second obstetrician in reserve on call for those difficult cases when we are very challenged. There is generally an adequate quorum, I believe, in terms of whether the need for a termination of pregnancy arises in an emergency or an acute situation. Where we have a bit more time - doctors work in teams - we very much work in a multidisciplinary fashion. When we are making important decisions such as this, we will gather all the information available to us from within our own field and, if required, from other specialist fields. We will put that information together and make the best decision we can, but we will make that in a multidisciplinary fashion. Nobody is suggesting that doctors would ever make such decisions in isolation, but this can be done in an expeditious manner, I believe.

Sections 58 and 59 remain in force. Abortion in Ireland is a criminal offence which is punishable by penal servitude. That law stands today and I need to know that I will not go to jail if in good faith I believe it is the right thing to save a woman's life to terminate her pregnancy. I want to know I will not go to jail and I want know, by the way, that she will not go to jail. It does not matter whether anybody has been sent to jail previously - that is not at issue. The point is there is a significant risk that I could be sent to jail or I believe and perceive there to be

a significant risk I might go to jail. That is something I want clarified or further guidance in.

Deputy Mattie McGrath asked about suicide. Suicide is extremely rare in pregnancy. A woman's wish to take her own life during pregnancy is terribly aware. As I have said, I am not for one moment suggesting that termination of pregnancy is a cure for suicide, but perhaps we must allow for the fact that in certain cases certain women will kill themselves during pregnancy and we must have a way of assessing that and we must treat these people with compassion and with expert care.

We should be very careful of absolute statements such as the so-called Dublin declaration, which I do not particularly recognise. I think it is not correct to say there is never an indication for termination of pregnancy and we need to be very careful about absolute statements. We are talking about real life and in real life there are rarely absolutes.

With regard to mental health, as Dr. Coulter Smith has pointed out, approximately 10% to 15% of women will be affected by a variety of disorders of mental health. In the vast majority of these cases, these women can be very successfully treated during pregnancy. They do not have to stop taking anti-depressants - they can receive their expert care and treatment during pregnancy. For many of these women we have no concern that they will kill themselves. They require treatment for their disease but we do not have a concern that these women will kill themselves. We have excellent perinatal psychiatrists. I appreciate we only have three, but we are not talking about dealing with all issues pertaining to mental health. We are talking about the very tiny number of women who wish to kill themselves during pregnancy. It is a tiny number of women and I believe we have the capacity to do that, but that is obviously a question that needs to be put to the expert psychiatrists who will address the committee later today. It must be stressed that we are talking about a small number of women.

Deputy Ó Caoláin asked a very interesting question about how the substantial risk to life is assessed. He also asked how we develop a tool with such precision that we can identify those women who will die either because of medical disease or through taking their lives. Of course, it would never be possible to come up with perfect legislation or regulation. We are asking for lawyers to draft legislation that will allow us some flexibility. It would be impossible, for example, to write a list of disorders that might qualify. That is not really what I am suggesting. I believe that two expert medical doctors or additional doctors in the variety of specialties might be required - for example cardiology, psychiatry or whatever. I believe that two consultant obstetricians, who are experts in the field and who are able to gain all the information they need and obtain advice from their colleagues, are able to determine when there is a significant risk to life in a pregnant patient. I believe they should have the ability and flexibility to identify those women and to treat those women appropriately without fear of prosecution. It is for doctors to make the medical decision whether someone is likely to die. This is a medical decision based on medical fact. Doctors must be able to make these decisions if they are to do their job properly and preserve life.

Dr. Sam Coulter Smith: I echo all the comments Dr. Mahony has made. If we introduce legislation which allows termination of pregnancy in this country what would be the impact on our services? I do not think we know the answer to that question. I agree that risk of death from suicide is extraordinarily rare. However, we do not know the number of people who go from Ireland to the UK seeking termination of pregnancy in that jurisdiction and we do not know what numbers might then come to us and not go to the UK. So we do not know the answer to that. There are people who will seek termination of pregnancy because of rape or incest, or because they have babies with lethal congenital abnormalities. Some of those women will

come to us and say they have significant mental health issues. Those women will then need to be assessed by the psychiatric services and the obstetrics services in this country. That is not a function we are actually doing at the moment, so I think there will be an impact, but we do not know how big or small it will be.

In terms of conscientious objection, I cannot think of any circumstances in which any health professional where a mother's life is imminently at risk would refuse to be involved in her care. I cannot see that that would be an issue if the mother's life is genuinely at risk. The legislation needs to have flexibility to allow the medical profession to make appropriate decisions. We need to trust our medical practitioners to make the appropriate decisions. I think the regulation that is put in place has to ensure that there are an appropriate number of suitably qualified doctors who make the decisions and they need to be protected by legislation.

Is termination of pregnancy ever necessary? I would say "Yes". In our hospital last year, we had six situations where I can absolutely tell the committee for sure that if intervention had not been made, that mother, if she had not died very soon after the event, would have died subsequently. I would say "Yes". Those situations do happen and, in our hospital, they happened six times in the last year.

If I have not answered all of the questions, the members can come back to me.

Dr. Mary McCaffrey: On Deputy Kelleher's question about whether lists should be published, I have huge concerns about the publishing of lists. Doctors will manage patients on a case-by-case basis and every case will be different. There is always a risk that if one publishes lists of people who will do A, B and C, one will actually discriminate against people. For example, in the UK one is not allowed to ask at an interview whether someone will perform a termination of pregnancy. It is a different scenario but the important point is that no practitioner will ever allow a woman to die because they will not do something. We are there to save lives and we do it all the time.

Deputy Ó Caoláin asked whether the legislation had ever affected me. No, it has not. The life of the mother has always come first. Pregnancies have ended earlier than anticipated in my practice and in other people's practices because the life of the mother was at risk.

Deputy Conway asked about cancer. While I would feel terrible even talking about cancer with Senator Crown in the room, I have had patients with cancer who have had appropriate surgical treatment in pregnancy, and who have then gone on to have their chemotherapy at a later stage in pregnancy and have their radiotherapy after the pregnancy is completed. Again, each patient is taken on a case-by-case basis. It is about multidisciplinary teamwork and it is about consultation, communication and dealing with the mother's life, which is the most important thing. There may be situations in which a baby will be delivered early because the mother needs further treatment but more and more of the evidence on cancer shows that one can coast to a point in the pregnancy at which the baby is viable. That is obviously what people are always aiming for.

On the suicide issue, we need to become very focused on the fact there are other treatments for suicide. If a male patient pitched up in accident and emergency tonight and said he wanted to kill himself, there would be medical treatments, drugs and therapies, and these would be reviewed in a couple of weeks. That is the first-line treatment, and cases are reviewed after a couple of weeks.

Those were the main questions asked.

Deputy Denis Naughten: I thank the speakers for their presentations. In particular, I thank Dr. Coulter Smith for his statistics, which give a context to what we are talking about. He said there were five to six terminations in the Rotunda in the last 12 months. Is it likely there would be a higher rate in a hospital such as the Rotunda because it is a tertiary referral hospital? Has he any indication of the numbers we are talking about on an annual basis?

Second, Dr. Coulter Smith made the point that one in every 500,000 women presents with suicidal tendencies during pregnancy, based on UK figures. Has there been any research on whether termination, where one has taken place, has increased or reduced the suicidal tendency, or whether it acts as a cure for that suicidal tendency?

Third, the point was made that there is a need for a referral pathway to be put in place for decision making in the case of smaller maternity hospitals. I thank Dr. McCaffrey and Dr. Monaghan for being present. They are based at two of the smaller hospitals, with Dr. Monaghan based at Portiuncula Hospital in Ballinasloe. To refer them back to the evidence we received earlier from the Medical Council, it was said there should not be specific provision for emergencies, yet Dr. McCaffrey broke her presentation into three categories in which she specifically talked about emergency situations and made the point, in regard to second opinions, that a physical signatory should not be required in an emergency situation. Can the witnesses comment on the evidence the Medical Council has given to us? In particular, I would like to hear Dr. Monaghan's view on the statement by the Medical Council. There is a genuine fear among people who are serviced by the smaller maternity hospitals that this could be constructed in such a way as to reduce capacity or result in the amalgamation of some of the smaller maternity hospitals into more regional centres.

Deputy Robert Dowds: I thank the expert witnesses. One of the points that comes across to me is the lack of certainty as to whether a woman's life is absolutely at risk. I very much empathise with that because my wife had very difficult pregnancies when she was at that stage of her life. My question relates to this. If we are to legislate adequately, is it possible to do so without going back and removing the article in the Constitution which puts great restrictions on abortion?

Deputy Seamus Healy: I thank the witnesses for their submissions, which have been very informative and helpful, certainly to me. I wish to address a number of issues. I would like to have clarification on the probability of real and substantial risk to the life of the mother. While we can all understand an immediate situation, is there a situation in which the life of the mother might be at serious risk in six months, 12 months or two years?

The question of local units and emergencies was raised earlier with the Medical Council and was probably not dealt with effectively, in my view. Dr. McCaffrey's submission suggested that the local units would deal only with emergencies and any other issues would be dealt with in tertiary centres such as Dublin, Cork or Galway. Is that what Dr. McCaffrey is suggesting?

With regard to emergencies, the Medical Council suggested no particular special procedures were necessary. What are the witnesses' views on that?

With regard to conscientious objection, the expert report suggested what while there is a necessity for conscientious objection, it is not always absolute. Do I take it from what people have said that this refers specifically to emergency cases?

Deputy Regina Doherty: I thank the witnesses for their presentations. Against the backdrop of the witnesses' description of the superb level of medical care and intervention that is currently on offer in Ireland, which is a given, Dr. Mahony in particular said there was something that was stopping her today from making sound medical judgments and decisions relating to the medical care of and interventions for women. Can I ask specifically what that something is, given the clarity of the medical guidelines that were discussed here earlier?

I ask all of the witnesses, generally, how many terminations or early deliveries have actually occurred in their hospitals arising from the threat of suicide as a risk to the life of a woman since the X case judgment.

Senator John Crown: We have already established that when I stand up, the microphone does not work, so please do not see any disrespect if I ask my questions from a sitting position. I first want to thank the witnesses and, not only that, but also to commend them. They have made me a little prouder to be a doctor today. There was great clarity, honesty and conviction in what they said, and I consider this is critically important in trying to address this issue.

We must seem as though we are perseverating on this. Extrapolating from the arithmetic advanced by Dr. Coulter Smith, and taking account of the fact that a disproportionately large number of complex pregnancies go to the referral centres, I am guessing that nationally, we probably have something of the order of 30 to 40 terminations of pregnancy which are necessary and which are now carried out to save the life of the mother. The witnesses can correct me if I am wrong.

I would also like the witnesses to clarify the following point. I do not mean to hint at any case or require anyone to appear to stand in judgment over particular colleagues, but I would like the witnesses to state whether or not they are of the opinion that there have been maternal deaths which were needless and which would have been specifically prevented had there been greater clarity in the legal framework. Have there been cases in which terminations of pregnancy for life-saving indications were not offered because doctors felt, perhaps in good faith, they were not adequately covered legally or might have been breaking the law if they performed them?

The distinction between a termination necessary to save the life of the mother as opposed to her health is something that has been raised both here and in the Dáil. It may be medically naive but my sense is that there are unlikely to be conditions which threaten one's health which do not also, even to some small extent, threaten one's life. As such, it is probably not a great issue. We will not go into medical detail on it, but is it necessary in performing a life-saving termination of pregnancy to kill the foetus *in utero* or can the pregnancy be delivered to give the life-saving indication the woman needs? This relates to an objection some others have raised.

Can Dr. McCaffrey clarify something she mentioned in good faith earlier about the hospital in the UK where nearly the entire cohort of anaesthesiologists refused to anaesthetise a termination patient? I am sure she was not referring to an emergency.

Dr. Mary McCaffrey: Absolutely.

Dr. Sam Coulter Smith: There were six terminations performed in the hospital last year. The incidence has risen in recent years, possibly on foot of the increasing age of those in the pregnant population, the complexity of illnesses we face and the rise in obesity levels, all of which increase risk. The figure of one per 500,000 refers to the incidence of suicide in the UK

population, not the incidence of presentation of suicidal ideation, which would be much higher.

Certainty of risk is very difficult to determine. There are many grey areas and we must trust in medical practitioners. We have a fantastic quality of health professional working in our health service. The problem is getting to see them, not with what happens when one gets seen. We must trust in the judgment of our excellent doctors and protect them in making decisions.

On the question of whether we need to review or repeal the existing law, I am not a lawyer and I will leave that question to lawyers. I was asked if we have ever had to perform a termination of pregnancy because of risk of suicide and the answer is "No". Senator Crown asked about the extrapolation of the figures from the Rotunda to get a national statistic. He is in the right ballpark. Tertiary referral centres would probably see more of the complicated cases and I would have thought the national figure is between 20 and 30.

I was asked if there had been any needless maternal deaths because people would not or felt they could not act. I am not aware of any such case. I was asked if there were circumstances in which a foetus had to be killed *in utero* rather than delivered. In most circumstances it is possible to deliver the baby or foetus without killing the baby inside.

Dr. Mary McCaffrey: I am not aware of any needless deaths due to needless obstetric intervention. I am not aware of any death from suicide because a termination was declined. Deputy Healy's question related to the smaller units. I thought my presentation made it clear that more severe medical cases including cardiac disease are referred to multidisciplinary teams in different units, generally in Dublin. We manage obstetric emergencies in smaller units although the three-man units vary in the number of cases with which they deal. The Waterford unit delivers 3,500 with three consultants, which is admirable. It would not really be considered a small unit. What matters is the skills mix, who is on duty on a particular day and whether an intensive care bed is available. The expertise of the clinician standing at the end of a bed must be acknowledged and he or she must be protected in law to permit the right decision for the particular patient at a particular moment. We must consider the track record of smaller hospitals on maternal death. While I do not want to tempt fate by discussing it, we have a strong track record in the management of patients, whether by referring them to other units or managing them locally.

While the Medical Council has said that a second signature is not necessary, it is always good practice to discuss very complex cases with a second colleague. I mentioned locum staff earlier who might be breezing into a hospital for a week or two. Many more things go wrong where locum staff are on duty. I did not get to discuss in my initial submission the idea of a national expert panel comprised, for example, of the three masters and, perhaps, the clinical director of CUH. If they are not on duty, they usually have a deputy standing in. It would mean there were resources to fall back on where the need to discuss a complex case arose. One hopes it never happens, but if it did and colleagues in the hospital disagreed on the approach, there would be a need to obtain the opinion of some at the level of Dr. Coulter Smith or Dr. Mahony. We should consider strategies to deal with these types of scenario. In general in smaller units, the track record in terms of maternal morbidity has always been good.

Dr. Rhona Mahony: While the incidence of suicide is extremely rare, as Dr. Coulter Smith points out, that is not the same thing as the incidence of suicidal ideation. It is very difficult for anyone to identify the incidence of suicide as cases are often returned as open verdicts in the Coroner's Court. I do not believe we have accurate data although we can say with certainty that it is extremely rare. It is also the case that some women will travel to other jurisdictions to terminate their pregnancies. It is therefore difficult to assess the true incidence of suicide,

suicide ideation and suicidal intent.

There will always be a lack of certainty in cases because what we deal with is medical probability. The assessment of a risk to life in the context of medical disorder is a medical decision and doctors must be trusted to make the decisions. This is our area of expertise and our job. What we request is legal protection in carrying out our task. I was asked if there is any specific obstacle. I take issue with sections 58 and 59 of the Offences Against the Person Act. They are problematic and need to be addressed and the European Court of Human Rights agrees with me. When we extrapolate the extra terminations of pregnancy that we anticipate the numbers are tiny. In my hospital last year we had three cases in which we had to intervene prior to foetal viability because of our concern that a woman would die. There is a tiny number of cases, 30 or 40 is an overestimate. The figure nationally is more likely to be between ten and 20. We never kill a foetus. That is not our aim. Occasionally it is required that we deliver a pregnancy before the baby is viable or capable of surviving in our neonatal intensive care unit. When there is any possibility at all that we can preserve the life of the baby we will do so. We are able to do so from very low gestations, from 23 weeks on and in those cases Members can be very certain that we will make every effort to preserve life.

In other cases we are required to terminate a pregnancy as part of a treatment of a medical condition because we feel a woman will die. That is not killing the baby. That is simply delivering the baby before it is viable. There is a difference. It is always our wish to preserve life and society should be very reassured about that.

There is a changing demographic. Older women are becoming pregnant. They have different disorders. They are more likely to have coincidental medical disorders. It is very important that doctors have the flexibility to do their duty with legal protection.

Deputy Catherine Byrne: I thank the witnesses for being here this morning. I hear Dr. Mahony loud and clear when she asks to be allowed to do her job and be protected as well. I have five children and have had my own misfortunes in having miscarriages. It is very difficult after the great joy of learning that one is pregnant when things do not go as one would like. That happens. What happens in such circumstances is the honesty and trust in one's general practitioner or the doctor in the maternity hospital. It is important for us all to hear that clarified again this morning because life is so important.

I want to refer to a point I raised with the Medical Council about paragraph 21.4 of its submission, which states: "Due to extreme immaturity of the baby, there may be little or no hope of the baby surviving. In these exceptional circumstances, it may be necessary to intervene to terminate the pregnancy to protect the life of the mother, while making every effort to preserve the life of the baby". Dr. Mahony has said that herself. I and my colleagues have received many e-mails and letters from people who have had to leave the country to have terminations, many due to the "extreme immaturity of the baby" and had to bring the dead baby back in a box in the boot of the car or have it cremated abroad and bring home the ashes. That has a devastating impact on people's lives. Does the quote I have read not mean that we should not be sending those people away when the doctors know as professionals that the baby is not going to live after birth? Dr. Mahony can correct me if I am wrong. Can we not help these people? Many young and older women experience these difficulties. Many of the e-mails and letters that I have received tell harrowing stories of people who had to go away when doctors in hospitals here told them that their babies would not live. Will Dr. Mahony clarify that point?

Deputy Mary Mitchell O'Connor: I thank the witnesses for their presentations. I am hav-

ing difficulty in understanding the presentation by the Medical Council. The council witnesses said explicitly this morning that special procedures do not need to be developed for emergency situations. Do the witnesses present agree with the Medical Council? We are trying to gather information and work on it.

The doctors say they need clarity. What deficiencies are there in the medical guidelines? Finally, does the ethos of the hospital affect how pregnant women are treated in hospitals?

Deputy Peter Fitzpatrick: I have two questions. At what point do women get the treatment to which they are entitled when there is a real and substantial risk to their life as opposed to their health? Is it possible to give legal clarity to doctors and patients about when it is permissible to terminate a pregnancy when a woman's life is threatened?

Dr. Rhona Mahony: Women in Ireland who face the threat of dying during their pregnancy require not only compassion and understanding but good, sound medical treatment and we must be able to treat them within this jurisdiction and be safe as doctors to do so but it is always a question of appropriate medical treatment based on medical circumstance. With regard to the Medical Council and special procedures not required to be developed, generally speaking in an emergency situation such as a woman who is actively haemorrhaging, who is dying, there is no time to have any protracted negotiation about what is the right thing to do. We simply treat that woman. Hospitals which practice obstetrics have the back-up to do that. We always have an obstetrician on call and a second one as a back-up. In the emergency situation when a woman is dying we have the resources to manage those women and we do so without hesitation if we are going to save life.

I still contend that as an obstetrician practising in Ireland I need further clarity to know that I am protected within the law. Sections 58 and 59 of the Offences Against the Person Act 1861 still stand. The Supreme Court judgment has not been legislated for although it is over 20 years since that judgment which itself is open to a degree of interpretation when it is not supported by legislation. Members should please be reassured that we are asking for legislation that is broad enough to allow us to do our job but we also want regulation and we want this whole process to be monitored. In the institute submission, which Members will hear later, and in all of our opinions we accept that we need broad legislation to allow us to do our job but that this should be regulated in the patients' interest so that society can be reassured that we act appropriately at all times and only to save a mother's life. It is a proviso of all the steps put forward that we would monitor terminations of pregnancy that might take place in this country in order to save a life so that we can be very clear that all decisions to do so are appropriate and accord with the wishes of our society which I believe is to preserve life. This is our purpose today, saving women's lives, not terminating pregnancy because that destroys babies.

In answer to the question about the ethos of the hospital, I assure the Deputy that we do not practise according to any philosophy, ideology or ethos. We practice according to clinical demand and the clinical situation. It is a science.

It is very difficult for us to assess the number of lives we might save in the scenario where we introduce termination of pregnancy. We believe we are saving lives. It is easy in an emergency situation where a woman is dying in front of us but in cases where the risk to life may be delayed, such as a woman with cancer or with a serious underlying medical disorder, it is my direct experience that these women travel quietly to other jurisdictions where they terminate their pregnancies. They are among the 4,000 women who travel from this jurisdiction to terminate their pregnancies for whatever reason. It is difficult for us to assess the negative impact of

not having a policy whereby we can terminate a pregnancy safely when the risk to life might be delayed. We as doctors need to be able to do that when it is necessary. We as doctors need to be able to do this when it is necessary. As I keep saying, I assure the committee these circumstances are extremely rare but they do exist. Doctors are simply looking for adequate protection to make proper clinical decisions to save mothers' lives and nothing else. This is a very narrow and confined context and I ask the committee to be very assured of this.

