DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE AGUS LEANAÍ

JOINT COMMITTEE ON HEALTH AND CHILDREN

Dé hAoine, 17 Bealtaine 2013

Friday, 17 May 2013

The Joint Committee met at 09.30 a.m.

MEMBERS PRESENT:

Deputy Catherine Byrne,
Deputy Ciara Conway,
Deputy Regina Doherty,
Deputy Robert Dowds,
Deputy Peter Fitzpatrick,
Deputy Seamus Healy,
Deputy Billy Kelleher,
Deputy Mattie McGrath,
Deputy Sandra McLellan,
Deputy Eamonn Maloney,
Deputy Denis Naughten,
Deputy Caoimhghín Ó Caoláin,
Deputy Mary Mitchell O'Connor,
Deputy James Reilly (Minister for Health),
Deputy Robert Troy,

Sentor Ivana Bacik,*
Senator Colm Burke,
Senator John Crown,
Senator Aideen Hayden,**
Senator Imelda Henry,
Senator Jim Walsh.*

* In the absence of Senators John Gilroy and Marc MacSharry, respectively.

** In the absence of Senator Ivana Bacik, for part of meeting.

In attendance: Deputies Gerry Adams, Eric Byrne, Michael Conaghan, Joe Costello, Michael Creed, Bernard J. Durkan, Frank Feighan, Terence Flanagan, Dominic Hannigan, Simon Harris, Kevin Humphreys, Derek Keating, Michael Lowry, Finian McGrath, Joe McHugh, Peter Mathews, Seán Ó Fearghaíl, Aodhán Ó Ríordáin, Joe O'Reilly, John Paul Phelan, Brendan Ryan, Arthur Spring, Billy Timmins, Peadar Tóibín and Liam Twomey, and Senators Paul Bradford, Martin Conway, Rónán Mullen, Catherine Noone, David Norris, Labhrás Ó Murchú and Jillian van Turnhout.

DEPUTY JERRY BUTTIMER IN THE CHAIR.

Heads of Protection of Life during Pregnancy Bill 2013: Public Hearings

Policy - Overview of Heads of Bill

Chairman: I welcome everyone to this morning's session. Is it agreed that we begin in public session? Agreed. I remind members of the committee, witnesses and those in the Gallery, be they members of the media or members of the public, to ensure their mobile telephones are switched off for the duration of the meeting as they interfere with the broadcasting equipment even when they are on silent mode. It is particularly unfair to members of staff who have to wear headphones.

This is the first of the sessional meetings of the Joint Committee on Health and Children dealing with the heads of the protection of life during pregnancy bill. The fundamental role of the Oireachtas is to enact legislation and in doing so it must act within the parameters set down by the people in the Constitution, Bunreacht na hÉireann. The Constitution is a living, dynamic document which is applied by the courts and ultimately interpreted by the Supreme Court. It is within this framework that the Government and the Oireachtas must act. Both are constrained by its provisions and neither can go beyond what is constitutionally prescribed. In this context, the Government has asked the committee to discuss and analyse the Bill. It has referred the heads of the Bill for our consideration and scrutiny.

I thank committee members and those who have joined us for the duration of the meetings for their deliberations in advance. I wish in particular to thank members of the committee from all parties and the Independents for their co-operation with me and the clerk in the composition of the hearings. Our approach and the approach of the Government is that we will have analysis of the heads of the Bill over the next three days. I hope we will do so in a manner that is calm, tolerant and respectful of each viewpoint expressed by Members of the Houses of the Oireachtas, committee members and witnesses. I also hope that similar to other hearings we held on other legislative proposals that our deliberations will be constructive and will have a positive role to play in assisting the Government in the formulation of legislation.

As part of our hearings it is important that we gather information and that we listen to and engage with the views of witnesses who have voluntarily given of their time to come before the committee to assist with the scrutiny of legislation. I know that I speak for all of us on the

committee when I say that I hope we will continue in the same vein and approach we took in the January hearings when the contributions were positive, helpful and courteous. Given that we are discussing a very sensitive matter with diverse viewpoints, it is incumbent on all of us to be respectful of all of the views expressed within this Chamber. I remind members that we are in the Chamber of Seanad Éireann and as a consequence there is a responsibility on all of us to uphold the dignity of the Houses of the Oireachtas.