Dr. Mary McCaffrey: I wish to address the issue of the special circumstances and answer Deputy Mitchell O'Connor. My understanding of what the Medical Council stated this morning is that one does not need special procedures or a second opinion or signatory to carry out an emergency procedure. As Dr. Mahony stated, if someone is bleeding in front of one and her life is at risk, one gets on with it. Smaller hospitals are very different because we do not have a second on-call obstetrician. At this point in time, we do not even have a formalised process in place to allow me telephone a particular master to obtain a second opinion. People want the legislation to be couched and worded in such a way that we will be protected and we will not end up in prison because we did something as a result of which someone decides we should be reported to the Medical Council. This is a huge fear among people because obstetrics is an extremely emotive profession.

With regard to the ethos of hospitals, we practise with clinical guidelines from the Royal College of Obstetricians and Gynaecologists in London, the Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland and the HSE. People practise evidence-based medicine in the best interests of patients.

Dr. Sam Coulter Smith: I do not think I have anything new to add to what has already been said in answer to the questions. A substantial number of women travel to the UK for termination of pregnancy because of foetal anomalies. It is regrettable that this situation exists, but today's discussion is not on this area; perhaps it is a discussion for a different day. With regard to emergency interventions, we have the Medical Council guidelines but our concern is that the law as it stands says something different. We want a change in legislation to protect doctors in performing the life-saving tasks they must undertake. I entirely agree with what has been said already on the ethos of hospitals. We have evidence-based practice in this country and guidelines from our institute and from the royal college in London. I do not think this is a huge issue.

Deputy Denis Naughten: To return to the evidence of Dr. McCaffrey and the comment she has just made on medical emergencies, we questioned the Medical Council on this matter this morning and it is of the view there is no need for special procedures to be developed for emergency situations. However, this does not mean there is no need for a second signatory. The impression we clearly got from the Medical Council, and it was difficult to get a straight answer from the witnesses, was that there should be no differentiation between an emergency and non-emergency situation and the same procedure should apply to both. If a second signatory were required, how would it apply in an emergency situation in a small maternity unit?

Deputy Robert Dowds: I understand if the witnesses feel unable to answer the question I asked because it is more of a legal question than a medical one, but I would be grateful if they were willing to hazard an answer.

Deputy Caoimhghín Ó Caoláin: To follow up on the instances, excepting the statistics on a situation where a woman's life is at risk on medical grounds and the even rarer - we hope - situation where there is not only suicidal ideation but intent, will the witnesses clarify their view as to whether the rarity, particularly in the latter case, is a reason not to legislate and regulate?

My view would be that where there is the possibility presenting there is an onus and responsibility on us as legislators that we should do so.

Dr. McCaffrey highlighted the situation at the Coombe Women and Infants University Hospital and referred to a well-structured clinic dealing specifically with medical problems in pregnancy. Would she like to offer any other view? Does she commend this particular clinic for replication throughout the network of maternity sites?

Dr. Mary McCaffrey: I will deal with Deputy Ó Caoláin's question first because he has given me an innings to say what I really want. I commend the model. The report of the Centre for Maternal and Child Enquiries, CMACE, on maternal mortality makes a very clear point that there is a real need for a specialty referred to in the UK as obstetric physician. These are general physicians with an interest in pregnant women and their illnesses. There was also an article in *The Lancet* on this matter. This model of care is being rolled out in the UK, but apart from the Coombe there is no official structure here, although I am open to correction and may be corrected by my two colleagues for having said so. There is a need for this type of specialty and I hope legislators and health care providers will go down a road which minimises people facing similar situations to those they face now. I commend the model, and it is worth being examined by health care providers and legislators.

I am a little unclear about Deputy Naughten's question.

Deputy Denis Naughten: The Medical Council stated there should not be a differentiation in the legal framework regarding emergency and non-emergency terminations. How would a smaller unit which has only one consultant available out of hours deal with a requirement for a second sign-off in an emergency situation?

Dr. Mary McCaffrey: The Medical Council has its opinion, and I understand other presentations will be made which will put forward the view that a second signatory would not be required. The legislators and the Minister for Health will finally decide what we will have. If legislation and regulations are introduced which determine we need a second signatory then a process will have to be put in place for the smaller hospitals to allow this to happen. In my opinion it would be best provided through a panel of experts, a buddy system or peers whom we would be in a position to ring to obtain this second opinion. Systems such as e-mail or Skype could be used. It will have to be examined because women will continue to be delivered in smaller units and there is no reason why they cannot continue to do so.

Dr. Rhona Mahony: We must be pragmatic in an emergency and save the woman's life. If a woman is dying in front of me I will not wait for a second signature; I will save her life because that is my job. With regard to suicide, I do not believe we should dismiss suicide and the potential for a woman to take her life during pregnancy. To do so would be judgmental and would assume women will lie and fabricate suicide ideation, which offends me. It also assumes that psychiatrists in this country are unable to assess suicide ideation, which I believe not be the case. However, I contend that suicide ideation and the real risk that a woman would take her life during pregnancy is extraordinarily rare. It does exist, but it is extremely rare. It must not be confused with general issues surrounding mental health.

Dr. Sam Coulter Smith: I hope we have demonstrated this morning that there is a requirement for legislation in this area. Life-saving procedures do not occur often, but they do occur. We carry out procedures which require interruption of pregnancy and therefore we need legislation, regulation and protection for doctors with regard to these procedures. Maternal medicine

clinics exist in other hospitals and are a fantastic multi-disciplinary care set-up. They provide best practice care for our patients and ideally should be rolled out to every maternity unit.

Chairman: We will now move to questions from non-members of the Oireachtas Joint Committee on Health and Children. Senator Fidelma Healy Eames and Deputies Terence Flanagan, Billy Timmins, John O'Mahony and John Paul Phelan have indicated. The Senator has two minutes.

Senator Fidelma Healy Eames: I thank the witnesses for their clarity. Dr. Mahony referred to the legal uncertainty in the narrow, rare situations in which mothers' lives may be saved by terminations. We must frame legislation. What should be the parameters of this space, the narrow, rare situation that Dr. Mahony described, and how might we describe it in legislation in a way that would be helpful to medics?

Dr. Mahony stated that the mother's view mattered and should be taken into account in interpreting risk. These hearings will not hear from any mother who has been in this situation in Ireland or other jurisdictions and who had been advised to undergo an abortion. Should their views form part of these deliberations?

I was struck by Dr. Mahony's statement that her hospital never kills a foetus. Sometimes, babies in other countries are born alive after abortion procedures. What would be an appropriate response to this issue in the proposed legislation and is there a duty of care in such situations?

Dr. Coulter Smith mentioned that there had been six terminations to save women's lives within the past year. Senator Crown also mentioned this fact, but I am not clear on the answer. Is Dr. Coulter Smith aware of any instance in the Republic of medical treatment being withheld on the grounds of a lack of legal clarity? Is it possible that such an instance might not have been reported because of that lack?

Deputy Terence Flanagan: Has any of the masters present withheld treatment or refused medical intervention to save a mother's life on legal grounds? Is there any evidence of pregnant women in Irish hospitals not receiving appropriate medical care due to the current state of the law? Should everything possible be done to protect pregnant women from the threat of suicide without terminating their pregnancies?

My next question is a difficult one, but it is critical that we have all of the facts as legislators. Regarding a suicidal patient, what is the exact procedure for terminating her pregnancy? If she is 24 weeks pregnant, what procedure is used on the baby? Are there constraints on carrying out abortions in the later stages of pregnancy, that is, after 30 weeks, where a woman presents with a threat of suicide?

Dr. McCaffrey constantly referred to a patient, but does she not believe that there are two patients, namely, mother and baby?

Deputy Billy Timmins: Dr. Coulter Smith has mentioned that one in 500,000 pregnant women in Britain commit suicide. Does he have the statistic for the number of pregnant women who present with suicidal ideation in Britain? Does the one in 500,000 figure relate to recent years? How long has this statistic been in the public domain? It is difficult to obtain information in this regard.

I wish to raise two issues with Dr. Mahony. I noted in her speech that she welcomed the legislation and regulation, but will she clarify her mention of legal protection? Is this as opposed

to the clarity of procedure that she requires of the legislation? Can legislation and regulation provide greater clarity of procedure than the current Medical Council guidelines? Have those guidelines prevented her from saving a mother's life? If so, how? I noted that Dr. Mahony is a member of the executive of the Institute of Obstetricians and Gynaecologists. Has that institute sought a change to the guidelines in recent years?

Chairman: The witnesses will reply to those questions before we move on to the next three speakers, Deputies John O'Mahony and John Paul Phelan and Senator Jim Walsh. Senator Ivana Bacik and Deputy Peadar Tóibín will also contribute.

Dr. Rhona Mahony: I will address an important point raised by Deputy Terence Flanagan. We do not anticipate the termination of pregnancies at 24 weeks. Let us be clear. When there is an opportunity to save a baby's life, we will do so. Currently, the threshold of viability in Ireland is approximately 23 weeks of gestation, after which point one might reasonably expect a chance of survival. We will offer a baby every opportunity to survive, including neonatal intensive care. Please, let us not ever discuss the ridiculous concept of the termination of pregnancies at 24 or 30 weeks. We will deliver a baby at 30 weeks, at which point the baby has a good chance of survival. In fact, the baby has a more than 90% chance of survival at 30 weeks. Let us not confuse the issue.

I have not withheld treatment, but this does not mean that I feel legally protected in this country in delivering appropriate medical care in all cases. People ask me about the legal uncertainty. The Offences against the Person Act 1861 remains binding law in this country. The judgment in the X case allows for the termination of pregnancy in the circumstance of a real and substantial risk to life as distinct from the health of the mother. This includes the risk of suicide. However, this situation is not supported by legislation. I see no reason for not legislating for it.

I am not a lawyer, but we are seeking relatively broad legislation that will allow us to do our job. We favour broad legislation with regulation because it is possible that, as medical expertise improves and as medical science advances, we may need to fine-tune or change legislation and regulation. The 1861 Act must be addressed. As it makes the termination of a pregnancy a criminal office, a woman and her doctor can be committed to prison. Doctors deserve legal protection in carrying out their jobs.

Dr. Sam Coulter Smith: I am not aware of any situation in which the lack of legal clarity prevented appropriate care. It has certainly not occurred in our hospital and I am unaware of it occurring anywhere else. I have never withheld appropriate treatment from a patient when it was required.

All appropriate mental health supports need to be made available for women who are at risk of suicide, have threatened to commit suicide or have suicidal ideation. The committee can ask the psychiatrists, but most people would agree that the termination of pregnancy is not a treatment in this regard.

I do not have the figures for the UK or Ireland on the number of people with suicidal ideation. The figure of one suicide in 500,000 pregnancies in the UK comes from its most recent triennial report.

Dr. Mary McCaffrey: I have never withheld treatment because of the law and I am not aware of it occurring in my unit. I have never heard of it from a colleague. Women receive appropriate treatment.

I have exhausted my very limited expertise on suicide. The psychiatrists will probably enlighten the committee this afternoon.

I am sorry if I offended anyone by mentioning patients and not babies. The word "babies" arose regularly in my presentation. I loosely used the term "patient" to mean the person with the illness or condition, but I reassure the committee that I used the word "babies" in my presentation.

Deputy John O'Mahony: The witnesses mentioned that suicide is rarely used as a reason for termination. Do mental health issues arise for mothers who lose their babies? Are these cases also rare and how do they compare with the figures for mothers who want to terminate their pregnancies?

Deputy John Paul Phelan: My question has been asked.

Senator Jim Walsh: I will ask three brief questions. I thank the delegation for the clarity of its answers. My first question relates to the European Court of Human Rights decision in the C case. The evidence before that court was that the woman had been undergoing chemotherapy for cancer for three years, then went into remission and subsequently unintentionally became pregnant. What treatment would the witnesses have afforded the woman in the C case or any other woman who presented to them in similar circumstances?

My second question is directed to Dr. Mahony, who has been particularly strong on the need for legislation. Perhaps Dr. Mahony will explain how in her opinion legislation should be designed and what impact it might have on current medical practice or if amendment of current legislation underpinning current medical practice would be satisfactory? It would be helpful if Dr. Mahony could provide clinical examples in her response in this regard.

My final question relates to changes to the Offences Against the Person Act 1861. Do the witnesses believe any change to or repeal of that Act should also include a duty of care to the baby? Emphasis has been put on doctors deserving legal protection, with which I do not disagree. I believe everybody would also subscribe to the view that mothers should be protected. Should the baby be afforded some protection in law?

Senator Ivana Bacik: I thank the three witnesses for their strong presentations and for the clarity with which they have provided us, in particular on the issues of time limits and, as described by the European Court of Human Rights, the chilling effect of the 1861 Act and the lack of legal clarity upon current medical practice. Dr. Coulter Smith and Dr. Mahony testified to that.

I have a specific question in relation to the drafting of legislation in terms of the assessment of risk. Dr. Mahony stated that in an emergency one opinion should be sufficient, which as I understand it, is the view expressed at chapter 6.2 of the expert group report. However, in respect of a non-emergency situation, two opinions are expressed in the expert group report, namely, two obstetricians or one obstetrician and one doctor, and in the case of suicide risk, an obstetrician and a psychiatrist. While the group weighs up the advantages and disadvantages in this regard it is not quite clear from its report which option is best. It appears to me as though the group comes down on the side of an obstetrician plus one other and that this would be the normal process. I am interested in hearing the witnesses' view on that matter.

Deputy Peadar Tóibín: Most of the questions I wanted to ask have been already asked. Are the views expressed by the three representatives present today representative of their pro-

fessional colleagues or are there many differing views within that group?

Senator Fidelma Healy Eames: I have one question for Dr. McCaffrey. She referred to consultations with many of her colleagues around the country, who between them have approximately 280 years of experience and stated that in this regard she was unable to identify any consultant who had met a woman citing suicidal ideation as her reason for wanting to terminate her pregnancy. Given many of those consulted have also practised abroad, did Dr. McCaffrey establish if this had been their experience in other jurisdictions where abortion is legal?

Dr. Mary McCaffrey: That was their opinion having practised abroad. In all of their clinical experience and practise they had not met a woman citing suicidal intent or ideation purely because she was pregnant. That was the view of the 12 consultants involved.

With regard to the two signatories, nobody among the people to whom I have spoken believed it was appropriate for an obstetrician to have an opinion on suicide. The view is that obstetricians are not specialist trained in psychiatry and that that is the remit of psychiatrists. Nobody believed they would be comfortable making a diagnosis of suicide as an obstetrician.

Dr. Sam Coulter Smith: As regards mental health issues in pregnancy and following pregnancy, it was stated earlier that the incidence of mental health issues in pregnancy is approximately 10% to 15%. The risk of suicide in pregnancy is extraordinarily low. We all know that women can suffer from post-natal depression and that the risk of suicide remains following pregnancy. It is my belief that the risk of suicide can increase a little post natally. However, that is an issue which the committee can explore later in more detail with our psychiatric colleagues.

On the question in relation to a specific case of cancer, each case of cancer is dealt with on its own merits. Each person would have a particular set of circumstances, be it a person who has previously had cancer, gone into remission and later become pregnant. One must deal with each situation as it arises and provide the most appropriate treatment for the patient at that time.

In terms of the assessment of risk in the emergency and non-emergency situations, it is my understanding that the institute has suggested that there should be two obstetricians and one person of the appropriate specialty involved in the decision as to whether a patient requires to have a pregnancy interrupted. Where a mental health issue arises, such a person would be a psychiatrist and in a cardiac case it would be a team of cardiologists. The decision would involve input from obstetricians and the other specialty.

Dr. Rhona Mahony: Between 2009 and 2011 two women in this country took their own lives during pregnancy. We may never know and can probably truthfully never say whether in these cases termination of pregnancy would have saved those lives. We are, once again, never dealing with absolute certainties. However, as a doctor, I believe we cannot dismiss it. When a woman feels during pregnancy that she is going to take her own life she needs to be treated in totality. I am not for one minute suggesting that termination of pregnancy cures suicide ideation but it might just be appropriate in a tiny percentage of cases. Therefore, we must not dismiss it and must be guided by our expert colleagues in the area of psychiatry.

I agree with Dr. Coulter Smith's remarks in regard to cancer. There are many different types of cancer in respect of which the risks and chances of recurrence are different. Again, we must be guided by our oncology colleagues in this regard. On the issue of legislation, without harping on I still contend that abortion in this country is, under the Offences Against the Person Act 1861, a criminal offence. On regulation, I believe that there will always be, where the opportu-

nity presents, two obstetricians involved in any decision to terminate a pregnancy where there are direct obstetric complications. I agree with Dr. Coulter Smith and the institute that where additional expertise is required, for example, in areas of psychiatry or cardiology, then at least one other doctor who is on the specialist register and is an expert in that field should be involved in the decision-making process. I do not believe any doctor wants to make these decisions on his or her own. In terms of how we practise medicine, we seek as much appropriate opinion as we can and practise as a team. Working together as a team and seeking each others' opinion is not a new concept to doctors in this country. I believe it is absolutely right that where possible, these decisions are not made in isolation but by an appropriate team with the appropriate expertise.

We want to do our job and to be legally protected in doing so.

Senator Jim Walsh: Perhaps Dr. Mahony would respond to my questions.

Chairman: Senator Walsh please show respect and courtesy to the Chair and the witnesses and stand when speaking.

Senator Jim Walsh: I do not wish to delay the meeting but would welcome a response to the two specific questions which I put to Dr. Mahony, namely, what changes does she believe legislation should engender in current medical practice or should we legislate for any particular changes and, if the Offences Against the Persons Act is repealed should any new legislation provide for a duty of care for the unborn child?

Dr. Rhona Mahony: The Senator's questions would be best put to the legal teams who will address the committee tomorrow. In relation to protection of the unborn, Article 43.3.3°, when a woman dies before her baby is viable, her baby will die too so that the concept of equal right to life in that context becomes a contradiction. On legislation, we need to look at removing the criminality in this country surrounding termination of pregnancy, particularly when it pertains to saving women's lives. We need to be very clear that we can save women's lives without fear of being put in prison. This is not about legislating for broad termination of pregnancy across a broad degree of category, but about protecting doctors to save and protect women's lives.

Chairman: We have reached the end of the time allocated for this section. As the witnesses do not wish to make any final concluding statements, I thank the members and our witnesses, Dr. Rhona Mahony, Dr. Sam Coulter Smith and Dr. Mary McCaffrey, for attending the hearing. We will suspend the sitting until 2.45 p.m.

Sitting suspended at 1.40 p.m. and resumed at 2.45 p.m.

College of Psychiatry Ireland, Mater Misericordiae University Hospital and Tallaght Hospital

Chairman: I remind members of the committee, members of the media and witnesses that mobile telephones should be turned off for the duration of the meeting to facilitate the broadcasting of these proceedings.

This is the third session of a series of hearings the joint committee will conduct over the next three days to discuss the implementation of the Government decision following the publication

of the expert group report into matters relating to the A, B and C *v*. Ireland case. I welcome Dr. Anthony McCarthy, Dr. Joanne Fenton and Dr. John Sheehan, College of Psychiatry Ireland, Professor Patricia Casey from the department of adult psychiatry in UCD and the Mater Misericordiae University Hospital, and Professor Veronica O'Keane, department of psychiatry in Tallaght Hospital and Trinity College Dublin. Thank you for attending the meeting this afternoon.

Before commencing, I remind witnesses that they are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence in regard to a particular matter and they continue to do so, they are thereafter entitled only to a qualified privilege in respect of their evidence. Witnesses are directed that only evidence connected with the subject matter of these proceedings is to be given. Witnesses are further asked to respect the parliamentary practice to the effect that where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable.

Members of the committee are reminded of the long-standing parliamentary practice and rulings of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the House or an official by name or in such a way as to make him or her identifiable.

I invite Dr. McCarthy top make the opening presentation.

Dr. Anthony McCarthy: The college is very grateful for the invitation to make a presentation to the joint committee. Pregnancy and the post-partum period can be, and frequently are, particularly challenging times for the mental health of women. The assessment and appropriate treatment of mental health problems during these times are extremely important.

Chairman: Perhaps Dr. McCarthy would keep the paper away from the microphone. It is difficult to get this right.

Dr. Anthony McCarthy: I am used to teething problems when working with babies in a maternity hospital.

Chairman: You are in a good place here in the Seanad Chamber, because there are probably a couple of babies here too, although perhaps I should not say that. I am only joking.

Dr. Anthony McCarthy: Unwanted pregnancies are particularly likely to be associated with considerable distress and mental health difficulties for the mother, and developmental difficulties for the child. Any woman who has such difficulties deserves compassionate professional help.

We are aware that abortion is a difficult and painful issue, not just for individuals but for the country as a whole. It is a highly divisive issue and our college is no different from other groups in society in having members with differing and opposing views on the subject. We are aware that these hearings are about the implementation of the Government decision and we will be confining ourselves to commenting on the clinical issues and organisational aspects and challenges of this potential implementation. We do not wish to add to the conflict and distress by commenting on the wider issues so passionately being debated in society.

We are also very aware that women who come to our clinics in the three Dublin maternity hospitals will themselves have widely differing views on their pregnancies and we wish to be able to provide assessments and treatments in a non-judgmental way to these women. For ex-

ample, one pregnant woman referred to a clinic may have had two previous terminations but will say that for her they were pregnancies, not babies. Another may have had a miscarriage very early in pregnancy and technically the pregnancy may be diagnosed as an empty sac with almost no foetal material but for her she was a mother, at least for a few weeks. These differences must be understood and respected by any psychiatrist assessing women in pregnancy.

The three of us who work as perinatal psychiatrists have considerable experience of assessing women with mental health difficulties in pregnancy. The fact that no maternity unit outside Dublin has dedicated perinatal psychiatry specialists is a major cause of disappointment to the college. This means that outside these three hospitals, there is no routine assessment of or screening for major mental health problems in pregnant women at a time of markedly increased risk and at a time when appropriate advice and intervention can have such vital benefits not only for the mother herself but for her bond with her new baby, whose long term development depends so much on her well-being.