This morning we will hear from the Minister for Health, Deputy James Reilly, the chief medical officer, Dr. Tony Holohan, and we are also joined by Mr. Ambrose McLoughlin, the Secretary General of the Department of Health and Ms Geraldine Luddy. I thank them for their presence this morning. Over the course of the day I hope that our hearings will be positive, constructive and that all members of the committee and of the Oireachtas will engage in the analysis of the heads of the Bill in a dignified manner. Each member will have three minutes for questions to the witnesses and the Chair will be impartial on adjudicating on the time allocated. I ask each member to comply with the time constraints. I do not wish to be in any way disrespectful to members but the ruling on time will be strict.

Before we commence, I remind members and witnesses that witnesses 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 on a particular matter and they continue to do so, 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 the proceedings is to be given and they are asked to respect the parliamentary practice to the effect that where possible they should not criticise nor make charges against any person, persons or entity by name 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 to the effect that they should not criticise, comment on or make charges against either a person or persons outside the House or an official either by name or in such a way as to make him or her identifiable.

I call on the Minister for Health, Deputy Reilly, to make his opening remarks.

Minister for Health (Deputy James Reilly): Thank you, Chairman and members of the committee. I am pleased to be present today to open the hearings on the general scheme of the protection of life during pregnancy Bill. I look forward to the presentations of the invited guests. I am confident the hearings will provide very useful input as we come to finalise drafting of the terms of the Bill. I was struck by the balanced and respectful approach taken by all during the previous three days of hearings held by the committee in January, and I echo the Chairman's hope that the present hearings will be as productive.

As all are aware, on 30 April the Government approved the drafting of the protection of life during pregnancy Bill 2013, subject to any technical amendments that may be deemed necessary following consultation with the Attorney General, and the publication of the general scheme of the Bill. The general scheme aims to give effect to the Government's decision in December 2012 to legislate in this area within the parameters of Article 40.3.3° of the Constitution, as interpreted by the Supreme Court in the X case, in order to implement the judgment of the European Court of Human Rights in the A, B and C *v*. Ireland case.

Before I proceed it is worth reminding ourselves of the findings of the judgment. Three applicants, A, B and C, all of whom had crisis pregnancies, brought proceedings against Ireland before the European Court of Human Rights claiming violations of Articles 2, 3, 8, 14 and 13 of the European Convention on Human Rights. In its judgment delivered on 16 December 2010

the Grand Chamber determined that there had been no violation of the convention in relation to the first and second applicants, Ms A and Ms B. The Grand Chamber determined that there had been a violation of Article 8 of the Convention in relation to applicant, Ms C. The court found that Ireland had failed to respect the Ms C's private life contrary to Article 8 of the convention, as 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 aim of the general scheme is to provide such a procedure. However, it is worth noting again that the issues at stake here are extremely complex and engage with fundamental rights.

I will now go through the general scheme head by head. I do not wish to pre-empt the committee's discussion but I am mindful that there might be issues still to be dealt with and my Department has already identified some provisions that might need to be revisited from a technical perspective. Furthermore, some of the participants in the hearings might also have identified additional technical issues that might need examination. I look forward to any suggestions that will lead to the improvement of the operation of the legislation.

Head 1 of the scheme deals with the interpretation of the Bill; it defines the meanings of some of the terms used for the purposes of the Bill, including appropriate location, reasonable opinion, and unborn. Head 2 deals with the risk of loss of life from physical illness. It provides that it is not an offence for a registered medical practitioner to carry out a medical procedure in the course of which, or as result of which, unborn human life is ended under certain circumstances. These are that the procedure is carried out in an appropriate location and two medical practitioners registered on the specialist division of the Medical Council register have certified that in their reasonable opinion there is a real and substantial risk to the life, as opposed to the health, of a pregnant woman arising from a physical illness that can be averted only by a termination of pregnancy. The process requires an assessment on medical grounds to determine if the test set out in the Supreme Court judgment in the X case is met. The Supreme Court held that the correct test was that a termination of pregnancy was permissible if it was established as a matter of probability that there is a real and substantial risk to the life of the mother, and this risk can only be averted by the termination of her pregnancy. It is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate.