The college was invited to send an additional nominee and we invited Dr. Maeve Doyle, who is a child and adolescent psychiatrist and chair of the child and adolescent faculty of our college, and is here to address any questions about children that are a regular issue for us.

The Supreme Court specifically recognised the risk of suicide as a legitimate basis for permitting termination of pregnancy where there is a real and substantial risk to the life of the mother which can only be removed by terminating the pregnancy. We understand that we have been invited here to provide expert psychiatric input into the complex issue of suicide and termination.

Suicide is rare in pregnancy, but it does happen and is a risk we always have to consider. Some figures help give a perspective on the rarity of suicide in pregnancy. In Britain, from 2006 to 2008, there were four suicides in pregnancy among more than 2 million live births, giving a rate of 0.2 per 100,000, or one in every half million births. Suicide rates are lower in pregnant women than in non-pregnant women. International studies suggest that the suicide rate in pregnancy is from a third to a sixth of the expected rate in non-pregnant women, indicating that frequently pregnancy confers a protective effect against suicide.

We are, however, always conscious of the need to be aware of, but also wary of, statistics with regard to suicide in pregnancy or the long-term effects of unwanted pregnancy, or termination of pregnancy, on mental health when dealing with any of our patients. We see real women, each of whom is an individual and must be treated as such and not as a statistic. In addition, research shows that there are differences between cultures and differences between countries where abortion is freely available and those where it is illegal.

Suicidal ideation in pregnancy is much more common than completed suicide. It is a complex issue but much of the public debate about the issue of suicide and its risk in pregnancy has, in our view, been simplistic, sometimes harsh and judgmental, frequently uninformed or misinformed, and contrasts markedly with the way suicide and its risk is usually discussed in other circumstances, particularly in light of recent discussions on cyberbullying and suicide, in which great sympathy has been shown, compared to the way some pregnant women have been pejoratively commented upon. We find that horrifying.

Although it would be impossible to discuss the issue of suicidal risk in all its complexity in a forum such as this, or in a brief submission, an introduction to some of the key concepts is important here to help inform the discussion so the language can be understood. So often suicide

is talked about as a threat, and no more than that. There are very significant differences between suicidal ideation and suicidal intent and plans. Suicidal ideation means that the person has ideas in their mind about ending her life. These may be just occasional thoughts, very frequent thoughts or constant thoughts. As psychiatrists we are used to making these differentiations. The woman may be relatively unconcerned about them because she knows that she would never act on them and has had them regularly before. Alternatively, she may be very upset and worried by them. She may be terrified by them, or feel haunted by them. Sometimes, a woman may be ambivalent, oscillating between having suicidal thoughts and rejecting such thoughts. Her mental state may fluctuate considerably. Frequently, but unfortunately not always, she will seek help because she is so worried or upset by them, and she does not actually want to die but she cannot stop thinking about suicide. We know there is a risk that she may eventually feel driven to it and she certainly needs to be heard, believed, and helped.

Some women report a passive death wish. They do not have suicidal thoughts but indicate that they wish they were dead. Others indicate a desire to harm themselves but again deny any thoughts of actually ending their lives. I am going into this detail because there is almost a notion that psychiatrists say "suicide" and tick a box. I want to provide some sense of the complexity of the issues and our ability to makes these differentiations.

Suicidal intent is different. Here the person has an intention or plan to kill herself; it is no longer just an idea. She may or may not seek help or inform anyone about it. If she does, she may have little faith that she can be helped - it may be a last resort - and here, sensitive and skilled professional assessment is vital. The intention may be immediate or impulsive, or a more long-term plan sometimes contingent on a particular event or happening. Suicidal ideation may or may not be associated with mental illness. Completed suicide is typically associated with major depression, bipolar affective disorder, schizophrenia arid alcohol dependence syndrome, but not exclusively so.

The term "threatening suicide" is often used loosely to describe both suicidal ideation and suicidal intention. It may apply to either, but psychiatrists use this term to describe the way ideation or intention is communicated rather than as a separate category in itself.

Psychiatrists are specially trained to assess the risk of suicide and to treat patients who are suicidal so as to minimise that risk. We are trained to assess whether patients have suicidal ideation or intention or both, to diagnose whether the person is suffering from a mental illness, and to make or recommend appropriate therapeutic interventions and plans.

Of course we cannot eliminate all risk, as we cannot foretell the future. However, despite comprehensive assessment, suicide is difficult to predict and absolute predictive power is extremely limited. There will always be both false negatives and false positives. Some people who will appear to have a low risk of suicide or deny such a risk will go on to kill themselves, while others who may appear to have a high risk will not complete suicide. Psychiatrists are best placed to make such assessments and decisions and do so on an everyday basis as part of their work.

There has been some well-publicised comment that psychiatrists will be manipulated by women threatening suicide. All psychiatrists are very familiar with a small but real group of people who will attempt to manipulate us. This may happen in many different situations in which we work. For example, an addict may threaten to kill himself unless we prescribe the methadone that he alleges was stolen from him, while another might threaten to kill himself unless we admit him to hospital. Others try to convince us that they are mentally ill and suicidal

when actually they may be trying to avoid a court hearing. The vast majority of people who present to us for help, however, are very genuinely distressed or depressed, are seeking help and need appropriate compassionate and skilled professional help. Women in pregnancy are no different in that regard.

The issue that psychiatrists will be asked to address if the legislation is implemented has two elements. The first is whether there is a real and substantial risk to the mother's life because of suicidal ideation or intent, which I have just covered. The second element, and one that only a small number of psychiatrists in Ireland have been presented with, is whether that risk can only be removed by terminating the pregnancy.

As perinatal psychiatrists working in maternity hospitals with over 40 years' experience between us, we have seen many women who are depressed or distressed and have suicidal ideation and sometimes intent in pregnancy. We have seen women who have harmed themselves in pregnancy, sometimes seriously, some of whom have tried to kill themselves, their babies or sometimes both. We regularly see women who have had terminations of pregnancy and describe many different reasons for this, including depression and other mental health issues. However, we have not had the experience of seeing any women who were suicidal where the appropriate treatment for their suicidal feelings would have been a termination of pregnancy. We also see many women with unplanned or unwanted pregnancies for whom termination is not a choice they would ever consider. We know that huge numbers of Irish women go to Britain in these situations.

There was no psychiatric input to inform the Supreme Court decision in the X case. However, given that the decision to legislate and regulate has now been taken, it is the State's intention to introduce accessible, effective and timely procedures so that women in these situations can be appropriately assessed. Clearly if very many of these women were to present to psychiatric services now who did not present before, this would be a considerable extra burden on already over-stretched services. However, we are not expecting a significant number of women to come to us because they will continue to go to the United Kingdom.

Particular consideration will need to be given to the challenges that could be faced in assessing pregnant girls who would need to be assessed by child and adolescent psychiatrists, and in assessing women with significant learning disabilities or those who may not have mental capacity. An assessment of capacity would be required, given the level of emotional distress and the possibility of mental illness being present. It must be remembered that any woman who is mentally distressed or depressed in pregnancy and who has suicidal intent or ideation requires sensitive, compassionate, skilled and non-judgmental assessment. In most circumstances they may need urgent care and treatment. If the woman is profoundly depressed and mentally ill, she would be advised not to take any major life decision at that time, and frequently admission to hospital might be advised. Ongoing review and monitoring would typically be required.

A psychiatrist should have the right to conscientious objection and of course in this area we would follow the very helpful Medical Council ethical guidelines. However, we then respect that all psychiatrists would still be responsible for ensuring appropriate and timely transfer of that patient to another psychiatrist.

We are very grateful for this invitation. We hope our submission is helpful and we will be happy to answer any questions.

Chairman: I thank Dr. McCarthy. I welcome Dr. Maeve Doyle to the meeting. It is now

my pleasure to call on Professor Patricia Casey to make her submission.

Professor Patricia Casey: I will be reading, but not verbatim, from this paper which I have submitted to the committee secretariat.

Chairman: Professor Casey has ten minutes.

Professor Patricia Casey: I thank the Chairman and members of the committee for inviting me to address this meeting on the expert group report on the A, B and C *v.* Ireland case. The committee secretariat should have my biographical details and if the Chairman wishes, I can provide him with my current CV. I have also all the scientific papers that I cited in my longer submission should he need them.

I wish to make two major points. First, suicide in pregnancy is very rare and when it occurs it is associated with mental illness. Mental illness in pregnant women can be treated and should be treated in the same way as it is in any other person in the population. The second point I want to make is that there is no evidence that abortion reduces suicide risk in pregnant women, and there is some evidence that it may have a negative effect in some instances.

Suicide in pregnancy is rare but it does occur. Dr. McCarthy has made most of these points already. A common theme running through much of the research in this area is that suicide during pregnancy is lower than at any other time in a woman's life. There is some protection for women during pregnancy apart from a small group who have major mental illness and who are at risk during pregnancy. It is important that we understand the rarity of suicide in pregnancy because there is an impression out there that many women in Ireland are dying by suicide because we do not have appropriate legislation to govern it. That is not the case.

Let us look at the figures to put the matter into context. The national suicide rate in women has been static for decades. The rate has been unchanged for four to five decades. In 2011, 100 women died by suicide. How does that compare with the figure for the number of women who die in pregnancy? A review of the three maternity hospitals in Dublin over a 21 year period found that there were no deaths during pregnancy that involved the delivery of more than 680,000 live births There were no deaths during pregnancy during that 21 year period. Turning to the British figures, the Centre for Maternal and Child Enquiries, CMACE, is the British organisation for examining mortality. We have recently aligned ourselves and become involved with that. Again, the British figures, to which Dr. McCarthy alluded, identified four deaths by suicide in a three year period. That is roughly one per 500,000 maternities. Of those, all had major mental illness. The report found that 69% had sub-optimal care. They were not diagnosed as having mental illness, they were given the incorrect treatment or treatment was stopped. There were problems of that sort with them. The Irish equivalent of that body has identified two deaths by suicide in Ireland in its draft report. It probably will not be published for a few years. We do not have any further information other than there were two suicides.

This information confirms that suicide in pregnancy is rare and that it is related to significant mental illness. The authors of this study also emphasise the critical importance of identifying and treating mental illness in pregnancy adequately. The report also sadly found that four women died during pregnancy in Britain. That is in a country in which abortion is readily available. These deaths had nothing to do with the non-availability of abortion but rather to do with the inadequate treatment of mental illness.

An issue related to abortion and suicide is our ability to predict suicide. We are not good

at predicting suicide. That is not because we are incompetent but because it is inherent in suicide that it is very difficult to predict. It consists of behaviour that is often unpredictable and somebody might be suicidal one day and a few days later be perfectly well. Other things might happen in their lives to remove the suicide risk or introduce new suicide risk. We are not good at predicting suicide. There are numerous studies suggesting and showing that, in fact, we are wrong more often we are right. In a hundred cases of people who would be predicted as dying by suicide, only three will actually die by suicide, according to some of the studies.

A woman who is pregnant and suicidal, as Dr. McCarthy states, needs proper treatment. In my clinical practice, as I am sure every other psychiatrist in the country does, if somebody is suicidal and at immediate risk, we admit them to hospital. We carry out a full assessment of them as well as getting background information from family members and their GPs. We arrive at a diagnosis and a plan of treatment. That can take time.

In my work as a psychiatrist, I run the attempted suicide service in the Mater Hospital in which we see and assess more than 400 attempted suicides in women per year. I have never seen a pregnant woman who was suicidal for whom an abortion was the only answer. I have seen pregnant suicidal women who needed admission to hospital, who were very ill and who needed treatment. I have seen pregnant suicidal women who have taken overdoses and asked for an abortion, but having spent time with them and conducted a full assessment and talked to them, in the two instances I am referring to, both women were being coerced by family and partners. The reason for the overdose was not because they wanted an abortion, even though on the surface that is what they said, but because they wanted to escape the incessant pressure that was being placed on them to make a decision to have an abortion. With support, they ultimately decided against the abortion and, I understand, gave birth.

That brings us to the next question. Is abortion an actual proven treatment for women who are suicidal? There is no evidence that abortion is a treatment that helps women's mental health or prevents suicide in pregnant women. This was recently investigated by a very large-scale study carried out by the medical royal colleges, headed by the Royal College of Psychiatrists in London. This examined all of the quality studies that were published in peer reviewed papers to ascertain whether abortion harmed women's health or helped their mental health during pregnancy. The outcome was the same: whether women with unwanted pregnancies gave birth or had abortions, it made no difference to their mental health. They identified one crucial element in a sub-group of people for whom abortion caused mental health problems. They were people who had prior mental health problems. Those whom one would think might benefit from an abortion were actually those most at risk of problems.

To summarise, suicide in pregnancy is rare. On the basis of the studies that have been done, there is no evidence that abortion helps women's mental health. Twenty years have passed since the X case decision. We now have much more information about the impact of abortion on women's mental health, including the possible harms associated with it. In essence, X case legislation would expect doctors to recommend an intervention - an abortion - that has not been shown to be of benefit to mental health in order to prevent a rare outcome - suicide - that cannot be predicted. In my view, legislation for the X case that includes suicide risk is not supported by any scientific evidence. The two tests envisaged in the X case - that suicide will occur, on the balance of probability, and can only be averted by abortion - cannot be met. In my opinion, suicide risk as a ground for abortion should be excluded from the X case legislation.

Professor Veronica O'Keane: I am grateful to the committee for inviting me to give this presentation today. I am a clinical psychiatrist at Tallaght Hospital in Dublin and a professor

of psychiatry at Trinity College. I led a national perinatal psychiatry service in the UK for five years. I have expertise in perinatal psychiatry and general adult psychiatry. I set up the psychiatric service in Beaumont Hospital. I have a great deal of experience of managing people with deliberate self-harm and organising services. I am here today to avail of this fantastic opportunity to explain my experiences with women who are suicidal and pregnant to the legislators of this country.

I will speak about the recommendations in the expert group report that relate to legislation and regulation for mental health grounds. It is important to say that the expert group report refers to mental health grounds, rather than just to suicide. That is slightly wider than the discussion that has taken place. There are two main areas of interest in this regard, namely, serious mental illness, which Professor Casey and Dr. McCarthy have spoken about at length, and unwanted pregnancies leading to suicidal ideation or suicidal intent. The first area - serious mental illness - has been covered by my two colleagues. It basically involves the management and care of women with pre-existing mental health problems. I refer to serious mental health problems like schizophrenia, bad bipolar disorder or severe and recurring depression. These women can become suicidal when they are depressed because of the mental illness, or sometimes because the biology of their pregnancies affects their brain function. In some rare cases, these women can become suicidal because they have unwanted pregnancies. When I worked in the UK, we managed each woman individually according to her particular problem.

I would completely agree with the evidence given by the other witnesses that the best way to manage and help women with serious mental illness is to treat the mental illness. When that has been done, these women usually go on to have babies. Unfortunately, not every pregnant woman with serious mental illness wants to continue with her pregnancy. This is as true of women who have serious mental illness as it is of women who do not have serious mental illness. Some women feel they cannot cope with the pregnancy. This is particularly true of women with serious mental illness who have had previous children taken off them and brought into care. When I worked in the UK, I dealt with a woman who had four previous pregnancies - the baby in each case had been taken into care - and was pregnant with her fifth child.

While there are rare cases of people with serious mental illness not wanting to proceed with their pregnancies, as I have outlined, cases of unwanted pregnancy and suicidality are much more common. Some women become suicidal because they cannot cope with the prospect of an unwanted pregnancy and unwanted parenthood. A person who experienced childhood abuse, particularly childhood sexual abuse, and then had an unwanted pregnancy during adolescence or early adulthood can feel unprepared and unable to parent a child. Perhaps she did not receive adequate parenting from her own parents. She might feel that she cannot give the child up for adoption because if she were to do so, she would be abandoning the child in the same way that she was abandoned when she was young. It is also quite common for serious suicidal ideation to be associated with unwanted pregnancies in cases of young adolescent girls who became pregnant while intoxicated. The culture of drugs and drink among our youth is a public health problem. I have seen very young women in my clinical practice who became pregnant - they were raped, by definition - without being aware of the circumstances in which they conceived. These girls, who are just emerging from the protection of childhood, are always terribly ashamed. They are sometimes absolutely preoccupied with ideas of self-loathing and are actively suicidal. It seems to me that the girls in these cases are often taken by their parents to London and other parts of the UK and Europe to avail of abortion services. Thus, they are no longer suicidal.

People are being presented with a scenario whereby the experts are saying that suicidality does not occur, or that abortion is never an answer or the only answer in a situation where a woman is suicidal and pregnant. That is because the experts in this area only see very rarefied cases. They only see cases of serious mental illness. If a woman or young girl is suicidal because of an unwanted pregnancy, the last place she will go is an obstetric unit. She will not check in there and say "I am pregnant". She will go to her GP. She will certainly not attend a perinatal psychiatrist because she will not have been to the obstetric services. She will go to her GP. If one studies the GP literature - Dr. Mark Murphy recently presented a study in this regard - one will see that the bulk of pregnant patients are seen by GPs. Some 97% of GPs have had consultations with patients in relation to unwanted pregnancies. That is why the discrepancy between the evidence that has been given here and what actually happens in real life exists.

I wish to discuss the recommendations of the special group with regard to the establishment of the criteria to be used when determining the risk to the life of the mother. It is important to note that the report states that "it is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate" but that the risk should be established "as a matter of probability". Dr. Anthony McCarthy addressed this point when he said that risk management is the bread and butter of psychiatry. It is central to our clinical practice. It is what we do every day. We work within the Mental Health Act, which obliges us as a legal process to assess a person's risk and to comment on their risk to themselves and to others. This is something we do all the time within legal frameworks. Written risk assessments are also done on voluntary patients who come into our hospitals. Most people in Ireland who die by suicide do not see psychiatrists. Those who see psychiatrists are managed quite well and get a fairly good deal in general. As Professor Casey said, just three of every 100 patients who attend psychiatrists and are predicted to be at risk of suicide will actually go on to commit suicide. They are managed by the service. The whole thrust of the national suicide prevention programme that the HSE is rolling out now involves getting people into psychiatric services so that risk can be managed.

It is a matter for the legal profession and for the legislators here to talk about how they might proceed to enact the legislation and the regulations. My position is that the recommendations which have been given to us in the expert group report are excellent. Psychiatrists can act in an advisory capacity in terms of helping to form the legislation and regulations and we can help to fine-tune it afterwards in the same way that we have worked with the Mental Health Act in the past ten years since its introduction in 2002.

My final point relates to the debate about whether we should legislate rather than the subject matter of the hearings. Some 130,000 Irish women have had abortions since 1983. This amounts to 5,000 per year or approximately 14 per day. What would happen if abortion services that are available in the United Kingdom and Europe were not available to Irish women today? Inevitably what happens when there are no abortion services available is that death and injury ensue; injury and death to women and death to babies. Unfortunately, in countries where abortion services are not available this is what happens. We must remember why we are here today: we are here because of the X case. The X case is the most obvious evidence of a risk of suicide that can be real and substantial and can only be averted by an abortion.

Chairman: There are 60 minutes for members for questions and answers. I call Deputy Billy Kelleher.

Deputy Billy Kelleher: I welcome the witnesses. In the context of the differing positions presented to us we will need to try to elucidate and get some further clarity. Professor O'Keane

highlighted the issue that 130,000 women have travelled abroad to the United Kingdom since 1983 for terminations. Professor Casey said that suicidality, suicide ideation and suicide are reasonably rare and that suicide in particular is very rare among pregnant women. Is there is a cohort of women who are in crisis pregnancies, who go abroad and who could be at great risk, but who are not being taken into account in the figures and statistics? This is critical question for the committee. Of the women who travel abroad, is there a higher percentage who go there because it is a crisis pregnancy or an unwanted pregnancy or for whatever reason, but who go abroad for a termination? In the event of such people being unable to terminate a pregnancy, is there a potential for self-harm and suicide? This issue is of critical importance to the committee in its deliberations and determinations. We need to get clarity on this issue.

An issue has been highlighted with regard to the ability of psychiatrists to assess suicide in its varying degrees, from ideation to intent to actual suicide. Do psychiatrists have the clinical ability to differentiate in most cases between the various forms or threats to the life of a woman? This is something we are also keen to get clarity on.

The two key issues I have highlighted are critical. There are varying views on these, even among the cohort here today. If that is the case, then what form of assessment is there? Are various assessments being carried out by psychiatrists in different hospitals? Are there set criteria or guidelines? When a psychiatrist comes out of college after studying psychiatry for a given number of years, what criteria are used in terms of assessing suicide ideation, suicidal intent and suicide itself? If there are varying views and assessments, then we will have a difficult task ahead of us as legislators in trying to address this particular issue.

I want absolute clarity before I leave this place today with regard to the 130,000 women who have gone to the United Kingdom for terminations. Is there a chance or probability that a higher percentage of these women, because they have found themselves in crisis pregnancies, would have suicidal tendencies and potentially carry out the act of suicide?

Deputy Caoimhghín Ó Caoláin: I welcome each of the panellists. I note that they have all emphasised, as have others who appeared before us this morning, that the risk to the life of the pregnant woman through suicidal intent is noted only in rare instances to their knowledge. I hope it is as rare as the panellists suggest, but I must pose this question to each of them in turn: is this a reason not to legislate and regulate for the rare situations which may present and which, they have all accepted at least, can occur? I call on each of the panellists who have contributed and the others among them to answer that question. I emphasise that we in this committee are only conduits. We are not determinants in this particular situation. The information is for the benefit of those whose responsibility it is to draft legislation and regulations.