The definition of "reasonable opinion" requires that this opinion must be formed in good faith and must have regard to the need to protect the right to life of the unborn and preserve unborn human life where practicable. The emphasis on preserving unborn human life means that a doctor will be obliged to make every effort to safeguard the unborn and, where it is potentially viable outside the womb, to make all efforts to sustain its life after delivery. The registered medical practitioners will be obliged to record this opinion in writing if certifying a procedure that will end unborn human life.

One of the two medical practitioners involved in the certification process will always be an obstetrician-gynaecologist and the other will be a medical practitioner in a specialty relevant to the risk to the life of the woman, for example an oncologist or a cardiologist. As indicated in the definition of reasonable opinion, the test requires a clinical diagnosis on the risk to the life of the pregnant woman and a foetal assessment. Therefore the expertise of an obstetrician will always be required. Second, a termination of pregnancy will most likely be carried out by, or under the care of, an obstetrician-gynaecologist, and therefore their inclusion here should be central in accessing services and ensuring patient safety. During the process of assessment it may also be appropriate that the pregnant woman's GP is consulted with her permission and where practicable and feasible.

Regarding appropriate locations, it is intended that these will be public obstetric units only. I believe the State's constitutional obligation and its responsibility to act in the common good demand that provision of terminations of pregnancy be only allowed in health-care facilities providing obstetric and mental health services and where relevant specialists are attached, which can be duly monitored and investigated, should the need arise.

Head 3 deals with emergency situations, where there is an immediate risk of loss of life arising from physical health conditions only. In an emergency situation, the opinion of one registered medical practitioner will be sufficient for the termination to be lawful. Doctors should not be prevented from saving a woman's life in a situation of acute emergency, because, for example, the required numbers of doctors are not available to certify or the woman in question arrives at a health facility that is not covered as an appropriate location under this Bill - that is to say, not a public obstetric unit. Therefore, in emergency circumstances, the reasonable opinion of one medical practitioner is required to certify that the termination is immediately necessary to save the life of a pregnant woman, but the medical practitioner who carries out the procedure will be required to certify the reasons for his or her actions, and notification of all emergency terminations will be sent to my Department.

Again, this opinion must be formed in good faith and have regard to the need to preserve unborn life where practicable. The emergency exception described will not apply in the case of a risk to life from self-destruction because of the more subjective nature of the diagnosis due to the absence of objective clinical markers.

Head 4 deals with a risk to the life of the pregnant woman from self-destruction. Assessment of self-destruction is more subjective and there are recognised clinical challenges in accurately assessing suicidal ideation, for example, the absence of objective clinical markers. Therefore, this assessment requires more safeguards to be put in place. In these cases, three medical practitioners registered on the specialist division of the Medical Council register must certify that in their reasonable opinion there is a real and substantial risk to the life of a pregnant woman arising from self-destruction that can only be averted by a termination of pregnancy. One of them must be an obstetrician-gynaecologist and the other two must be psychiatrists.

I am aware that the role of the obstetrician in this assessment has been raised. However, the test in this case will always be a multidisciplinary test, as it requires a clinical diagnosis on the risk to the life of the pregnant woman and a foetal assessment. Therefore the expertise of an obstetrician will always be required.

Head 5 provides for the notification to the Minister of the certified medical opinions referred to in heads 3, 4 and 5. It is undoubtedly important to record the number and nature of terminations of pregnancy carried out under this Bill, in order to monitor its correct implementation and detect any potential abuse of its provisions. Therefore, the legislation includes a clear requirement on providers to notify for all terminations carried out under this legislation within 28 days.

Head 6 provides for the establishment of a formal process to allow a woman to seek a medical review of her case. The establishment of a formal framework providing for an accessible, effective and timely review mechanism is one of Ireland's obligations under the judgment in the A, B and C *v*. Ireland case. The purpose of this formal medical review process is to provide a mechanism for the woman, where she so requests, to have access to a review of the clinical assessment made by the original doctor or team of doctors. In practice, this will only arise where the woman's request for a termination in line with the X case criteria has not been granted, or when she has been unable to obtain an opinion in this regard. It is important to note that this

formal review pathway is in addition to and not in substitution for the option of a woman seeking a second opinion as with normal medical practice.

It is intended that the Health Service Executive will act as the convenor for the purpose of the formal medical review process and will appoint authorised persons to establish and convene a review committee drawn from a review panel. It will also establish a panel of relevant experts for the purposes of this formal medical review. Members will be nominated by the Institute of Obstetricians and Gynaecologists, the Irish College of Psychiatry, the Royal College of Surgeons in Ireland and the Royal College of Physicians of Ireland. The HSE will draw from this panel when it needs to establish a review committee to consider an application made under this head.

As soon as possible but no later than seven days after receiving a written request from the pregnant woman the HSE shall establish and convene the committee drawn from a panel maintained by the executive. The committee shall complete its review as soon as possible but in any event no later than seven days after the HSE has formed the review committee.

Head 7 sets out of the functions of the review committee in physical illness matters. These provisions precisely mirror the provisions in head 2 for the initial assessment in both the number and specialties of the doctors involved.

Head 8 sets out the function of the review committee in the case of risk of loss of life through self-destruction. These provisions precisely mirror the provisions in head 4 for the initial assessment in both the number and specialties of the doctors involved.

Head 9 sets out the general provisions for the committee for both physical risk and risk from self-destruction. It aims to empower the review committee to obtain whatever manner of clinical evidence it requires to reach a decision, and to call any relevant medical practitioners to give evidence in person and to vindicate a woman's right to present her case at the meeting of the review committee or someone authorised on her behalf.

Head 10 sets out that reports from all review committees must be reported to the Minister by the executive. Information that will have to be provided includes the total number of applications received; the number of reviews carried out; in the case of reviews carried out, the reason the review was sought; and the outcome of the review. Again, this information is required to monitor the implementation of the legislation to ensure the principles and requirements of the system are upheld.

Head 11 provides for a notification system for all terminations of pregnancy carried out under the terms of the Bill. I consider it very important to record the number and nature of terminations of pregnancy to monitor the Bill's correct implementation and to detect any potential abuse of its provisions. Therefore, the legislation includes a clear requirement on providers to notify me, as Minister for Health, of all terminations carried out under the legislation within 28 days. This will be done without disclosing the names of the women involved.

Head 12 deals with conscientious objection. In this regard, professional health personnel, namely, medical and nursing personnel, will not be obliged to carry out or assist in carrying out lawful terminations of pregnancy if they have a conscientious objection, unless the risk to the life of the pregnant woman is immediate. Where a doctor or other health professional has a difficulty in undertaking a required medical procedure, he or she will have a duty to ensure another colleague takes over the care of the patient, as is normal in current medical ethics. I should note

that the right to conscientious objection is a human right, which is limited to persons only and cannot be invoked by institutions.

Head 13 reaffirms the freedom to travel and freedom to information as per the 13th and 14th amendments to the Constitution, for the avoidance of doubt. Head 14 on regulations is a standard provision in regard to ministerial powers to make regulations.

Head 15 states certain regulations must be made to provide for prescribed forms listed in heads 2, 3 and 4. In this regard, I will make regulations to set out the way in which medical practitioners will certify their opinions regarding the risk of loss of life to the woman, and whether a termination of pregnancy is required. These regulations will require, for example, certificates to indicate the clinical grounds for the opinion and other relevant details of the case at hand. Under this head I will also make regulations regarding the functioning of the review committee.

Head 16 also deals with regulations, this time on the prescribed notification form to be filled in under the terms of head 11 on notifications. Head 17 is a standard provision for the laying of the regulations before the Houses of the Oireachtas.

Head 18 repeals sections 58 and 59 of the Offences Against the Person Act 1861, as they will be replaced by the provisions made in head 19 of the Bill. Consequential amendments may need to be inserted in existing Acts subject to legal advice from the Attorney General and these are being explored.

Head 19 specifies the offence of performing or effecting, or attempting to perform or effect, a termination of pregnancy. This updates the law in this area. The penalty for the offence is up to 14 years imprisonment or a fine or both.

Head 20 contains a standard provision dealing with the Short Title and commencement date of the Bill.

I reassure the committee that the only purpose of the legislation I will bring before the Houses of the Oireachtas is to clarify what is lawfully available by way of treatment in cases where there is a real and substantial threat to the life of a pregnant woman, and to set out clearly defined and specific circumstances in which this treatment can be lawfully provided.