I will make only two final points because we have little time, unfortunately. There was much emphasis placed on the fact that there are only three perinatal psychiatrists in the jurisdiction. We are delighted to have all of them before us this afternoon. However, Professor O'Keane is not one of them, yet, as she has quite rightly stated, she has perinatal psychiatric expertise. I posed this question already to the Medical Council representatives this morning. Where are we short in terms of the necessary professional cover to effectively provide the necessary supports for pregnant women when issues relating to mental health, and the more serious situations that might present relating to either suicide ideation or suicidal intent, arise?

I have one final question. I am a little concerned with regard to the remarks on the suicide ground for abortion being open to abuse. I have read Professor Casey's submission and listened carefully to what she has said. This is not what she stated but it is almost a suggested subtext

and I put the question to her and I hope she will take it respectfully, please. There is a suggestion that professional colleagues of Professor Casey would be complicit in such abuse. How would she answer that? That is how I read what she is suggesting, that is, if this particular aspect was opened up in terms of suicide grounds, then it would be open to abuse. Ultimately, the decision must be made by the medical practitioners and in this instance in respect of suicidal intent the decision would have to be made by psychiatrists first and foremost.

Deputy Seamus Healy: I thank the witnesses for their submissions. I will be brief. I gather from what we have heard this afternoon and this morning suicide in pregnancy is rare indeed. There is a suggestion - it has been made regularly - that legislating for suicide in this area would open the floodgates on the basis of mental health. I call on our witnesses to address that subject and the related issues. Deputy Ó Caoláin raised this issue as well or he referred to it indirectly. I am referring to the question of whether the suggestion is being made that women may manipulate their doctors in this area. I call on the witnesses to address this point.

There are only three perinatal psychiatrists in the country. What effect does this have on the assessment process? How do our witnesses envisage that assessment process taking place? Will there be a need for additional resources in this area to deal with it?

Deputy Ciara Conway: I thank the witnesses for the presentations. Before lunch we heard from the masters of the maternity hospitals. They said clearly that abortion is not a treatment for suicide or suicidal ideation and I do not believe anyone is espousing that it is. However, I contest the message that has been portrayed somehow to the effect that women who are in a crisis situation of mental health or a crisis pregnancy would somehow be able to dupe professionals into giving them an abortion. I take offence on behalf of women and of professionals at the suggestion that they would be duped by women who are in crisis. That needs to be to the fore in our minds as we contemplate and reflect on what is going on today.

Professor O'Keane made the worthwhile and timely point that these women often will not end up in maternity hospitals or departments of psychiatry but will arrive in their local general practitioner's surgery, or in a surgery up the road, for fear of the negative stigma of having the feeling of suicide ideation and of inquiring about access to abortion services. What do professional psychiatrists say we, as legislators, need to do to inform and instruct general practitioners who are at the coalface, and who are not represented in these hearings? They are the people whom women in crisis pregnancy will be faced with to make hard decisions and get information. The information women receive at that point will be instrumental in their outcome. That is important.

It has been said that one woman in 500,000 may die from suicide in pregnancy. The fact that the numbers are so few is not a reason not to legislate. One suicide is one too many. What if that one person was one's mother, sister, aunt or daughter?

There has been some discussion about getting a second opinion when someone presents. Dr. McCarthy said there is division within the College of Psychiatry on this issue. How many psychiatrists would we need to make a decision such as this? This morning, we heard from the masters of the maternity hospitals that if a patient had an underlying cardiology issue they would consult a cardiologist and for a mental health issue they would consult a psychiatrist. Given the division in the college, what would the psychiatrists consider the most effective number of opinions to make that decision?

Dr. Anthony McCarthy: Are women with high risk pregnancies going abroad? Without

seeing the 130,000 women and assessing them, we cannot say definitively. However, what is our impression? We regularly see women in pregnancy who report to us that they have had previous terminations. The reason is often that they were very depressed or suicidal, and did not want the pregnancy because they were worried about their mental health. The rates of suicide and infanticide for countries where abortion is illegal and not available to mothers are much higher than in countries where abortion is available. In Ireland, for example, between 1900 and 1950, 10% of women of child bearing age who committed suicide were pregnant at the time of the suicide. Nowadays, it is 2%. Whether that is due to contraception or abortion we do not know. Certainly, the rates have gone down in that time.

The statistics for infanticide before 1900 are appalling. Dr. Elaine Farrell's study in Queens University Belfast suggests 4,960 cases of infanticide between 1850 and 1900. Dr. Clíona Rattigan's painful book on infanticide and pregnancy in Ireland *What Else Could I Do* reveals epidemics of infanticide and suicide between 1900 and 1950. These studies suggest there was a huge problem and that it has been reduced, possibly by socioeconomic factors - women are not so poor - and possibly by contraception. I have no doubt, however, that many women are going to England for terminations of pregnancy. That is the direct answer to Deputy Conway's question.

Do we have the ability to differentiate risk of suicide? I tried to say we have huge skills. We are trained all the time to do risk assessments. Do we always get it right? No. Do we get it wrong sometimes? Of course. Are we trained at doing risk assessment? Yes. Do we come up with effective treatment plans all the time or most of the time? Yes. Of course we sometimes get it wrong. We all do the same training but we must make decisions, like the decisions clinicians in Holles Street make about when to induce labour or when to do a caesarian section. Medicine involves subjective decision making on the basis of some objective facts. We have much objective training but there will be differences because of subjective elements. That is human nature. That is life and we have to deal with it.

If suicide is so rare can we not legislate? That is an issue for the Legislature. These things happen. They are rare. The Legislature is dealing with the issue. If it does not deal with it my obstetric colleagues feel very exposed. The 1861 Act is still there. The Legislature has to make up its mind about that. We are clinicians and not legislators. We can, obviously, be in difficult clinical situations.

Yes, we are short of perinatal psychiatrists. Do we need more? Yes. As Professor O'Keane said, women who are pregnant will present to their GP and not to a psychiatrist. They may go to a positive options group or a well woman clinic where they will be assessed. If they are depressed and distressed they may be suicidal but there is no question of them even thinking of an abortion. They may be referred to a local psychiatrist and treated in that way. A very small group, in my view, will be depressed, distressed, want an abortion and be prepared to access a process. If a woman feels she has to go through a process of two psychiatrists and an obstetrician and possibly face an appeal and legal issues, she is not going to come near us. That is not going to change, particularly. I do not see this epidemic coming our way because the legislation, in looking at the life of the mother in this way, is so narrow.

Will legislation open floodgates? Because it is so narrow, I cannot see that happening. I am not a predictor of social trends and with society changing other things may happen. At present, however, I cannot see floodgates opening.

The final question was about women duping psychiatrists. I referred in my submission to

the appalling abuse of women and the suggestion that they are all manipulators. That is dreadful. The fact that we, in addition, are supposed to be naive and easily duped is another matter. I do not take so much offence at that. The women we see should be taking offence and not us. We can deal with it.

Professor Patricia Casey: Deputy Kelleher asked if we know how many women are going to Britain for abortion and might be suicidal. We do not. The British statistics do not record the reason for women having abortions, except in very broad terms such as mental health, physical health and so on. I have seen women who have been to Britain for abortions. They say they did not want to be pregnant but when I ask if they were given any treatment, help or advice they say they were not. That is crucial. We do not know if these women are going to Britain because they are not being given alternatives to abortion. If they are depressed do they see general practitioners or people who can treat them? That is the problem. We do not have any concrete facts on which to base decisions. Is there a potential for self-harm and suicide among women who go to Britain? We do not know because we do not have the statistics.

Can we, clinically, differentiate between suicidal ideation, suicide intent, passive death wishes and active death wishes? The answer is, "Yes". We have a difficulty, however, in identifying which individuals, of the people we are seeing, will go on to take their lives. I can know how a patient is, in the here and now, but I cannot tell if a certain lady will, in two months, six months or ten months, have died by suicide because she is now depressed. All the studies suggest that we cannot answer that question. Studies have been conducted on people who are attending psychiatrists. When psychiatrists have been asked to predict which patient would die by suicide we have not been able to do that. Deputy Ó Caoláin asked if this is rare and whether this is a reason not to legislate. Legislation must always be based on good medicine and on fact. There are many assumptions in these questions that if a woman is suicidal in pregnancy an abortion is the only thing that will help and there is no other alternative. That is a chain that does not necessarily flow. It is a linear chain which assumes that a woman who is suicidal needs an abortion and that the abortion will be helpful. An abortion may harm people and there is no way of knowing. The balance of evidence is that abortion either has a neutral effect or it can have a negative effect in some cases. There are too many unknowns there to suggest that this kind of legislation would be based on anything scientific or evidence-based.

I agree there is no doubt that we are short of perinatal psychiatrists. However, psychiatrists around the country see suicidal people every day. They carry out suicide risk assessments throughout the country, from Kerry to Donegal and from Drogheda over to Galway. These can be done on anyone who is suicidal. We need more perinatal psychiatrists for difficult cases.

Deputy Ó Caoláin referred to the possibility of abuse which I have mentioned in my report. The reason I raised the question whether the suicide ground for abortion would be open to abuse is because it is a valid question. Lots of people are asking it. I am not answering it here but I am giving the committee some information that may assist. I refer to a comment from the British Pregnancy Advisory Service published in its May 2012 edition. It is the biggest provider of abortion services in the UK. The agency stated: "It is not the case that the majority of women seeking abortions under ground C are necessarily at risk of damaging their health if they continue the pregnancy but it is significant that because of the law, women and their doctors have to indicate that this is the case".

These are valid issues to raise when discussing such a serious matter. On the question as to whether legislation will open the floodgates, it may not open the floodgates immediately but there will certainly be widespread abortion within a short period of time. I think what will hap-

pen is that even though Dr. McCarthy does not believe that people will come near a psychiatrist, what will happen is that GPs, in good faith, will send women who are pregnant to the doctors to be assessed to see if they come within the X criteria. The system will be described as cumbersome and in due course it will be dismantled. I think there will be a gradual opening up - as has happened in every other country. We are no different from any other country in the world. On the question whether women may manipulate, I do not believe that women will manipulate. I believe that in every situation we have to take a complete history and reach our diagnosis based on the totality of the information.

Both Deputy Conway and Professor O'Keane stated that women will not go to maternity hospitals. It is surprising that women who are currently suicidal do not even come to the psychiatric outpatient clinics or to the self-harm services, such as the ones I run. General practitioners send people with suicidal thoughts and suicidal plans to those services for assessment all the time. We are not seeing the women. I recently saw two women who had overdosed and both of them wanted abortions but that was because they were being coerced. However, we are not seeing many of these women at all.

Professor Veronica O'Keane: I will not repeat what my colleagues have said. However, I wish to make two points in response to the questions that have been asked. I refer to Deputy Kelleher's question about the 130,000 women who have gone to the UK and the percentage of that number who may have been suicidal. This can be answered by inference, although not directly, from looking at the reasons women have abortions in other jurisdictions where it is legal and available. Most women have abortions for mental health reasons. It would be my view and one could say in all probability that certainly a percentage of those women who go to the UK do so because they are very mentally distressed and suicidal. The issue of suicide is important. I have to disagree with my colleague, Professor Casey, in this regard but suicide does not always occur in the context of mental illness. People can have an episode of depression. They could be at the beginning of an episode of depression which is a mental disorder; it is not really what would constitute a mental illness. They may take their life in the context of stresses that are unbearable to them, such as unemployment in the case of men, which may be more familiar to us.

As for the opening of the floodgates and what this legislation might mean and might create further down the line, my advice as a professional is that this debate is springing out of a need. It is springing out of reality, as a result of cases we have all lived with nationally and which have traumatised us. We are here to advise the legislators about it. I do not think legislation should be prevented because there is a fear that the legislation could be abused. We need to put in place some mechanisms so that it will not be abused, such as with the mental health legislation. An inspector of mental health services inspects the service from the point of view of the patient, to ascertain whether psychiatric units are adequate and also whether the treatment of patients is adequate. Any legislation could be managed in this way.

I refer to Deputy Conway's point about two psychiatrists being necessary. We seem to have differing views here. As professionals we will all work within the law, whatever it is. If we do not work within it, the professional organisations will pull us in. There is a system of reporting colleagues. I do not really see why two psychiatrists are necessary for this particular legislation if there is a redress board for the patient. I believe that is one of the recommendations of the expert group.

Senator Colm Burke: I thank the guests. I refer to the expert group report which gives a number of different options as to the number of specialists, such as whether there should be two specialists and an obstetrician or one specialist and an obstetrician. What would be the most

workable solution from among those proposals? My second question is about a person who is suicidal. One of the consultants this morning said that if a male is admitted to hospital with suicidal tendencies there is a course of treatment to be followed. I assume a pregnant women would be prescribed a course of treatment. Can a women who is 18 weeks pregnant be managed successfully to bring her safely to a time when the baby can be delivered and survive? I refer to a UK report, the CMAC report, which contains ten recommendations. It states: "Women whose pregnancies become complicated by potentially serious medical or mental health conditions should have an immediate referral to the appropriate specialist centres of expertise as soon as their symptoms develop". The report further states: "The assessors have been struck by the lack of appropriate referral of potentially high-risk women and lack of consultant involvement remains a problem in the care of women with serious medical problems". Reference was made to referrals to GPs. Are the delegates of the view that enough is being done in terms of referring pregnant women in these types of circumstances to specialists at an early stage?

Senator Marc MacSharry: I thank the witnesses for their presentations. In a situation where there are only three perinatal psychiatrists available for the entire country, if my sister, wife, niece or neighbour, for example, presented to her GP stating that she was suicidal and wished to see one of the delegates, how long would it take before she, as a person living outside the main centres of population, would be likely to secure an appointment? Assuming that a woman in that situation does obtain an appointment and notwithstanding the unique circumstances of every case and the complexity of the issues involved, how long might it typically take to deliver a diagnosis that the person was suicidal and that, post-legislation, an abortion, in the rarest of instances, as Professor O'Keane outlined, might be part of the proposed treatment? The delegates indicated that, as a profession, for every 100 suicides they might predict, only three would typically materialise. Are they of the view that a similar proportionality would apply in the case of women who are pregnant and suicidal? Is it conceivable, in other words, that we might have a situation where 100 terminations are deemed necessary in order to save three lives?

Deputy Denis Naughten: I thank the delegates for their evidence. Professor Casey indicated that United Kingdom statistics show that four women per year die by suicide before the birth of their baby. Is it her view that this rate would be higher if abortion were not available in that jurisdiction?

The figures referred to by Professor O'Keane seem to suggest a much higher frequency of suicidal ideation in pregnancy than those indicated by the other delegates, the suggestion being that much of this incidence tends to present at GP surgeries. It is disappointing that we do not have evidence from GPs in this regard. In this context, is she of the view that where a decision has to be made by a perinatal psychiatrist, a far greater number of cases will present to them than is currently the case?

The expert group made a recommendation that in cases of physical illness in pregnancy, two medical professionals would have to sign off on a termination. In regard to a mental illness, the recommendation is that a sign-off be required by one physical health specialist and one mental health specialist. Does Dr. McCarthy agree with that recommendation or is he instead of the view that sign-off should require the agreement of two psychiatrists or two perinatal psychiatrists? Professor O'Keane indicated her view that there is not a requirement for sign-off by two psychiatrists. The difficulty I have is that we are hearing three very different stories from the five eminent professionals opposite. Does Professor O'Keane not agree, in light of the variation in views across the profession, that having only one psychiatrist signing off might lead to

inconsistent decision-making across the country?

Senator John Crown: I hope the delegates will not assume any disrespect by my remaining seated. It seems I am too tall for the microphone. I have several questions for Professor Casey. I accept her evidence that suicide in pregnancy is rare as extremely credible and entirely within her professional competence. Her statement that there is a lack of evidence that abortion will ever end a suicidal tendency in a pregnant woman and will never save her life is plausible but a little speculative. Does she believe that this set of circumstances has never happened and could never happen? If she believes it could happen even once, would she not, as a doctor, want the legislation in place to make sure women are protected against that eventuality occurring, being cognisant of the fact that if suicide does occur, there will, according to the two-patient theory, be two deaths?

I apologise if I am being somewhat provocative in making my next point, and I apologise for not being here for the entirety of Professor Casey's oral presentation. Her prepared statement alludes to the argument that there might be a floodgate phenomenon, that is, an abuse of the suicidal ideation clause in any abortion legislation. With great respect, this is entirely without her professional competence. It is not something she should be discussing because it is not something that is within her remit as a psychiatrist. It may be within the remit of those who look at sociological trends or of lawyers or forensic analysts of various kinds. It is not, however, something that a psychiatrist should be testifying about. In fact, that level of testimony would perhaps be more appropriately heard at the meeting on Thursday. I also note that Professor Casey is an affiliate of an organisation which has a non-professional - entirely legitimate but non-professional - argument to advance on this issue.

Chairman: Professor Casey is here in her professional guise. It is only fair to point that out. She is presenting here today as an eminent psychiatrist.

Senator John Crown: I respect her opinion on matters related to psychiatry, but she has strayed outside that area of competence to comment on a broader social policy which is more relevant to her other affiliation.

Chairman: The Senator has made his point. Before asking Dr. McCarthy to respond to points made by Members, I ask him and his colleagues to be as brief as possible in their replies. I am conscious that four other Members wish to speak.

Dr. Anthony McCarthy: Thank you, Chairman. I will try to bring together the various points raised in so far as I can. There is probably more agreement among my colleagues and me than speakers have represented. There certainly are some differences, but also a great deal of common ground. That is important to state at the outset.

On the question of the numbers of perinatal psychiatrists, it is important to understand the processes involved. Women who are suicidal in pregnancy will usually present at their GP or at a Well Woman or Positive Options clinic, for example, before perhaps going on to consult a psychiatrist. On the question of whether a second psychiatrist should have to adjudicate in such cases, it is my personal view that because it will be a rare occurrence and such a difficult area, certainly initially, for a psychiatrist not to get a second opinion would be foolish. I have to disagree slightly with Professor O'Keane on that point. It is my view that the opinion of a second psychiatrist should be required.

We do not, of course, carry out terminations. An obstetrician would do so and would, there-

fore, obviously have to see the patient. I doubt, however, that there are too many obstetricians who would say they have a competence in assessing suicide risk. They will certainly want to see the patient but the question of whether a person fulfils the criteria in regard to threat of suicide would have to be determined by a psychiatrist. As I said, that determination should be made by two psychiatrists.

On the question of the recommendation regarding early referrals in the Centre for Maternal and Child Enquiries, CMACE, report, I should point our that I am the CMACE assessor in psychiatry in this country, although it is now referred to as Confidential Maternal Death Inquiry in Ireland. We certainly have seen a delay in referral to specialist treatment, but that is not a problem merely in pregnancy. There is a delay in referral across every specialty not just in psychiatry, and it certainly can be an issue here.

On the question of whether we could treat a woman who is suicidal in pregnancy early enough to ensure her safety while protecting the pregnancy, the reality is that the vast majority of women who are depressed in pregnancy will not come to me saying they are suicidal and that an abortion will make them better. The vast majority will say they are suicidal, miserable and feeling awful - all the typical symptoms of depression - and will want to be admitted to hospital or otherwise treated. It will not be a question of keeping them well enough to sustain a pregnancy; that will arise in only a tiny percentage of cases. I am trying to imagine what patient might fulfil the criteria speakers are worried out. Perhaps the issue might arise in cases I have seen where women have taken a very serious overdose, almost killed themselves in pregnancy and are too unwell to go home. A woman in that situation might be saying that she really wants a termination at that point in time. It may be the case, however, that at that particular moment she does not have the competence to make that decision because she is so depressed, perhaps even delusional. In a circumstance like that, we would of course keep the patient in hospital and provide treatment. Very often such a patient will get better. I certainly have seen women who were later delighted that their depression was treated and who then wanted to keep the baby.

Equally, not every woman who is suicidal in pregnancy and saying she does not want the baby is mentally ill. That is a ridiculous suggestion. Many will be seriously depressed and that depression might make them feel they want to reject the pregnancy. Some, however, are just distressed, hopeless and depressed and feel, because of socio-economic, personal, relationship or many other factors, that abortion is the only option. Men are more likely to abuse and beat women up during pregnancy than at any other time. A woman in that situation wants out; she is not mentally ill. That is what we must recognise. These are real issues. At the moment, she is likely to go to England or Northern Ireland to have a termination of pregnancy. If that is not available there, I would be worried about a lot of these women. That is the truth of it. So long as it is there, it is going to be a tiny group and that is the reality. That is what we must face as a country, namely, what we want to do about that or whether we want to leave it as an export.

On waiting times to see perinatal psychiatrists, there are only three of us and we are all based in Dublin. Most women who are depressed are going to want to see their psychiatrists locally. It may not be a perinatal specialist. The specialism that we have is going to be rarely addressed to this particular issue. Our specialism relates to women who may previously have had bipolar illness or schizophrenia and who are on particular medication or who may have had particular obstetric experiences. These women want to see someone who understands the obstetric issues and the interrelationship between these and pregnancy and psychiatry. They do not necessarily want to come and visit in those circumstances. This is a very small group of people. If the legislation does come in and if guidelines are introduced, I imagine there will be

pressure on us to see these people quickly. I do not personally look forward to that. I will be looking for more resources as a result. Those are all the answers I can give.

Professor Patricia Casey: I am probably not the person who should answer the question relating to a workable proposal because I do not believe we should be legislating for suicide risk under the proposed legislation. I am of the view that it is going to be bad law because it is not based on any evidence relating to suicide and pregnancy that we know of.