As the committee is aware a very significant amount of work was involved in producing the heads of this legislation. More than 50 drafts were composed as we moved to produce what we believe to be balanced proposals which meet our obligations. I commend the heads of the Bill to the committee and I look forward to hearing its discussion and deliberation on the proposals.

I am joined by the Chief Medical Officer, Dr Tony Holohan, who was closely involved in all of the work on the heads of the Bill. I am also joined by the Secretary General of the Department of Health, Dr. Ambrose McLoughlin, who is fully conversant with the detail of the proposals. We are also joined by Ms Geraldine Luddy and Ms Alessandra Fantini from the Department and they have done much work on the heads of the Bill. Dr. Holohan and Dr. McLoughlin will remain with the committee to be of assistance in ensuring the proposals in the heads are fully understood and to answer questions on areas where members require explanation.

It is important in the first instance for the committee to have an opportunity to be satisfied there is no ambiguity as to what the heads mean. Of course, as the committee knows, the next phase is the drafting of the legislation. I look forward to working closely with colleagues in the

Chamber as we discuss the final legislation and any amendments it may require on Committee Stage.

I again publicly state my gratitude to the committee for its earlier hearings which informed the composition of these heads. I thank the Chairman, committee members and all of those participating in these public hearings for the invaluable contribution they are making to this issue and for the assistance they will provide to me and my officials. I acknowledge Deputies on both sides of the House who have discussed these matters with me and I thank all those persons who recognise the great sensitivities involved and the need for our discourse to be respectful of differing views. I will now hand over to the Chief Medical Officer, Dr. Tony Holohan, who will provide further details on the principles underpinning the general scheme.

Chairman: I thank the Minister for his opening remarks. As members were notified by e-mail yesterday afternoon, the Minister will leave us shortly. Before I call Dr. Tony Holohan, I acknowledge the presence of Ms Alessandra Fantini whom I forgot to mention at the beginning.

Dr. Tony Holohan: I am pleased to be here on behalf of the Department to contribute to the hearings on the general scheme of the protection of life during pregnancy Bill. The Minister has already provided the background and a detailed presentation on the heads of the Bill. I will begin by setting out the principles which underpin the legislation and commenting on matters of professional medical practice which arise in the context of these heads. These guiding principles are derived from the work of the expert group chaired by Mr. Justice Sean Ryan of which I was a member. It is important the committee understands these and how they guided the drafting of the heads.

The first principle behind the general scheme is that it should provide legal clarity by way of legislation and regulations on the circumstances in which a termination of pregnancy is permissible, which is where there is a real and substantial risk to the life, as opposed to the health, of a woman. The aim of the general scheme is to bring clarity to the existing situation. As the Minister has already alluded to in his presentation, the scheme does not confer any new substantive rights to termination of pregnancy. Rather, it provides for rights which already exist, within constitutional provisions and the Supreme Court judgment in the X case. Its purpose is to confer procedural rights on a woman who believes she has a life-threatening condition, or whom others believe on her behalf she has a life-threatening condition, so she can have certainty as to whether she requires this intervention.

The second principle underpinning the legislation is that the State will uphold the right to life of the unborn as far as practicable, as per the constitutional obligations in Article 40.3.3°. This means that where a woman has a pregnancy which places her life at risk and her foetus is or may be viable, she may have a right to have the pregnancy brought to an end but not a right to deliberately end the life of the foetus.

The third principle is that termination of a pregnancy must be necessary to save the woman's life. In these circumstances, termination of pregnancy will always be considered a medical intervention which operates within all the existing arrangements that pertain to other medical services and interventions, and standard medical practice should be adhered to as much as possible in its delivery.

I should note, however, that certain additional requirements are considered appropriate due to the fundamental constitutional rights at stake here, namely, the right to life of the pregnant woman and the right to life of her unborn child. The requirements provided for in the legisla-

tion include a process for assessment, a process which sets out the number of doctors required for this assessment, the process of certification, the locations where terminations might take place, a formal medical review process, and a notification system. The requirements provided for in the legislation include a process for assessment, which sets out the number of doctors required for that assessment, the process of certification, the locations where terminations might take place, a formal medical review process and a notification system. We have heard those details outlined by the Minister.