Senator Colm Burke referred to specialist referrals. CMACE - the British equivalent of CMAC - commented that 69% of women dying by suicide received sub-optimal care. Some of that was not because of delays in referral, it was actually after referral that they were not treated properly. Anything that promotes early referral and vigorous treatment is absolutely essential as a way of combating maternal suicide.

Senator MacSharry raised the question of how rapidly suicidal patients can be referred. Even though there are only three perinatal psychiatrists in Ireland, there are psychiatrists all over the country. People can be referred to accident and emergency departments because all of the psychiatrist services in Ireland have psychiatrists on call 24 hours a day. These services have junior doctors and consultants on call and people can be referred to them. There is not, therefore, a problem with regard to emergency referral for any person, whether it be a pregnant woman or anyone else.

The point relating to whether the unpredictability will increase the potential number of women who are being referred for abortions and who turn out not to be suicidal is absolutely correct. If one predicted that 100 women were suicidal and in need of abortions and if only three of them would actually die by suicide, then there is going to be an over-referral. That is one of the difficulties. We would err on the side of caution. When men or women who are suicidal come into the accident and emergency department of the Mater hospital, if I am not sure whether they are actually suicidal, then I will admit them. If the choice is between abortion or not, some psychiatrists may err on the side of caution rather than running the risk of a woman taking her life. That is a concern.

The UK statistics indicate that four women there die in pregnancy each year and a question was asked as to whether the number would be higher if abortion were not available. I doubt it because abortion is available there. If it was thought that abortions would have helped these women, they would have had them. As already stated, the CMACE report emphasised that there were also deaths by suicide after the birth of children. It also emphasised that all of these were due to mental illnesses which had not been adequately or vigorously treated. Unfortunately, some did not fall into that category. However, suicide sadly does occur even when the best treatment in the world is provided. This is because it is unpredictable.

Senator Crown accepts that suicide is rare and speculates that I am incorrect in stating that abortion never ends a suicidal tendency. We must practice evidence-based medicine. I do not know if the Senator has read the relevant royal college's report - perhaps he did not hear that part of my evidence - during the compiling of which it carried out a systematic review and concluded that, for all the relevant confounders, regardless of whether a woman with an unwanted pregnancy had an abortion or gave birth, it made no difference to her mental health. There is also a study which was carried out in Finland, which I did not have an opportunity to refer and which focuses on related suicide in women who had abortions or miscarriages or who gave birth. That study indicates that among those who had abortions, the suicide rate was three times the national average. In those who gave birth, it was half the national average. There is data

to support the proposition that there is no evidence that abortion helps women's mental health.

On the floodgates phenomenon, I have already outlined my view that there will be a gradual attempt to extend the law. It has already been suggested at these hearings that it should include mental health as well as suicidality. That process has begun and I think there will be widespread abortion in a short period.

Professor Veronica O'Keane: I will be brief. One of the reasons there appears to be some disagreement between the expert witnesses is because we are debating slightly different matters. Professor Casey is talking about not bringing forward legislation and the rest of us are talking about what might be in that possible legislation and regulation. I came before the committee to talk about the shape that legislation and regulation might take because that is what we were invited here to discuss. Some of the disagreement to which I refer may be related to that.

Among the body of psychiatry there is absolute consensus that we are able to assess risk. Reference was made to the fact that perhaps only three out of every 100 people who are assessed die by suicide. This means that 97 people do not die. All of medicine - not just psychiatry - is about risk assessment and risk management. If somebody is at risk of suicide, we will do everything we can to prevent that. It is in our interest to save a person's life and to bring them back to as full a position of health as they can enjoy. That is why we become doctors; that is what we do.

On the final point, Professor Casey said that psychiatrists run the risk of erring on the side of caution. I wish to point out that it is not psychiatrists who are running the risk. We are just conduits for this proposed legislation, if it is brought forward. It is the woman who runs the risk. It is the woman who - when she has been supplied with the relevant information or whatever from the experts requested to provide it under the process that will be legislated for - will decide. The expert group report emphasises the fact that it will be the woman who will decide whether she wants to continue to have a termination of pregnancy. It is not psychiatrists who are making the determination, it is the woman who is involved.

Senator Jillian van Turnhout: I am conscious of the time constraints and I will not, therefore, repeat questions which have already been asked. I thank our guests for their presentations.

It is clear that we are operating within the parameters of the proposed legislation and supporting regulations. In that context, will our guests indicate what they think should be the role of psychiatrists in this area? Should it take the form of advisory sign-off? Is there a need to differentiate between particular situations? Dr. McCarthy and Professor O'Keane both referred to childhood abuse. Will there be a need to differentiate in respect of children and vulnerable adults in the context of the supporting regulations? I would welcome our guests' views on this matter.

Deputy Peter Fitzpatrick: Is there an increased risk of mental health problems - such as depression, panic attacks or disorders or substance abuse disorder - among women who have abortions? Are women who have abortions more likely to commit suicide? Does motherhood protect against suicide?

Deputy Regina Doherty: I thank our guests for coming before us. Professor O'Keane actually referred to the elephant in the room, namely, that suicide in pregnancy is very rare. However, this is not to state that it does not occur. We have not addressed the needs of all of those people to whom reference was made. It is ironic that we are here to discuss matters

which arose as a result of the judgment handed down in the X case. We have not talked about a scenario such as the one that arose in the X case which involved a 14 year old girl who did not have an obstetrician and whose mother saw fit to take her to the United Kingdom to prevent her child from losing her life because she expressed severe thoughts of suicide. We must ensure we do not lose sight of all of these people, whether they be 14, 24 or whatever age. In the experts' opinion, what option is best for dealing with those people who do not have a perinatal psychiatrist, a psychiatrist or, in many cases, an obstetrician?

Deputy Mary Mitchell O'Connor: With regard to the floodgates phenomenon, I am hearing much criticism about the psychiatry profession. It is being said that one stop shops will be set up where two psychiatrists will come into a town, sign all these documents and then the floodgates will be open. I ask the three witnesses, as professional psychiatrists, to comment on that criticism that is being made.

Professor Veronica O'Keane: We have addressed the floodgates phenomenon and I do not want to repeat it but my view is that whatever happens in Ireland must be determined by reality. Effectively, what is happening in Ireland is that Irish women who are suicidal are travelling to the UK and they are availing of the private health services there. I do not know whether that will change because of the introduction of this legislation. Professionals will operate within the limits of the legislation. If the limits of the legislation say that it is only in extreme and rare circumstances where the substantial risk to the life of the mother can only be averted by a termination, that is the law we work within but obviously the need is there. Women are travelling to the UK and are having terminations there, and the majority of them are having those terminations for mental health reasons. That is not to forget about the tragic group of women who have hugely wanted pregnancies and who, shamefully, are going to the UK to have terminations. We are not including that group of women. It is not the case that everybody who goes to the UK has an unwanted pregnancy.

The point made by Deputy Doherty is extremely valid, and we have lost sight of this in the sense that what has promoted the entire debate is the X case. That was something that could happen to any 14 year old child or any teenager in this country. Currently, these people are travelling to the UK. We are effectively using their services and I do not believe there is a will on the part of the Irish people to take away the choice we have as citizens to travel to the UK. We voted on that as a country and we said we wanted to have that right and therefore that is effectively part of the services women are using.

Chairman: Professor Casey has three minutes.

Professor Patricia Casey: On the role of psychiatrists *vis-à-vis* the proposed legislation, psychiatrists are people who treat mental illness. If somebody is depressed, anxious, has schizophrenia or whatever we offer them treatments. We have already heard from Professor O'Keane at the outset that not everybody who is suicidal has a mental illness. They are suicidal simply because they do not want to be pregnant. At least, that was my understanding of what Professor O'Keane said. If I understand her correctly, I wonder about the role psychiatrists have if somebody does not have a mental illness. If somebody is not mentally ill, what are we doing? That is a very important issue. Are psychiatrists being used in this debate simply to get the Government off the hook and to find an easy way out for some of these cases? I do not know, but it is something on which the members need to reflect.

Deputy Fitzpatrick asked if abortion increases the risk of mental illness. There is debate about that within psychiatry. A big study from the Royal College of Psychiatrists - a systematic

review - showed there was no increase generally and that whether a woman had an abortion or gave birth to an unwanted child the outcome was the same, but for a sub-group of women - those with prior mental health problems, those who were being coerced and adolescents - there was an increased risk. A psychiatrist by the name of Ferguson who is a pro-choice person has done a lot of research on this and he believes that abortion increases overall the risk of mental illness post-abortion by about 30%. There is disagreement on it but everybody agrees that certain groups are vulnerable to an increased risk of mental illness after abortion, particularly people with prior mental illness.

On the question of whether abortion increases suicide, there is an association between higher suicide rates and having had an abortion from a series of studies in Finland to which one can refer. On the question of whether motherhood reduces the risk of suicide, there is a body of evidence showing that parenthood and motherhood is protective against suicide.

Deputy Doherty asked about the X case and said that we had lost sight of that person. I would agree. Unfortunately, when Miss X presented she did not have a psychiatrist. She was not receiving any treatment and in the judgment the judges mentioned that no treatment suggestions were offered. If she had had input at a psychological level who knows how she might have felt?

We do know about Ms C, who was another young woman in very similar circumstances. She was the same age, had been raped and was taken to England for an abortion because she was acutely suicidal. She came back here and went public. She said that she was not fully informed about what was happening but, more significantly, she was suicidal and was in hospital for a considerable period.

On the floodgates phenomenon and criticism in this regard, I do not believe psychiatrists will be responsible for the floodgates opening because psychiatrists are people of integrity who will act within the law and in good faith, but there will be many people coming forward for these assessments. Our colleague Dr. Siobhán Barry commented on that recently. She believes there will be huge pressure on services and that assessments will not be able to happen quickly enough. There will be an attempt to dismantle the current restrictions and extend them.

Chairman: Dr. McCarthy has three minutes.

Dr. Anthony McCarthy: I will try to be as quick as possible. Deputy Mitchell O'Connor asked a question about people setting up in a town. The recommendation would be that anyone doing this should be on the specialist register and approved by the College of Psychiatry of Ireland and by the Medical Council to do this sort of work. The idea that all of us who are working so hard, and overworked, would be going around in caravans is wrong. As long as this is not being done by a private external service I would have no concerns about that.

On Deputy Doherty's question, children are a key issue in all of this and there are detailed issues in that regard on which the committee would need our support and advice.

With regard to legislation and guidelines on, for example, children in care, there are particular circumstances. For a 17 year old or any child under the age of 17 to have a psychiatric assessment, her parents must consent, but she can have a termination and medical treatment without consent. There are many similar issues with regard to the Mental Treatment Act that must be addressed and worked through, and we would be very happy to work with the committee on that.

On whether abortion is bad for women's mental health, Professor Casey has mentioned that a few times. This is the area in which every one of us working in this field would highlight the importance of appropriate assessment and not seeing people as statistics but as individuals. Every one of us working in the perinatal service will have seen women who had terminations of pregnancy and who will feel profoundly guilty about that during a subsequent pregnancy, and it will have a negative effect on them. We have also seen many on whom it has not had a negative effect but instead was something positive. When we ask them how it affected them they reply that it was right for them at the time. We must look at the individual in the circumstances and not generalise. Overall, it is neutral in terms of statistics but for individuals it is hugely important. It is vitally important that they are assessed properly at that time and if they are mentally ill and do not have the capacity, with treatment we help them. If not, we do not label them as mentally ill.

Professor Casey mentioned that if these people are not mentally ill, there is a question with regard to what we are doing with them. I trained as a psychiatrist but I also trained as a psychoanalytical psychotherapist; I got a master's degree in that area. I do not just treat mental illness. I treat people with psychological distress that is not necessarily illness but overlaps with it, or it is part of the picture. Those of us in psychiatry should not be just tablet prescribers. We should be providing psychotherapy, support counselling and many other services as well.

As to whether we are supposed to have an advisory or signing-off role, it is clear that our role is advisory in this regard. We will be the key advisers on the mental health issue and suicidality.

Chairman: That concludes members' questions. The session is now open to non-members for 20 minutes. Eight members have indicated they wish to contribute. I will take the first three, Deputies Terence Flanagan, Aodhán Ó Ríordáin and Bernard Durkan, in the order in which they indicated they wished to contribute.

Deputy Terence Flanagan: Professor O'Keane's submission suggests suicidal ideation can be addressed only by the termination of a pregnancy, yet her colleagues in perinatal medicine say they have never seen such a case. What do the psychiatric textbooks say on that matter? Has the professor any scientific basis for her belief that abortion will help a suicidal woman? The professor stated that if a woman told her she was suicidal, she would believe her. Has there been any investigation into these types of cases?

Will members of the panel state how often they have had to treat a pregnant woman who stated she was suicidal? How accurately can a threat of suicide that is likely to be acted upon be assessed? Do the delegates agree with Dr. Justin Brophy that suicidality can easily be feigned? Should there be restrictions or time limits associated with the provision of abortion where suicide is threatened or where there is a risk? Do the delegates agree with abortion after 30 weeks, for instance, where suicide is threatened? If not, what would the options be? Do the delegates believe that there are two patients in the pregnancy and that the unborn child deserves a duty of care?

Deputy Aodhán Ó Ríordáin: I thank the expert witnesses for attending. Discussing whether suicidality should be part of the legislation is completely futile because it has to be part of it. Otherwise, the X case legislation we are bringing before the House and on which we must vote would not be in keeping with the Supreme Court judgment and the two referendums passed by the people. It would not be in keeping with the thinking on the X case, which was based on a suicidal 14 year old. I wish we could refrain from debating whether suicidal ideation

should be part of the legislation because it has to be. If it were not, the legislation would not be in keeping with the Supreme Court judgment. On that basis, I ask Professor Casey, who has said legislation must be based on good medicine and fact, to note the fact that legislators must deal with the constitutional provisions laid down by the Supreme Court and the people. Given the fact that the threat of suicide will be encompassed by the legislation, how does Professor Casey believe it can best be dealt with by those practising in her field?

Deputy Bernard J. Durkan: Let me hark back to the issue of the patients, the women. In the absence of legislation, to what extent can women or girls who are pregnant, under whatever circumstances, be reassured that they will be treated equally and fairly? In the event of legislation, would there not be an obligation on all practitioners, at all levels, to ensure each case was treated in accordance with that legislation?

With regard to the reference to the opening of the floodgates, reference was made to UK statistics. What about the statistics for Northern Ireland? To what extent are they available to those who wish to pursue the argument in question?

Consider the number of women who have died in pregnancy, in whatever circumstances, over the past 25 or 30 years. Professor Casey stated the number was very small. Could this be clarified? Other Members of the Houses will have knowledge of some of these cases.

How does the panel suggest pregnant women or girls may best be reassured, particularly where there might have to be a debate among a number of people, including medical and legal practitioners, or others, on the proper procedure in given circumstances? What is the right way to go about that? Can the panel give us an opinion that would reassure women in the circumstances in question?

Senator Terry Brennan: Let me tell a short story that I may have told Senators previously. Ten or 11 years ago, I met a young man whom I had been told had been about to commit suicide ten or 15 minutes previously. I asked what I was going to do and how I could ensure it would not happen. I got into my car and drove to the young man's grandmother's house, where he was at the time. I went into the kitchen, where the young man was standing with his back to the fire. He was in great form, talking to everybody. He did not ask me why I was present. I was present because I had been told by the last person I had spoken to that he was going to commit suicide. On looking at the young man, I said to myself that it was ridiculous and that it would not in any way happen. I did not have a clue how to proceed. I was an ordinary guy and was connected to the young man through football, which he played. I probably got talking to him about the contribution he could make to his team and stated I wanted to see him back playing football. This happened. The man is now married and has three children. I do not take any credit.

What are the main issues faced by the panellists in establishing the facts when a woman says to them she is suicidal and mentally ill and wants an abortion? I have great confidence in mothers and mothers-to-be. I am aware that rapes happen within marriages. What is the panel's view on issues that arise regarding rape in marriage?

Professor Patricia Casey: I did not hear all the questions, unfortunately, because I could not hear Senator Terry Brennan and Deputy Terence Flanagan properly. I will answer the questions I heard. I was asked whether I believe there are two patients in pregnancy. I believe this absolutely. If one is prescribing medication to a pregnant woman, one must ask whether it will harm the baby and the woman. Of course, we regard ourselves as having two patients.

I did not hear what was said about Dr. Brophy.

Chairman: We will come back to that at the end.

Professor Patricia Casey: All right. Deputy Ó Ríordáin expressed irritation with me that I am not supporting legislation for the X case. I have come here to give my expert opinion to this group. I have done so in good faith and based on my many years of clinical experience as a professor of psychiatry and as a clinical psychiatrist in the Mater Hospital, and based on research. This is what I will do. If this is not what the Deputy had in mind, I apologise to him. I hope I have given my view with integrity and to the best of my ability.

Deputy Aodhán Ó Ríordáin: I am not questioning anybody's integrity. My point is that we have to legislate for suicide. It is not a question of whether people believe we should do so.

Senator Jim Walsh: That is not true.

Chairman: Senator Walsh should note we are not going to have a slagging match. We will have a very calm and dignified debate, as we have had all day. The Deputy has made his point.

Deputy Aodhán Ó Ríordáin: As part of the X case judgment, which we were debating, in that eventuality-----

Chairman: The Deputy has made his point.

Deputy Aodhán Ó Ríordáin: How does the professor feel the legislation can best be dealt with?

Chairman: Professor Casey has made her comment in good faith.

Professor Patricia Casey: On the question as to how pregnant women can be reassured in the absence of legislation, we always do the best we can for every man and every woman, irrespective of whether she is pregnant. We have a very good track record on maternal mortality. We know from the limited statistics we have on suicide in pregnancy in Ireland that there was no maternal mortality from suicide in a 21-year period. I do not know whether the Deputy was present when I presented these statistics from the masters of the maternity hospitals. The data were gathered from 1980 to 2011 and out of 685,000 deliveries, there were no deaths by suicide in pregnancy. While we do not have a lot of information, we have some, including that crucial information and, consequently, the Deputy may be assured that women will get the necessary treatment when they are depressed and suicidal. Deputy Durkan mentioned something about the North of Ireland and the reason the floodgates have not opened there. Let us see what happens in the coming weeks, now that the Marie Stopes organisation has moved in there. Senator Terry Brennan wanted to know what to do when someone states she is suicidal and wants an abortion. I have seen two women like that in my practice in the Mater hospital. They came in after overdoses and stated they wanted abortions. However, by spending time and talking with them, I ascertained that while they initially were stating they wanted abortions, what was behind the words was they were being encouraged strongly, under threats from their partners and parents, to have an abortion. This is the reason it is important to spend time listening to what women are saying.

Professor Veronica O'Keane: I thank Deputy Terence Flanagan for drawing my attention to a point that has not previously been raised, which is that death during pregnancy is rare. However, suicide is an important cause of death during pregnancy even where abortion is avail-

able. In the confidential inquiry into maternal deaths in the United Kingdom, which assessed three years of deaths, it was found that maternal suicide was more common than previously thought and, overall, was a leading cause of maternal mortality. I thank the Deputy for drawing my attention to that point.

As for the question about abortion after 30 weeks, obviously every effort would be made by obstetric colleagues and by the medical profession in general to save a baby's life if it is viable and that is a given. As for Deputy Ó Ríordáin's comments, I fully agree with him. I also came before the joint committee thinking the subject matter of this hearing was about enacting legislation in respect of suicidal ideation. In response to Deputy Durkan's question, the answer is that in the absence of legislation, it is almost impossible to manage these highly complex cases. Unfortunately, we have seen this with the death of Savita Halappanavar towards the conclusion of the writing-up of the report. As for the last point made by Senator Brennan, the assessment of suicide is something about which doctors are trained. Indeed, we are taught about it in our undergraduate career and it continues through. In highly complex cases, we combine the expertise from various disciplines, as well as from medically aligned disciplines, and are used to such complex case management conferences.

Chairman: I note nine minutes remain for answers in this module .

Dr. John Sheehan: I refer to Deputy Terence Flanagan's question on whether we, as perinatal psychiatrists, have ever seen a situation in which termination of pregnancy has been the treatment for a suicidal woman. To reiterate our statement, with more than 40 years of clinical experience between us, we have not seen one clinical situation in which this is the case. While I acknowledge Dr. O'Keane would state that suicide is a leading cause of maternal death, one should consider how rare is maternal mortality. It is a statistical leading cause because the rate is so rare with one in 500. That is the first point I wish to make. On the question of pregnancy at 30 weeks, such a pregnancy is viable and if the baby is induced at that stage, it is likely to do very well. At the Rotunda Hospital, we try to save lives from 24 weeks onwards and, consequently, 30 weeks certainly is a very viable foetus.

As for the reason we are in attendance, Deputy Ó Ríordáin raised the question of what is the best approach regarding the expert report. We have tried to discuss and consider this question because from listening to all of us, one can discern exactly how complex is the situation. In our clinical practice, we regularly see women who are suicidal. Some will have thoughts of suicide, some will have intention of suicide and others will have thoughts that they wish they were dead. As is evident here today, what tends to happen is the notion of suicidality tends to get narrowed down to a person being suicidal or not. Clinically, however, this is not the situation as clinically, the situation is highly changeable. A person may have strong suicidal feelings on one day but may change on the next day or *vice versa*. As Senator Crown noted earlier, I am not a legislator but when one considers what is the best option for legislators, the job they have is extremely difficult. Even if one merely tries to follow what is being discussed at this meeting today, it is extremely difficult because of all the different dimensions.

Another aspect that really has not been brought out pertains to when the expert group considered the emergency situation in a medical context. In such a situation as when, for example, a woman has had an epileptic fit and the baby must be delivered very quickly, speed is of the essence. In psychiatry, precisely the opposite is the case. Someone who is intensely suicidal often needs admission to hospital. It is exactly the opposite to the medical intervention and, consequently, even the notion of carrying out an emergency termination is completely obsolete in respect of a person who is extremely suicidal. I reiterate that in our practice, we see people

who are profoundly depressed, who feel hopeless, worthless or utterly helpless to deal with situations. In such situations, one can see clearly the intervention usually is to admit such people into hospital, day hospital or home care but the intention is to support and help them through the crisis they are in. It is not to make a decision that is permanent and irrevocable. In a manner, this covers the other question raised by Deputy Durkan on how do we treat women who present. Members can perceive that our emphasis really is on providing the best care possible to the women we see. This is because it both benefits the woman and there is loads of research demonstrating that good mental health care for the woman leads to better child development, better bonding between mother and infant, better infant development and better IQ development. There are loads of potential benefits and this is the reason we strive to provide the best care possible for women.

In addition, the question raised by Senator Brennan on whether there is a floodgate phenomenon or whether this could happen has come up several times. However, as psychiatrists, we distinguish between assessing risk - at which we are good - and actually picking out the individual who will go on to complete suicide or, in other words, predicting the future. None of us can actually do that; it cannot be done. Unfortunately, the proposed legislation is almost at the curve, which for psychiatrists is whether one can identify that woman where there is a real and substantial risk. As I noted, that is for legislators but even from a mental health perspective, we are good at the assessment of risk but it is impossible to be absolutely certain about prediction.

Dr. Joanne Fenton: I have a couple of comments. As the three perinatal psychiatrists, we came together to give a joint statement on what we felt was our position clinically to move forward. It is very important to take the individual lady who presents to us as being paramount. She is pregnant, it is her issue and she is an individual. We all have come across and assessed many women who have had terminations. Some would have stated this was what they needed at the time and some continued to have extreme guilt about that, which already has been mentioned. However, one must remember that it is absolutely individual and for us, with our 40 years of experience, we have never assessed a woman for whom our management would be to advise a termination and for the legislators, this must be taken into consideration.

Chairman: Deputy Timmins is next and three minutes remain.

Deputy Billy Timmins: I will not use the term "conflicted information" but the difficulties Members of the Oireachtas have in trying to formulate legislation can be demonstrated by what they have heard today. Notwithstanding the fact that the Government has decided to legislate for the X case, it is important that we hear the views on suicide because it is the issue that is causing most concern.

Most of what I was going to ask about has been clarified. However, I would like to seek clarification on the issue raised by Professor O'Keane concerning the British study on causes of maternal mortality. We have the statistic that it is one in 500,000. My understanding is that the maternal mortality rate in Britain is in the region of one in 6,500. Can Professor O'Keane clarify that because if it is a leading cause, what are the other causes? We should not give a wrong impression about it.

In her submission, Professor O'Keane mentioned that overall "a pregnant, compared to a non-pregnant, teenager in the US is more than twice as likely to die by suicide". She referenced a US study. While I know that we can all quote scripture, I also have information that shows that, by contrast, pregnancy has overall a protective effect against suicide, which also references a US study. Is the reference Professor O'Keane gave dealing strictly with teenagers? Is

there a study that shows that overall pregnancy has a protective effect against suicide? That is quoted in another study in the United States.

Deputy Michael Creed: I thank the witnesses.

Chairman: The Deputy has one minute.

Deputy Michael Creed: I will stay within that time limit. I have two brief questions. As I understand them, the current Medical Council guidelines refer to suicide being grounds for termination of which the medical profession have to be aware. Can I ask our colleagues with perinatal experience about this? They have already referred to the fact that in their extensive careers of more than 40 years of combined experience, they have not been involved in a case where termination has been the appropriate treatment for somebody with suicidal tendencies. Could they elaborate on case management where suicide is identified as a condition of a pregnant woman? What might the alternative treatment option be in terms of case management in that particular context, bearing in mind the current Medical Council guidelines as opposed to statutory change that is being contemplated?

Professor O'Keane referred to the recent tragic death of Savita Halappanavar. Can she share with the committee the substantiated knowledge she has regarding that death?

Chairman: That is the subject of an independent inquiry.

Deputy Michael Creed: I appreciate that but bearing in mind the fact that we are awaiting reports from HIQA and the HSE, in addition to an inquest, maybe she might share with us whatever substantiated knowledge she has.

Chairman: That would not be appropriate to today's meeting.

Senator Paul Bradford: She raised the matter.

Chairman: We are not going to discuss it at this meeting. I apologise to Senators Bacik and Walsh but our time is up. I call on Dr. McCarthy.

Dr. Anthony McCarthy: The first question was about suicide being the leading cause. These confidential inquiries into maternal deaths report every three years. In the report for 2002-2005, suicide was definitely the leading cause. The numbers are small but the causes of maternal death are small. It might be two cardiac, one renal or one rupture of an aneurysm. In that report, suicide was the commonest cause and also in one of the subsequent reports. While there are very few suicidal cases, as members of the committee are probably aware, truthfully we also know that with many cases going to coroners' courts, in general with suicide, we also have to look at accidental deaths and open verdicts. We are all aware of women who almost certainly kill themselves in pregnancy but there is an open verdict. Very often a coroner is under huge pressure to do that. Those women have not been spoken about today but they are a real issue as well, believe me.

With regard to the management, I have certainly seen women in pregnancy who have seriously harmed themselves or have tried to kill themselves. As Professor Casey and Professor O'Keane have said, when treated they were better and wanted to keep the child. I have also seen women in pregnancy who did not threaten suicide but I knew a week later that they were no longer pregnant because they had gone to the UK. I have also seen women in pregnancy, particularly with a foetal abnormality, who had threatened suicide. In one case, she did not

threaten me - I hate that pejorative word - but she was desperately seeking a termination of pregnancy. She had booked to have it in the UK a few days later. She was so desperate that she wanted it out now. Of course, under the current guidelines it felt much safer to say: "Well, you are booked to go to the UK. We're not going to do anything today." If the situation changes and she has that termination here, that may be a different issue. However, that will be for my obstetric colleagues to decide rather than me, because she will not be threatening, to use that awful pejorative again. That is an example of a very broad spectrum of people whom we see.

Chairman: Does Professor Casey wish to reply briefly? She does not have to if she does not want to.

Professor Patricia Casey: I did not think any of the questions were directed at me.

Chairman: If Professor O'Keane wishes to reply, she may do so briefly.

Professor Veronica O'Keane: In response to Deputy Timmins's question about children, it is true for children that overall, both in the UK and the US, a pregnant teenager is more likely to commit suicide than a non-pregnant teenager. A pregnant adult is less likely to commit suicide than a non-pregnant adult. If there are specific questions, we have an expert here on child and adolescent psychiatry who has not given any evidence. Perhaps she wants to give some evidence at this point. My point simply was that adolescents are at a hugely increased risk of committing suicide if they are pregnant.

There seems to be some confusion about the issue concerning suicide being a leading cause of death in pregnancy. It is a leading cause of death in pregnancy and it is also rare. The reason it is rare is simply because all deaths in pregnancy are rare. That is the sum of it.

Suicide post partum is the leading cause of death overall. They are the statistics in relation to that.

Chairman: That concludes this session. I thank Dr. McCarthy, Dr. Sheehan, Dr. Fenton, Professor Casey, Professor O'Keane and Ms Maeve Doyle for attending the committee.

Sitting suspended at 4.45 p.m. and resumed at 5 p.m.

Institute of Obstetricians and Gynaecologists, Irish Family Planning Association and Maternal Death Enquiry Ireland

Chairman: I welcome everybody to our session. I remind members, witnesses, Members in the Gallery and media that mobile phones should be turned off for the duration of the hearings as they interfere with the recording of proceedings.

You all are welcome to the session. This is the fourth session in our series of hearings that the joint committee is conducting over three days to discuss the implementation of the Government decision following the recent publication of the expert group report into matters relating to A, B and C *v*. Ireland. In that regard, I welcome the following: from the Irish Family Planning Association, Mr. Niall Behan, chief executive; from the Institute of Obstetricians and Gynaecologists, Professor Robert Harrison, chairman, Dr. Meabh Ní Bhuinneáin and Professor Fionnuala McAuliffe; and from Maternal Death Enquiry Ireland, Professor Richard Greene. I also welcome Dr. Caitriona Henchion, medical director of the Irish Family Planning Association.

I remind witnesses that they are protected by absolute privilege in respect of the evidence they are to give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and continue to so do, they are entitled thereafter to only qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against a person or persons or an entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice and ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official by name or in such a way as to make him or her identifiable.

I again welcome Mr. Niall Behan and ask him to make his opening remarks. He has ten minutes.

Mr. Niall Behan: The Irish Family Planning Association is glad of the opportunity to assist the committee on this important issue. The IFPA, as we are probably better known, provides medical services to in excess of 20,000 clients per year. Those are mainly contraceptive services and family planning services but also treatment for sexually transmitted infections and post-abortion care. Through our national network of pregnancy counselling services we provide information and support to almost 5,000 women and girls experiencing crisis pregnancies that were unplanned or unwanted, or developed into a crisis because of changed circumstances.

Women use our services because they feel they are not currently in a position to care for a child or, very often, another child. Their reasons include financial worries, diagnosis of a serious foetal abnormality, a pre-existing health problem or relationship issues, or sometimes a combination of all of those issues.

The IFPA knows from its counselling service that women who choose abortion are from all walks of life and each woman has her own reasons for deciding to have an abortion. Women's experiences of abortion are diverse and complex and the decision to have an abortion is not one that women take lightly.

The experience of the IFPA and of many doctors is that medical service providers in Ireland are prevented from acting in the best interests of pregnant women's health at some points, and must navigate some grey areas of law to protect themselves and patients from prosecution. As a service provider, therefore, the IFPA very much welcomes the Government's decision to implement the judgment of the European Court of Human Rights in A, B and C *v*. Ireland.

Very few of the women who avail of our service 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 a very early stage of pregnancy before the risk is imminent and with our services, we are not talking about emergency situations. They tend to be women who have had serious complications during previous pregnancies or who have underlying health conditions, and usually they have been advised at some point previously not to become pregnant or that becoming pregnant again could impact on their health. For example, applicant C in A, B and C *v*. Ireland was six weeks pregnant when she realised that she had difficulties. These women have taken a decision to terminate the pregnancy rather than incur a risk to their lives or to their health. They are not prepared to wait until the risk to their health deteriorates to such an extent that it becomes a risk to their life.

The serious risk posed to a pregnant woman's health can be for a range of reasons, includ-

ing heart issues, kidney diseases, oncology, neurology, gynaecology, obstetrics and a range of genetic conditions. The pregnancy may exacerbate the risk to women of a pre-existing condition, for example, epilepsy, diabetes, cardiac disease, some auto-immune conditions and severe mental illness.

The case may be that there is a risk to a woman's health rather than to her life. From our perspective as a medical services provider, it is very difficult. We do not see any kind of bright line distinguishing between a women's life and her health. Indeed, no other country in Europe forces doctors or medical services to make the distinction that is made in Irish law where abortion is only allowed to save a woman's life, but not to preserve her health. Most countries offer abortion on the basis of the adverse consequences for women's health as the only way to ensure that a full range of sexual and reproductive health services are available to her.

For women in these circumstances the burden of accessing abortion services is placed on the woman rather than on the health care system, and that is an important distinction to make. Women who make the journey to the United Kingdom for medical reasons do so in the context of legal uncertainty. There is a chilling effect in the current law and the standard medical referral protocols may not be applied. Women in this context must leave the mainstream health-care service. They must make their own way to a private medical facility in another country without the protection of the protocols that apply in other situations. While some doctors make *ad hoc* arrangements, we know of women who have travelled without medical files detailing their medical history or proper referral from a doctor.

These women travel outside the State to avail of services that are criminalised in Ireland, a journey that in many cases involves significant psychological, physical and financial burden - a burden that was recognised by the European Court of Human Rights. These burdens fall most heavily on those who are already disadvantaged or vulnerable, namely, those with little or no income, women with care responsibilities, women with disabilities, women with mental illness, women who experience violence, young women and women requiring travel visas. It is critical that medical service providers and, indeed, the women themselves can rest assured that accessible and appropriate services will be put in place and that women can be confident that their decisions will be respected and free from discrimination, coercion and stigma, and that their rights will be fully vindicated.

In that regard, the legislation and guidelines must not be so complex as to render them ineffective in practice. As the European Court of Human Rights has stated, they cannot be theoretical and illusory. The Government must be guided by the expert group's unambiguous direction so that the potential options are effective and accessible. The expert group considered it insufficient for the State to interpret the court's judgment as requiring only a procedure to establish entitlement to termination without also giving access to such treatment. In this regard, I am heartened by the discussions today that have focused on the barriers that may arise, such as conscientious objection, refusal to care and capacity to provide services.

In regard to the threat to life by suicide, the IFPA has dealt with clients who have had suicidal thoughts or threatened suicide. A small number of individuals followed through on these threats by taking overdoses. The expert group gave extensive consideration to the appropriate legislative and health service response to the risk to life by threat of suicide and the IFPA welcomes the clarification by the export group report that a termination of pregnancy is lawful medical treatment regardless of whether the risk to life arises on physical or mental health grounds. The expert group's approach would place suicidal intent in the context of pregnancy and existing health services without stigmatising either mental health or a termination of preg-

nancy.

The final issue I wish to raise is criminalisation of abortion. It is clear from the expert group report that the legislation implementing the A, B and C judgment must remove sections 58 and 59 of the Offences Against the Person Act 1861. We understand that some Members of the Oireachtas may be concerned that legislating this way where a pregnant woman's life is at risk might lead to an increase in abortion rates. From the thousands of women we have seen over the years, it is our opinion that criminalisation of abortion does not deter women from seeking termination or lead to lower abortion rates. It has been the IFPA's experience that when a client decides to terminate her pregnancy she has made her decision rationally and is unlikely to change it regardless of the legal obstacles in her way. Her focus quickly shifts to the practicalities of organising and financing the procedure in another country.

Chairman: I call Professor Richard Greene from Maternal Death Enquiry Ireland.

Professor Richard Greene: On behalf of Maternal Death Enquiry Ireland I propose to explain the background to this issue and outline the very good health care that is available to women in Ireland. Maternal Death Enquiry was established in the 1950s in the United Kingdom and has since then produced a number of good reports which have improved the care of patients in obstetrics. Ireland became involved on the basis of the scientific approach taken to ascertaining the causes of maternal deaths and because we could learn more by being part of a larger cohort of patients or, unfortunately, deaths of patients. In 2007, we established a working group to initiate a confidential inquiry with the support of the then Department of Health and Children, the HSE, the Institute of Obstetricians and Gynaecologists and other interested parties. The inquiry commenced in 2009.

I will now speak briefly on the definitions of maternal death. We refer to direct deaths as those resulting directly from pregnancy. Indirect deaths result from diseases which existed prior to or developed during pregnancy and were aggravated by the physiological effects of pregnancy. Coincidental deaths are those where the pregnancy was only coincidentally related. As it is difficult to identify the nominator when calculating maternal mortality rates, we take the figure used in the United Kingdom, namely, 100,000 maternities or those women who deliver babies alive or older than 24 weeks and stillborn.

The great value from undertaking this inquiry is that the case ascertainment in confidential inquiries internationally has been shown to detect somewhere of the order of 1.5 to two times the number of maternal deaths found in civil registration procedures. There are many reasons for this discrepancy. Confidential inquiries are also valuable because they can assess the causes of death and identify whether lessons should be learned in terms of altering care or improving outcomes for women during pregnancy.

We have carried out comparisons in Ireland with the CSO's figures. Maternal mortality in Ireland is often touted as being low compared to other countries. The triennial report for 2009-11 identified 25 maternal mortalities based on the scientific approach of the maternal death classification system. Of these mortalities, six were classified as direct maternal deaths or associated directly with pregnancy, 13 were indirect maternal deaths and the remaining six were attributed to coincidental causes. During this period there were 225,136 maternities in Ireland, giving an overall rate of 8.6 maternal deaths per 100,000. It is important to note from a care point of view that there was no evidence of clustering in any hospital. The exercise should be treated with caution given that it is the first time to attempt it in Ireland and perhaps some cases were not identified but we have received a phenomenal response from clinicians not only in ma-

ternity units, but also general hospitals. Our maternal mortality rates compare favourably to our nearest neighbours if we use the same classification system. During the period in which Ireland experienced 8.6 maternal deaths per 100,000 maternities, the UK experienced a rate of 11.3. If one takes international civil registrations of maternal deaths, Ireland again has a comparatively low rate of maternal deaths.

In regard to causes of maternal deaths, direct deaths are closely associated with pulmonary embolism, or clot to the lung, amniotic fluid embolism and multi-organ failures secondary to a condition called HELLP, which is associated with pregnancy. Indirect causes included cardiovascular disease, influenza including the H1N1 variant, epilepsy, chronic obstructive pulmonary disease and bleeding esophageal varicose veins. There were also two suicides, one of which occurred during pregnancy and the other during the postpartum period after the woman had delivered her baby. Both cases were well known to the psychiatric services and under care. The notifications for 2012 have also identified three women who committed suicide around the time of pregnancy, one during pregnancy and two post-delivery, all of whom were known to the psychiatric services. This indicates that pregnant women in Ireland are availing of a very high level of health care. While these figures are inevitably a factor of Ireland being a wealthy country with a highly educated population and excellent health care system, it is important that women understand this country has very good results. We need to take away some of the scare concerns the public has.

The value of the confidential inquiry is that we have a really good baseline for one of the markers for maternity care in Ireland and it shows that we are doing exceptionally well. We do not have information on whether termination of pregnancy has reduced or otherwise affected these figures. Inevitably it is part of the total health care package that will continue to assist women in having, I hope, successful pregnancies.

Professor Robert F. Harrison: I wish to make an initial statement and then pass to Professor McAuliffe.

Chairman: Professor Harrison has ten minutes.

Professor Robert F. Harrison: I will not take ten minutes.

Chairman: The witnesses have ten minutes between them.

Professor Robert F. Harrison: I am chairman of the Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland. The institute is the corporate representative of obstetricians and gynaecologists in Ireland. Based on our standing orders, its objects are to represent obstetric and gynaecological opinion in Ireland in a professional advisory and administrative capacity; to act as the advisory body in Ireland in matters relating to education, training, research and administration in the specialty of obstetrics and gynaecology; and to promote excellence in the areas of patient care, professional standards, education and research in obstetrics and gynaecology. There are approximately 120 professionals in obstetrics and gynaecology in Ireland. That number has remained static, despite a 40% increase in the number of births. There are 126 trainees. The institute has 223 members or fellows, of whom 24 are associates in training. The executive council, on whose behalf this presentation is being made, has members elected from the body from various areas throughout the country, including Northern Ireland. The duration of my position on the executive council is three years. We are the group that really represents our specialty.

Our brief, as stated in the letter, is to make a presentation solely on the implementation of the recent Government decision following the publication of the expert group report. I am no longer involved in clinical practice, although I am still on the specialist register and, therefore, feel it more appropriate that our position be given by someone who is on the register, namely, Professor Fionnuala McAuliffe who, among other things, is consultant obstetrician-gynaecologist and specialist in maternal and foetal medicine at the National Maternity Hospital. She is also head of the faculty of women's and child's health at UCD. Present to help her with questions is Dr. Meabh Ní Bhuinneáin, consultant obstetrician-gynaecologist at Mayo General Hospital. I will try to keep quiet, unless my experience of 47 years is needed.

Professor Fionnuala McAuliffe: As we have heard from Professor Greene, maternal health services in Ireland are among the best in the world. Pregnant women and their families should be reassured that they are receiving the very best of care in pregnancy. One measure of maternal health services is maternal mortality rates, about which we have just heard. Our accurate figures in Ireland show that these rates are approximately one mother dying per 12,000 pregnancies. These low rates compare very well with those in the United Kingdom and the rest of Europe.

Another measure of maternity care is the number of cases of severe maternal illness during pregnancy. This is the number of women who, without timely treatment, risk maternal death. Ireland is one of the leading countries to collect this type of information. The rate of severe maternal illness during pregnancy recorded in Dublin is three per 1,000 pregnancies, which compares very favourably with the Scottish data of four to six per 1,000 pregnancies. However, we are never complacent and it is our absolute priority to ensure pregnant women receive the very best of care. In order to maintain these very high standards and improve on them, we need to continually adequately resource our maternity services.

I will make some general comments on the report of the expert group on the judgment in the A, B and C *v.* Ireland case. We very much welcome the opportunity to have an input and applaud the expert group report. It is important that obstetricians have legal clarity when making difficult decisions regarding termination of pregnancy or delivery of a very premature baby when treatment is required to ameliorate the threat to a mother's life. The situation where termination of pregnancy or delivery of a very premature baby is required in order to avert a substantial risk to the life of the mother is rare, although it does occur. The majority of cases we see as obstetricians arise in women with prior medical disorders such as severe heart, lung or liver disease, or where a mother develops severe pregnancy-related blood pressure. If the baby is delivered at a stage before it can survive, unfortunately, it will die. However, once the baby reaches a stage where it can survive, it is current practice that every effort be made to support its life. The test to be applied can only be a medical one, to which exact precision and timing cannot be applied. As doctors, we deal with probabilities and cannot precisely predict death or its timing. However, obstetricians are the experts in maternity care and if two senior obstetricians in consultation with the appropriate medical specialties consider there is a substantial risk to the life of the mother which can only be ameliorated by termination of pregnancy or delivery of a very premature baby, we will take this decision. That is our current clinical practice and it is imperative that we be allowed to continue this practice in the interests of pregnant women in Ireland. These are complex and difficult cases and a multidisciplinary team approach is required. However, obstetricians are those clinicians who are experienced in the care of pregnant women and, therefore, should be central in the assessment of sick pregnant women and to any decision-making process when there is a substantial risk to the life of the mother.

I will now make some specific comments on the report of the expert group. Chapter 6 deals with the procedures for determining entitlement and access to termination of pregnancy. On paragraph 6.2 outlining the test to be applied, as stated, it can only be a medical decision with appropriate documentation. On paragraph 6.3 dealing with the qualifications of doctors involved, it is the view of the institute that this should be a consultant obstetrician on the specialist register. On paragraph 6.4 dealing with the number and role of doctors involved, it is the institute's view that it should be two consultant specialist registered obstetricians and gynaecologists, plus, where the condition under review warrants this but only then, other consultants on their own specialist register as a team assessment. On paragraph 6.5 dealing with emergencies, it is the view of the institute that no special provisions are required and that established clinical practice guidelines for emergencies will apply.

In regard to paragraph 6.6 dealing with location, the considerations listed were acknowledged, but it was considered that all licensed general hospitals, not just recognised maternity units, should participate in providing these procedures, as necessary. Mothers with complex medical disorders are often cared for in general hospitals with access to intensive care. Therefore, it is imperative that all recognised licensed hospitals be able to provide these life-saving procedures. Where neonatal care is not available to care for a very premature baby, and provided the woman's health allows, *in utero* transfer pre-delivery to a unit that has appropriate facilities should be considered. This is established current practice in Ireland.

With regard to the formal review process under paragraph 6.7, it is the institute's view that the medical model at the woman's request or by another person acting on her behalf is the preferred option. With regard to the composition of the review panel under paragraph 6.7, it is the institute's view that all specialties are to source and provide from within their appropriately qualified ranks consultants practising in Ireland to form a panel that can be called upon for a second opinion. There should be a minimum of two obstetrician gynaecologists plus other specialties similarly qualified, as appropriate. In obstetrics and gynaecology, the institute would act as a list provider. The panel should be indemnified against possible subsequent legal proceedings and have access to formal legal expertise. With regard to the convenor under paragraph 6.7, it is the institute's view that a nominated person or unit in the Department of Health, whom the woman can access directly, should convene the panel from the list supplied by the professional bodies. With regard to access to courts for appeal and conscientious objection under paragraphs 6.8 and 6.9, these were acknowledged as read and, in the latter case, it was noted that this may extend to other health professionals. With regard to the monitoring system or monitoring review panel under paragraph 6.10, it was the view that these important cases need close monitoring and regular review. With regard to chapter 7, options for implementation, it is the view of the institute that statutory legal protection is required for health care professionals and patients. With regard to alternatives for implementation under paragraph 7.4, it is the view that paragraph 7.4.3, concerning legislation plus regulation, provides the necessary flexibility and protection for health care professionals and their patients.

In conclusion, we are grateful to have the opportunity to participate in the discussion. We respectfully request that the institute have input into the final wording to ensure we are allowed to continue with current practice, which includes the provision of life-saving treatments to pregnant women.

Deputy Billy Kelleher: I have two questions, the first of which is to Mr. Niall Behan of the Irish Family Planning Association. With regard to the submission made about the services the IFPA provides in assisting people in the decision they make, we know this is a very complex

area and that circumstances can arise in which a woman decides that, ultimately, a termination is most appropriate for herself. Listening earlier to the psychiatrists and their analysis and interpretation of statistics and facts, I saw clearly that there was even some divergence among those eminent people. Does the IFPA assist people in terms of accessing psychiatric services first and foremost, or does it consider that if a person has made a decision to terminate a pregnancy, for mental health reasons or due to suicide ideation, intent or otherwise, it should suggest that maybe, initially, some form of psychiatric support is the most appropriate option? The evidence to date from the psychiatrists suggests that intervention is of assistance and it is not necessarily the case that termination is the correct decision at the end of the day. If a woman is given assistance, she may ultimately decide that a termination is the only option for her, but at least she would be given support.

On the issue of lack of legal clarity, have the representatives of the Institute of Obstetricians and Gynaecologists, in their professional capacity, ever had difficulty in arriving at a decision to intervene and interrupt a pregnancy to save the life of the mother? We hear a lot about the fact that this is seldom carried out as a procedure to save the life of the mother and there are varying views as to how many such interruptions are carried out every year - we have heard mention of 20 to 40 times a year. Have the representatives of the Institute of Obstetricians and Gynaecologists experienced circumstances in which they felt they could not intervene at a particular stage to save the life of the mother because of lack of legal clarity or the threat represented by sections 58 and 59 of the 1861 Act? Has that affected their professional capacity to intervene in saving the life of the mother?

Deputy Caoimhghín Ó Caoláin: I join with other members in welcoming all of the panellists. To address Mr. Behan's contribution on behalf of the Irish Family Planning Association, I note that in his submission Mr. Behan has very correctly pointed out - this is also my opinion, and a number of colleagues have already expressed a concern in this regard - that the first point of contact is often with the local GP, although, sadly, GPs do not have an opportunity to come before the committee over these three days. Mr. Behan said: "The experience of the IFPA and of many doctors is that medical service providers in Ireland are prevented from acting in the best interests of pregnant women's health, and must navigate the grey areas of the law". That is an important point to make.

When Mr. Behan went on to talk about those who avail of the IFPA's services, he noted the fact that there are a small number of people presenting for whom the risk to their lives is real and identifiable. Of those who do, he indicated that a very small number again, which is consistent with all of the evidence we have had, have suicidal ideation or intent. Can Mr. Behan give us any indication of the numbers of those who might have attempted suicide over the period of time? I am hoping "unsuccessfully" would be the point to add. Does Mr. Behan consider it likely that women who have the financial means and who have either suicidal ideation or suicidal intent will continue to travel in order to access abortion services rather than face the psychiatric services within this State? Is that something he would recognise?

Professor Greene's presentation with regard to maternal death enquiry, MDE, was broadly statistical, I think it is fair to say. I welcome the statistics he has shared with us. He has not drawn any conclusions *per se* in terms of his contribution, either in writing or orally, today. Would he like to elaborate on this in any way, particularly in regard to table 2 and the comparisons with other international settings? Are there conclusions of views that he would deduce from the information presented in table 2?

Time beats us all the time here. None the less, in conclusion, I welcome the obstetricians

and gynaecologists and I thank Professor McAuliffe for her contribution. I seek one small clarification. She made the point that in certain circumstances general hospital settings could be appropriate for particular decisions to be taken, which is outside the remit of obstetricians and gynaecologists. However, many of these general hospitals do not have maternity units. Will Professor McAuliffe elaborate on that and give us a sense of the situations she would see as appropriate to the particular point she shared with us in the course of her contribution?

Deputy Ciara Conway: I thank all contributors for their evidence thus far. I would like to ask the Institute of Obstetricians and Gynaecologists how it deals with minors - young girls who present as pregnant to its services. We had some discussion about this earlier with the psychiatrists and I would like to obtain clarification for the committee. Is it the case that medical consent can be given by somebody at the age of 16, with the anomaly this throws up in terms of persons being recognised in law as children up to the age of 18? What is the institute's procedure for making an appropriate referral for that child? We heard from Professor O'Keane in the last contribution that pregnant teenagers are at a much greater risk of dying by suicide than non-pregnant teenagers. I would like to get the witnesses' real-life experience in regard to how they deal with young people - children and adolescents - when they present in their clinics. Among the recorded maternal deaths, were any of the women who tragically died under the age of 18?

How will the review panel with a convenor, mentioned by the obstetricians and gynaecologists, work in practice? I have a vision of a young woman in crisis being told to put the crisis aside for a couple of hours or days or weeks. What will this look like in respect of getting a second opinion from the review panel by contacting the convenor? How will that work for practitioners and people receiving the service? As Niall Behan correctly pointed out, the European Court of Human Rights recommended that whatever we do must be tangible and practical. It cannot be theoretical and cumbersome particularly for women who find themselves in crisis.

Senator John Crown: I have a series of short questions for Professor Greene, for the benefit of my colleagues who do not have a background in interpretation of medical and epidemiological statistics. Will he elucidate the difficulties which occur in attempting to draw conclusions statistically when one is dealing with such small numbers? Several statements have appeared in the lay media suggesting that one could define a cause and effect relationship between the availability or non-availability of abortion services in a country and its maternal mortality rates. I would be troubled by that supposition because maternal mortality is such an extraordinarily rare event that it is very hard to make any kind of calls and statements with regard to other potentially confounding factors. It has been frequently suggested that not only is this one of the safest countries in the world from the point of view of maternal mortality but that it is number one. It has been suggested that this is somehow because we do not have legalised abortion.

Could my colleagues from the institute answer a question I have asked repeatedly of professional representatives today - are they aware of any case in the history of this State where a woman died needlessly as a result of the legal vacuum surrounding abortion? I am not trying to stray into individual cases or to ask for editorialisation about contemporary cases. Has it happened in the past 30 years, since the issue came onto the constitutional horizon? Will the institute be recommending that there be a specific and relatively liberal regime for making emergency decisions with respect to the need for abortion when the mother's life is in danger?

The role of the Irish Family Planning Association in giving post-abortion counselling has become an issue-----

Chairman: The Senator should deal with the specific topic for today rather than straying

into that area.

Senator John Crown: I will try not to stray into other areas but the association does provide post-abortion counselling services. Will the witnesses clarify how in the event of a legal change it would police the medical veracity of what is said to clients attending their clinics?

Professor Fionnuala McAuliffe: In response to Deputy Kelleher's question about the lack of legal clarity, we feel strongly that it is in a patient's and the public interest that doctors work within a legal framework. If a woman is at substantial risk of dying in the immediate hours and days, there is no legal difficulty, we press on and offer treatment. I am, however, aware of cases in which there is a substantial risk to the woman's life which is not immediate and around which there is legal uncertainty. We have referred those cases to the UK for treatment.

In response to Deputy Ó Caoláin's question about general hospitals and termination of pregnancy, most of the cases we deal with involve patients with severe medical disorders. Many of them need access to intensive care units, physicians and so on, for example, a patient with a deteriorating heart problem would be in coronary care in a general hospital. If a time came when we felt that termination of pregnancy or delivery of a very premature infant was required that would happen in the general hospital because the maternity unit would not have the facilities to look after that patient. That is why we feel strongly that the general hospitals need to be included. If, for instance, the woman was in an intensive care unit in a general hospital and deteriorated suddenly and needed delivery of the baby there would not be time to transfer her to a maternity unit. It would not be safe to do so. That is why we feel these life saving procedures should be carried out in all hospitals. Most of our patients are medical patients and need access to intensive care units and physician input. Many of these are already being cared for in general hospitals.

In response to Deputy Conway's question about minors, the age of consent is 16 so if the patient is over 16 we treat her as any other patient. If she is under 16 her next-of-kin needs to consent. Thankfully, our rates of teenage pregnancy are relatively low. If the patient was medically very unwell and was under the age of 16 we would require her next-of-kin to consent on her behalf. If she is very unwell we will go ahead and treat her. If somebody was at substantial risk of a life-threatening problem she would receive intensive psychiatric or medical treatment. That treatment would continue and the issue of delivering the baby earlier, termination of pregnancy, would require her input and that of her next-of-kin.

In regard to the review panel, the patients we are discussing are usually receiving intensive medical treatment which is ongoing and the issue of the termination of pregnancy or delivering the baby early is part of that package but the other treatment will continue in the background. I agree with Deputy Conway that we need a review panel that would be timely. We discussed this at institute level and decided that there should be a panel available of ten, 20 or 30 doctors so that one could quickly get a second opinion if required. The details will have to be worked out but I totally agree with the Deputy that we need something that will act in a timely way and will be workable. The psychiatrists have a system for a second opinion in place whose structure we might consider for this panel.

In response to Senator Crown I am not aware of any case in which a woman died as a result of the legal vacuum. If a woman is in imminent danger we press on and treat her. One of our concerns about the emergency situation is that if a woman is really very unwell we do not want doctors to delay treating her because they have to get two consultant obstetricians, plus or minus a physician, filling out paperwork while she needs to proceed to deliver the baby either

before or after viability. I am not suggesting any great change in practice. If any pregnant woman in any hospital in the country is very unwell she will receive treatment. It is important that doctors be protected so that in the emergency situation they can get on and deliver that emergency treatment.

Professor Richard Greene: In response to Deputy Ó Caoláin's comment about the absence of a conclusion, I was giving a factual account, the most recent and detailed account of maternal mortality in Ireland. The only conclusion I can draw is that when we do that we have figures that are very good in comparison with the rest of the western world. It is a marker of the health care provided to women in Ireland. In another conclusion and in partial response to one of Senator Crown's questions, I do not have evidence to support in any way the claim that we are number one or are in the top few with respect to maternal mortality because we do not have termination. That evidence would not stand up internationally when one reads literature on maternal mortality. In fact, many developing countries provide termination and their maternal mortality rates are in the order of between 800 and 1,000 per 100,000. Countries in Europe which have social and medical termination of pregnancy have the same region of maternal mortality as ourselves, so I do not think such conclusions can be made. What we are looking at is the fortune of an educated, well-fed healthy population with good medical health care which includes a component, as Professor McAuliffe noted, of undertaking the termination of pregnancies appropriately to protect the mother's life.

In response to Deputy Conway's question on women under 18, the answer is "No", thankfully. To answer questions on clarifying the statistics, in table 2 we give the figure of 8.6 per 100,000 and we show a confidence interval thereafter. If this figure is taken on average and worked out statistically we would see no difference between 5, 4.7 and 12.4; we could be anywhere in this group of figures and be the same, so effectively what these statistics show is that we are not dissimilar from the UK.

Dr. Caitriona Henchion: I will answer Deputy Kelleher's question on the issue of women who might present with suicidal ideation. In the first instance if they were already attending a psychiatric service they would be encouraged immediately and facilitated to liaise with that psychiatric service before making any full decision. If somebody presented who was not in contact with any service we would seek, if possible, to liaise with her GP to try to arrange for her to have appropriate care before she would make a decision. In the event where somebody is absolutely certain, has already come to a decision and does not wish to do any of these things, it is an individual case of trying to add up what is in that person's best interest. Overall our idea is to try to liaise with psychiatric or general practice services to assess a woman and help her with her mental illness.

To answer Deputy Ó Caoláin on whether women might still choose to travel, this will be an individual choice and some women would still choose to travel even if they felt they might meet the criteria because they might not want to have the delay or the problem of going through the assessment. Other women in that position who cannot afford to travel would certainly be very much able to be facilitated by the service.

Mr. Niall Behan: In response to Deputy Ó Caoláin with regard to our two clients who attempted suicide, thankfully they were unsuccessful in their attempts. These two cases happened within the past three years and that is as far back as we looked. One of the clients specifically mentioned a particular barrier to being able to travel to the UK for an abortion as one of the reasons she attempted suicide.

With regard to accessing psychiatric services, abortion services and mental health services are still very much stigmatised in Ireland and many of our clients express strong views on this. They speak about the personal and social implications of accessing abortion services and psychiatric services. It is our experience that women who are not involved in psychiatric services who want to travel for a termination to the UK will travel in preference to being stigmatised, as they would see it, with a mental health illness.

With regard to Senator Crown's question, the IFPA has in place a range of stringent policies and procedures for our services and if a specific complaint is made to us which is apparent and viable we can deal with it. We have been in contested areas of public discourse and have provided services for the past 40 years so it has always been like this for our organisation and we must have these policies and procedures in place.

Chairman: A number of speakers are offering and I ask members to be brief.

Senator Colm Burke: I have a question for the Institute of Obstetricians and Gynaecologists on the options set out in the expert group report. I asked this question this morning and I seek clarification. Three options are given with regard to the decisions to be made by psychiatrists. These are: that the decision would be made by two psychiatrists or two specialists; that the decision would be made by a psychiatrist or specialist and an obstetrician; or that the decision would be made by two psychiatrists or specialists and an obstetrician. What is the view of the institute on cases where the issue of suicide is raised? Should an obstetrician be part of the decision-making process?

In smaller units from 5 p.m. on a Friday to 9 a.m. on a Monday only one obstetrician is on call. What procedures are in place at present to give support where a decision must be made by an obstetrician? What procedures would the institute like to have in place? In many smaller units a locum is brought in during holiday periods and works at weekends. What supports does the institute suggest putting in place to deal with an emergency or a situation where decisions must be taken to terminate a pregnancy?

Senator Imelda Henry: I thank the witnesses for their presentations. We are here today as part of the legislative process and we will spend three days listening to medical and legal professionals and other groups putting across their viewpoints on a very complex issue. The wording of the legislation will be very important and I hope when we come to it that the wording will be correct and that the medical profession will have legal support when a decision to terminate a pregnancy must be made in the very rare circumstances it will arise. We must trust our doctors and medical professionals. We have heard from the masters of the big maternity hospitals in Dublin. We also have wonderful maternity hospitals throughout the country, in particular in the west of Ireland and I welcome Dr. Meabh Ní Bhuinneáin from Mayo General Hospital. I had a rare disease and I am very lucky to be alive. I do not think of Dr. Ní Bhuinneáin every day but I do so from time to time and I am very glad she stayed in the west of Ireland and is so involved in her profession. I do not have a question but I am disappointed we do not have somebody from the GP association before the committee, because sometimes a pregnant woman goes to her GP because she is troubled but will not go any further.

Deputy Regina Doherty: That is right.

Senator Imelda Henry: In Sligo, GPs have referred people to the Marie Stopes clinic in Belfast and I am disappointed we do not have anybody from the IMO before the committee.

Chairman: It was invited but declined.

Deputy Mattie McGrath: I welcome our guests and thank them for coming and giving their views. In particular I thank the medical professionals. I am also disappointed the IMO has not come before the committee but at least it was invited. Others were not invited and are not happy. The IFPA website states it believes abortion is an aspect of private life and has to do with reproductive rights. It also states it supports the choice of access to termination during pregnancy in all circumstances. This makes the IFPA, which is partially taxpayer funded, an abortion advocacy group. Considering this, does it support choice in all circumstances? Does it think the unborn child is entitled to any protection under the law? I also query the consultation the other groups had with their members. People have complained that they were not consulted, which would be unfortunate if true. South Tipperary General Hospital has top class facilities. All of my children were born there. I thank the hospital for the excellent delivery service provided by its midwives and doctors.

Chairman: It would be unfair to say that the Irish Family Planning Association, IFPA, was an advocate of abortion. It is a sexual health and reproductive rights organisation.

Deputy Mattie McGrath: Let it answer the question.

Deputy Peter Fitzpatrick: The IFPA provides information and support to 5,000 women and girls experiencing pregnancies. How many had suicidal thoughts and how many committed suicide? What approach did the IFPA take to those women and girls? It has stated that women and girls in Ireland who require abortion services experience stigma and discrimination and lack support and information from the State. Will the delegates elaborate in this regard, please?

Chairman: I will take all speakers together.

Deputy Denis Naughten: A number of my questions have already been asked. When Dr. Ní Bhuinneáin responds, will she address the comments of Senator Colm Burke? They are relevant in the west.

Mr. Behan stated that the IFPA catered for 5,000 women annually and that it had encountered two cases of attempted suicide in a three-year period. When Professor Veronica O'Keane presented earlier today, she made the point that the level of threatened suicide and suicidal intent and ideation encountered by front-line services was far higher than was encountered by perinatal consultants, as the former met many of the clients in question. The IFPA sees many women and the figures it has provided seem to tie in with those of the perinatal consultants, not those provided by Professor O'Keane. Will the witnesses clarify this point?

To clarify, is it Professor McAuliffe's opinion that no special provision should be made for emergencies? I presume this was only meant in the context of the expert group report and that she is actually seeking special provision for emergencies and that the current procedures would be maintained, would not fall under the terms of new legislation and would not require a second consultant for approval. Will she clarify whether this is the case?

My final question is for Professor McAuliffe and Dr. Ní Bhuinneáin. There are 120 obstetrics and gynaecological consultants. Are the witnesses satisfied that there is an adequate geographic spread of those consultants to ensure that existing maternity facilities can provide the services in question and make decisions in the difficult situations that may arise?

Deputy Seamus Healy: Most of my questions have been asked, but I will ask one of the Institute of Obstetricians and Gynaecologists. We are dealing with this issue on the basis of the probability of a real and substantial risk to the life of the mother. What is the institute's opinion in terms of fatal foetal abnormalities? Does this issue fall within the context of a real and substantial risk to the life of the mother and, if so, how?

Deputy Robert Dowds: Professor McAuliffe mentioned referring some women to England. What were the reasons, how many has she referred and did she make those decisions because of the inadequacy of current legislation?

Deputy Regina Doherty: My question will follow on from Deputy Dowds's. Professor McAuliffe mentioned that, when the substantial threat or risk to the life of the mother was immediate, professionals knew exactly what to do, but that there was a grey area when the threat was not immediate. Professor McAuliffe stated that, in certain scenarios, she sent the latter category of women to another jurisdiction to be treated before returning to her. If she wanted to include this category in legislation, how would she suggest it should be framed?

Deputy Catherine Byrne: I seek a point of information. I am glad to hear that Ireland is probably one of the safest places to have a baby. Why did the IFPA enclose in its submission legislation from a number of European countries? Was it purely for informational purposes or did the IFPA have a specific reason for doing so?

Chairman: We only have 29 minutes remaining in this session. Professor McAuliffe might commence.

Professor Fionnuala McAuliffe: I wish to clarify for Senator Colm Burke the point about two obstetricians. Having discussed the matter in detail, we believe that two obstetricians would be involved in making decisions in all cases where it was felt that the termination of a pregnancy or the premature delivery of a baby was required. Whether the threat owes to suicide, heart disease or lung disease, obstetricians should be central. Two obstetricians plus the relevant specialist registered psychiatrist should be involved.

Deputy Mattie McGrath referred to the consultation process. We convened a group of senior institute members on 4 December, discussed the report in detail, devised a draft document, circulated it to the members of the institute's executive and discussed it on 14 December. The executive's members are chosen from and represent their regions. Their role is to communicate with their members within each region. The document was passed unanimously by the executive on 14 December. There was adequate consultation with the institute's members.

Deputy Naughten mentioned emergencies. In emergency medical situations, the usual procedures and policies are often put aside to prioritise the provision of medical treatment. The same would pertain were a woman's life in serious danger. If she needs immediate treatment, one obstetrician should be sufficient. We would not expect the requirement for two obstetricians or the usual paperwork to pertain, as women's lives could be lost. In emergency cases, people often write their notes afterwards. The priority is to deliver first-line medical services.

Regarding the question on fatal foetal anomalies, the institute's remit was to give an opinion on the expert group report, which was confined to a substantial threat to the life of the mother. It was not within our remit to address fatal foetal abnormalities. Our brief is confined to the report.

Deputy Dowds asked about the legal framework. There should be a legal framework in

which we can act in these cases. We do not have a register of the cases in question. As a maternal medicine consultant, I am a specialist in this area and I see many such cases. There are a number of cases every year in which there is some legal uncertainty. We refer those patients abroad for treatment. I do not have the exact numbers. It is important for our patients and the public that doctors work within an appropriate legal framework. We request that legislators provide a robust framework.

I was asked about how we deal with cases of immediate risk and so on within the legislation. Medical expertise plays a role in this regard. We have experience of looking after pregnant women and we have knowledge of the literature. If two senior obstetricians believe that there is a substantial risk to the life of the mother - we will not define percentages or timelines, as doing so is impossible - the criteria will be fulfilled. Legislation to this effect would cover all situations in which there is a substantial risk to the life of the mother.

Dr. Meabh Ní Bhuinneain: I am happy to answer the questions on the smaller units. I thank members for their favourable comments on the maternity service in the west at this time.

On the smaller units, which issue was dealt with at length this morning with Dr. McCaffrey, these services are in isolated areas and operate out of hours. Unfortunately, obstetrics tends to be busier out of hours than during normal working hours. There has been much change in this area over the past ten years as a result of the review of maternity services. There are now informal networks linking hospitals all around the country with the maternity units in each area. These networks are not formalised in every part of the country but they do afford a greater communication between tertiary specialists. Also, owing to mobile phones, the ability to contact colleagues out of hours is greater.

In terms of a consultant going off duty in a small unit leaving the duty of care with a locum, the substantive consultant has a duty to ensure that the locum is suitably qualified for the services. We have experienced huge difficulties staffing these units. However, for the purpose of today's discussion, if the substantive consultant is not adequately satisfied that the locum can perform all duties that might arise, he or she would not then be able to go fully off call. While the response time might not be the ten to 15 minutes for obstetrics which is often the case, the consultant will be responsive by phone and be able to return to the unit within 30 or 60 minutes, which in the type of situation we are discussing today is often the timeframe involved.

There is recognised urban drift of professionals and different working groups towards the urban centres, which is difficult in a country that does not focus on rural training and streaming in the context of the delivery of these services in the long term. In practice, it is possible in many situations of imminent risk to get second opinions and often to get a second pair of hands. It must be remembered that currently all the maternity units are sited in general hospitals outside the free-standing maternity units in Dublin so that there are specialties who have not been involved in this process, including general surgeons who attend emergencies and general physicians and anaesthetists with intensive care expertise who are part of teams on duty at weekends. The brief needs to be widened to include other medical practitioners who will of course be governed under the Medical Council provisions that will change in due course as the Government legislates on this issue.

The question was asked as to whether we are satisfied that with a consultant spread of 120 we have enough geographical spread. That will depend on what happens with reconfiguration. The reason we have sought regulation with the legislation is to ensure we can adapt to situations as they arise. If a unit suddenly loses some aspect of its acute service then the geographical

spread might not be acceptable. We may have to regulate for this to adapt as time proceeds.

Mr. Niall Behan: I will respond first to Deputy McGrath's question on the IFPA. We are a medical organisation and see 20,000 clients per annum. We have reached our conclusion on abortion and criminalisation of abortion based on our dealings with the many women who have come to our services. As a result of that dialogue, we believe it is best that these decisions are left to the woman and her doctor and that criminal law should not come into it and does not serve any purpose in this discussion.

The fear is that if criminal law is removed the abortion rates will increase. We know that this is not true. There is enough evidence available which suggests that the criminal law does not impact on abortion rates. That is the reason we included some information in our submission on what happens in other countries. We also included that information because in the A, B and C judgment the court suggested to the Irish Government that in seeking to resolve these very difficult issues, it should look to what happens in other European countries. As such, we need to look beyond the UK, which is to where we usually look for an answer. That is the reason we included that information in the submission.

Other questions - I apologise if I have not taken on board everybody's questions - were on issues such as suicidal thoughts and how many clients we saw. I referred in my opening statement to two female clients who had followed through on their threats and committed suicide. Many more of the women we saw may not have been suicidal but owing to mental health reasons such as depression and so on were in crisis pregnancy. The vast majority of those women have travelled to the UK.

On the criminalisation of abortion, how we might respond to that and our view in regard to the unborn, we must look to what has happened around abortion rates in Ireland during the past ten years, which rate has decreased fairly substantially. The last time there was a similar hearing to this on the abortion issue, parliamentarians heard from a range of people. The medical advice given to parliamentarians at that time was that to reduce abortion rates we needed better sex education and greater access to contraception. From that the Crisis Pregnancy Agency was established. That has been successful in terms of reducing abortion rates during the past ten years.

Chairman: Would Professor Greene like to comment?

Professor Richard Greene: No.

Chairman: There are 15 minutes remaining for this session. I call Deputy Ó Caoláin.

Deputy Caoimhghín Ó Caoláin: I had only limited time to question the obstetricians and gynaecologists and would like if I may to put some further questions on that issue to Professor McAuliffe. On the 1861 Act, I expect that it would be the professional experience of Professor McAuliffe and her colleagues that there are no instances in their knowledge where the overhanging threat of that extant legislation would have impacted negatively on decision making by professionals. However, as others have already indicated to the hearing during earlier sessions, there is a great discomfort at the fact that this legislation remains on the Statute Book and all that this implies in terms of contravention of the law as it stands and the possibility or risk of legal action being taken against a practitioner. I would welcome if Professor McAuliffe could elaborate on that point and presume she will confirm that while there are no known cases in that regard, there is nevertheless a powerful discomfort that needs to be addressed by the removal

of that legislation.

I would also like to raise at this point one final question which has not been asked in the course of questions to the witnesses before us. Uniquely among the contributions made here today in relation to the composition of the review panel, the Institute of Obstetricians and Gynaecologists indicated it would accept appointment of a member of the legal profession as chairperson of the review panel, which merits a little elaboration as it is not something we heard in earlier contributions. I would like to hear further on that, please.

Deputy Denis Naughten: I have some questions for Professor McAuliffe in relation to the smaller units. The master of the Rotunda, Dr. Sam Coulter Smith, made the point earlier that there is a need to put in place a referral pathway for decision making in the case of smaller maternity hospitals. Dr. Ní Bhuinneain made the point that in the situation prior to reconfiguration there would be another specialist in the hospital, perhaps not another obstetrician but another specialist. I presume her recommendation is the second option, that the sign-off would be made by an obstetrician with one other specialist. Is that her view or does she believe there should be this pathway, as was referred to earlier this morning?

On the issue of suicide, Dr. Mary McCaffrey made the point that none of her colleagues for whom she spoke this morning had felt they were competent to deal with making a decision on termination on the grounds of suicidal intent. In these circumstances does Dr. Ní Bhuinneain believe it should be up to the perinatal psychiatrist to make the call in that regard or should the obstetricians have a direct role in making the decision?

Professor Fionnuala McAuliffe: In response to Deputy Ó Caoláin, we feel strongly that there must be a legal framework within which to make our clinical decisions. That would protect the public, our patients and health care professionals. We are not aware of a case of maternal death because obstetricians were reluctant to act, but we strongly feel robust legislation is needed to give a framework for our work.

In respect of the chair of the review panel, we discussed this issue briefly and felt they could be recruited from either the medical or the legal profession. That is our position; we have not come down strongly on one side or the other.

In response to Deputy Naughten regarding the situation in smaller hospitals, if a woman presents at a smaller unit on a Saturday night with severe blood pressure and needs delivery as her life is in danger, that patient will be looked after. That must be clearly stated. We have lovely data from Professor Greene. Our units in the hospitals are of very high quality and the results are excellent. In an emergency a specialist can make these decisions and offer life-saving treatment. If time allows and the patient is unwell but not immediately in danger, one could refer her to a larger unit where, perhaps, there is more expertise available. However, if a woman arrives at any maternity unit in the country at the weekend, at night and is very unwell and needs delivery at whatever stage of the pregnancy, she will receive that treatment. That is part and parcel of running a maternity unit, regardless of its size. As Dr. Ní Bhuinneain said, if a patient arrives and there is some uncertainty as to whether she needs delivery, a second opinion can be sought by telephone. That is why it is important that we make provision for emergency cases, whereby one doctor can make this decision to allow a woman's life to be saved.

With regard to suicide, the institute believes two obstetricians should be involved in any decision to deliver a baby before or after viability, termination of pregnancy or delivery of a preterm baby in the suicide case. We feel that in any case in which there is a substantial risk to the

life of the mother, be it suicide or medical, two obstetricians should be involved in that decision.

Professor Richard Greene: I wish to comment, as a practising obstetrician, in response to Deputy Ó Caoláin who asked about the 1861 Act. I am not aware of cases, but, as a practising obstetrician, I am very aware of the difficulty that this causes for us on a regular basis. It is not uncommon for people working in the unit to have concerns, for example, about the constitutional equal right to life of the child. This comes up as a discussion point when one is making these very difficult decisions, which is why we need legal clarity on the issue. The other point is that it is very easy to make a decision if a mother is going to die because of excess bleeding or blood pressure to deliver her baby immediately. It is not very easy to do so where there is a threat to the life, but it could be some weeks or months down the road.

Senator Colm Burke: To clarify, Professor McAuliffe said two obstetricians should decide in the case of suicide. Is that correct?

Professor Fionnuala McAuliffe: Yes.

Senator Colm Burke: Does she mean two obstetricians and one psychiatrist?

Professor Fionnuala McAuliffe: Yes.

Senator Colm Burke: The expert group report gives three options which does not include that one. Is the institute going outside the expert group report's recommendation?

Professor Fionnuala McAuliffe: Yes, we are. We feel there should be two obstetricians who are on the specialist register making any decision if there is a substantial risk to the life of the mother, plus any number of other specialties required. If it is a psychiatric case, we might need one or two psychiatrists. If it is a liver case, we might need a liver specialist and if it is a heart case, we might need a cardiologist and a cardiac surgeon. In any situation where there is a substantial risk to the life of the mother where termination of pregnancy or delivery of a very premature infant is required, we strongly feel two obstetricians on the specialist register should be involved in that decision.

Chairman: We will proceed to the session of 20 minutes duration for non-members of the committee. I call Senator Walsh. I apologise for omitting to call him in the last session.

Senator Jim Walsh: Thank you, Chairman. As we come to the end of the first day of hearings, we can be reassured about the very great degree of confidence in the quality of our maternal health care. In fact, Professor Greene started by talking about women availing of the very high level of health care on offer in this country. I welcome the statement of the obstetricians and gynaecologists that outcomes and maternal health care here compare favourably with best international comparators.

I have a question for the obstetricians about the duty of care. Do they think the current two patient model is one we should try to preserve and that there should be a duty of care to the baby in any legislation introduced? Second, with regard to legislation, a number of the groups have made the point that they are anxious that the 1861 Act be repealed. If it is repealed, should there be sanctions in certain circumstances for illegal abortions?

Will the IFPA representatives identify circumstances which occur in the other countries they mentioned where they would disallow abortion or would they allow it in all circumstances? Do they consider that the unborn child is entitled to protection within the system and the legislative

framework? I believe I understood Mr. Behan correctly when he said doctors were prevented from giving women the best care. That flies in the face of everything we have heard this evening and previously. Would he like to reconsider this in the context of these comments or will he give us evidence based, not opinion based, reasons if he does not resile from that position?

Dr. Sam Coulter Smith, an eminent obstetrician who appeared before the committee earlier, said such practices could put women's lives at risk. He was referring to the investigation currently under way with regard to Mr. Behan's association. Would he like to take the opportunity to clarify the matter and make an appropriate statement on it?

Chairman: The Senator's question is out of order and I will not allow it. It would be unfair to the witness and the committee.

Senator Jim Walsh: It is not. It is very pertinent.

Chairman: The committee has discussed that issue. We are awaiting an investigation. The Senator is being unfair.

Deputy Terence Flanagan: Will Professor Harrison say if the institute has consulted its full membership about the expert group report? What form of consultation was taken in that process?

My next question is for Mr. Behan of the Irish Family Planning Association. Considering the low level of maternal deaths in this country, why does he think Ireland is an unsafe place for a woman to be pregnant?

Senator Paul Bradford: My questions are for Mr. Behan. Will he confirm his organisation's policy position as outlined on its website, which indicates that the association is in favour of - we will not upset anybody by using the word "advocate" - the availability of abortion in all circumstances?

Chairman: That question is not relevant to what we are discussing in the context of the Government decision.

Senator Paul Bradford: With respect, it is very relevant if an organisation is presenting here and if the stated policy of that organisation on its public website is that it favours the availability of abortion in all circumstances. I would like that to be confirmed.

My second question for Mr. Behan is that point 24 in his presentation mentions the need for progress and legislation before the next tragic case. We have heard today from a wide variety of witnesses who have all put on record that to the best of their knowledge, there have been no maternal deaths arising from our current constitutional position and legislation. Could Mr. Behan let me know what tragic cases he is referring to? Would he confirm his organisation is in full compliance with and fully respects the law of the land at present?

Senator Fidelma Healy Eames: I thank the witnesses for their forthright and helpful information. Can we get some more specifics about the cases that Professor McAuliffe had to refer to Britain as a result of the lack of legal clarity in the Republic of Ireland? What are the circumstances surrounding them? This could be helpful when we are framing the legislation because information could help us to narrow down and define the problem we must address.

In helping us frame legislation, would the witnesses propose that time, support and intervention would be useful to a pregnant woman who believes she is at risk of suicide before a termi-

nation is provided? Would that be helpful? I am aware a lot of time is spent running around to get various things signed off before a termination but we should also think of the mother who is feeling suicidal and who believes she is suicidal. Bearing in mind all of the psychiatric evidence that abortion is not the way to treat to suicide, and given the job we must do to frame the legislation, what type of time, support and intervention would be helpful?

Deputy Michael Creed: I thank the witnesses for their evidence. In the context of the institute's support for legislation and clarity, are we talking about transposing the current Medical Council guidelines so they have statutory standing and, if so, what is the institute's outlook on those guidelines as they relate to suicide as a grounds for termination?

How long has it been the institute's policy that we require a legal framework for this? As a public representative for some years, I do not recall having been lobbied by the institute previously to provide legislation in this area. Has the institute adopted this position recently on foot of the A, B and C *v*. Ireland judgment and the X case report?

In respect of the reference made about treatment abroad, are we talking about termination exclusively or the range of obstetric and gynaecological conditions, including human assisted reproduction, for which we do not have a legal framework here?

Mr. Niall Behan: I am conscious a number of these questions are not directly relevant to the report of the expert group but I will answer as best I can.

On the issues around the circumstances in which protection would be given to the unborn, in part of our submission, we included information on what happens in other European countries. In other countries, some protection is afforded to the unborn at particular gestation periods and in particular circumstances. The difficulty in Ireland, and the expert group deals with this well, is that the constitutional referendum in 1983 tried to equate the life of the unborn with the life of the woman. Essentially that has given the unborn more rights than the woman in practice and we have women travelling to another jurisdiction for abortion services as a result.

On the remarks in our opening submission and women not getting the best care, we would not be here without the A, B and C *v*. Ireland case. We would not be here if that woman could have got a determination from her doctors. We would not be here today if C in the A, B and C *v*. Ireland case had got a determination and if the law was in place. Professor McAuliffe has already mentioned cases where women have had to be sent to Britain. From our perspective, the question is what would happen in those cases if a woman could not travel because she could not afford it or did not have the necessary documents.

The Irish Family Planning Association has always respected the laws of the State. That does not stop us advocating for our clients and bringing to the attention of lawmakers circumstances where the law is a barrier to health care.

I hope I have answered all the questions but I am happy to answer any more.

Senator Paul Bradford: I asked a simple question. Is Mr. Behan's organisation fully compliant with current Irish law?

Chairman: He has already answered that.

Mr. Niall Behan: Yes, of course it is.

Professor Fionnuala McAuliffe: To answer Senator Walsh, as obstetricians we have an

equal duty of care to mothers and their babies and that, of course, will always continue. While we would bow to the superior knowledge of our legal colleagues, it is our preference to have the 1861 Act repealed.

In response to Senator Healy Eames, at the moment, there is no legal certainty for us taking decisions where there is a substantial risk to the life of the mother. We have no legal framework for such decisions and that leads to uncertainty. To reiterate, these are rare cases, and I am aware of a small number where there is legal uncertainty. We have referred cases to Britain for a second opinion and the woman has had a termination in Britain and come back for continuation of treatment in Ireland. If we had legal certainty in these very rare cases where there is substantial risk to the life of the mother, where women have severe medical disorders, we could look after all women where there is a substantial risk. How could this be accommodated in the legislation? If senior doctors could act when they feel there is a substantial risk or threat to the life of the mother which can only be averted by termination of pregnancy or early pre-term delivery of the baby, that would cover the cases we come across where we feel uncertainty.

Is legislation or regulation required? We seek a legal framework and certainty and would defer to our legal colleagues on how that is best framed. At present there is legal uncertainty and we are looking for legal certainty, the nuts and bolts of which we would leave to the legal experts.

I will respond to the query about the expert group. This is the second time I have been asked this question. The answer remains the same. We convened a group of people from the institute on 4 December and came up with our report, which was circulated to the members of the executive of the institute. It was passed unanimously at the meeting of the executive which took place on 14 December. Each executive is represented because it represents an area within Ireland. It amalgamates the views of its members.

I was also asked whether we have been lobbying for this previously. The answer to that question is "No". Our remit was to respond to the expert group. The committee has heard that response today.

Chairman: Would Dr. Ní Bhuinneain or Professor Greene like to comment at this point?

Professor Richard Greene: I cannot remember who asked about the care given to somebody who has suicidal ideation in advance of the carrying out of a termination. Regardless of suicidal ideation or medical conditions, it is absolutely the case that our first point of care for women involves looking after them as best we can. The question of termination arises if it is part of the treatment that is needed.

Senator Jim Walsh: I wish to put a question to the obstetricians. I understand that when a person with suicidal intent who is beyond a certain gestational period is being treated, efforts are made to made to induce the baby and save the baby's life. Are we saying prior to that gestational period being reached, the baby's life will be forfeited and the treatment will not take place?

Chairman: I thank the Senator.

Senator Jim Walsh: I am trying to find out whether the treatment that would be done post-viability could be applied to the earlier stage. As one of the witnesses said, a person who feels suicidal one day might not feel suicidal the next day. Could we try to bring the woman through such a situation to the gestational stage at which the baby could be induced safely?

Chairman: Before I call Professor McAuliffe, I would like to acknowledge the presence in the Gallery of a former Senator, Dr. Mary Henry. I welcome her to this meeting.

A Member: A former Deputy, Geraldine Kennedy, was here earlier.

Chairman: I did not see her.

Professor Fionnuala McAuliffe: I reiterate that we are talking about a small number of rare cases in which there is a substantial risk to the life of the mother. If we feel this risk can only be averted by the delivery of the baby - whether that is before viability or afterwards - that will be part of the care package. These decisions are made in conjunction with the mother, her family and a number of health care professionals. Of course we always include the life of the baby. If we feel we can prolong the pregnancy, absolutely we will do so. We may feel we are looking at a situation in which the life of the woman is in imminent danger, however. If the mother dies, the baby dies. If we can preserve the life of the mother, that gives the baby the best chance to continue. We take a team approach, including the family, when making these complex decisions. When the baby has reached any chance of survival, we always offer appropriate support.

Chairman: I thank Mr. Niall Behan and Dr. Caitriona Henchion from the IFPA, Professor Robert Harrison, Dr. Meabh Ní Bhuinneain and Professor Fionnuala McAuliffe from the Institute of Obstetricians and Gynaecologists, and Professor Richard Greene from Maternal Death Enquiry Ireland for being here this afternoon. I thank the members of the committee for their forbearance. I thank the Members of the Oireachtas who are not members of the committee for being here. I understand Professor Harrison would like to make a brief comment in conclusion.

Professor Robert F. Harrison: This has been a somewhat disparate session compared to the sessions earlier in the day. I thank the committee for inviting us to the meeting. As the corporate entity representing the obstetrics and gynaecology specialty in Ireland - we will be most intimately connected with the administration of the legislation or regulations that must come into being, in our view - the institute hopes to be invited to engage actively on this issue by providing input and support to the Department of Health.

Chairman: I thank Professor Harrison.

The joint committee adjourned at 6.45 p.m. until 9.30 a.m. on Wednesday, 9 January 2013.