The fourth principle deals with the issue of suicide and states that, given the more subjective process and recognised clinical challenges involved in the evaluation of suicidal ideation, the legislation should reflect this in the checks and balances that it provides for.

The fifth principle deals with the issue of consent which is enshrined in current ethical standards for doctors, set out by the Medical Council under the Medical Practitioners Act. This principle provides that it is always a matter for the patient to decide if she wishes to proceed with a termination of pregnancy following a decision that it is the only intervention which might save her life.

The sixth principle provides that there must be an ability to monitor the impact and operation of the legislation, so therefore it provides for a mandatory monitoring and reporting system. It specifies that, in order to ensure that the general constitutional prohibition on abortion is maintained, the State will regulate and monitor the exercise of a woman's right to lawful termination of pregnancy as stipulated by the Supreme Court judgment in the X case.

I would now like to expand briefly on the issue raised in principle 3, which I have spoken about, regarding adhering to standard medical practice. To reiterate that principle, where termination of a pregnancy is necessary to save the woman's life, the procedure is to be considered a medical intervention and standard medical practice should be adhered to as much as possible in its delivery. The general scheme has put this principle into practice by ensuring that, as far as possible, the processes it sets out for assessing the risk of loss of life do not go beyond what would normally occur in clinical practice. For example, in terms of setting out the assessment process, the general scheme provides for more than one medical practitioner to be involved. This reflects the fact that it increasingly the case that doctors do not act alone in assessing and managing patients where the complexity is of a similar order to that of a pregnant woman who has a real and substantial risk to her life.

Evidence-based practice in many disciplines provides more and more that doctors work as part of a team or consult with colleagues as a matter of course. Emergency situations are the exception here, of course, and these are considered separately - as we have heard from the Minister - by the general scheme, with different requirements set out where the risk of loss of life, for physical health reasons, is immediate or imminent. In addition, the general scheme does not preclude patients from seeking a second or subsequent opinion in relation to any or all members of their treating team, as per standard practice. This is a routine feature of medical practice enshrined within Medical Council guidelines.

Although the general scheme sets out the process to follow in assessing whether a termination of pregnancy is required, I must note that it is silent on how the certification might come about. This was deemed appropriate since clinical scenarios where the X case criteria might apply are bound to be complex and certainly unpredictable, and therefore attempting to predict and set out specific clinical referral pathways in legislation would be unsafe and unsound. Therefore, the general scheme expects and indeed necessitates that standard medical practice

would apply as in all other medical practice.

I am the Chief Medical Officer and I have confidence in the medical profession in this country. I believe in the integrity and professionalism of our doctors. We have a highly trained and motivated set of doctors working in this country. They have a track record of high quality, patient-centred care which puts patients first. While none of us is blind to the fact that by today's standards of service, we would not necessarily deem the practices and behaviours of the past - or some of them - as appropriate, I think it is absolutely fair to say that our doctors and our medical colleges have shown a consistent commitment to the public interest in the work they do. For many years they have relied on voluntary altruistic endeavour in the training of the next generation and in the pursuit of research knowledge and understanding, which is the bedrock of evolving evidence-based care. They are showing leadership in every aspect of all major health reforms that are under way, at a scale and pace that would simply be impossible without their active engagement. This is true of doctors right across the spectrum, whether they are GPs, obstetricians, psychiatrists or any other speciality. It is my hope and expectation that the doctors who will give evidence to this committee in the coming days will do so in a manner that reflects their duty of professionalism and respect for one another as colleagues, and that remembers their responsibility to ensuring that this committee and the wider public are informed through evidence and science.

It is perfectly rational and reasonable that society would seek to place limits and boundaries upon certain services provided by doctors where there is a public interest to do so, and to provide clear oversight and accountability arrangements for doctors in the delivery of these services. That is precisely what these heads seek to do, while recognising and respecting the latitude there must be for medical practitioners to carry out their duties in the interests of their patients with clarity and certainty about the legal framework within which they must operate. It is vitally important, therefore, that guidance is developed for doctors on the appropriate operation of this legislation. That is best done by the doctors themselves through the professional colleges and the Medical Council, all of whom have a strong track record in this regard. The Department and my office have a strong and very good working relationship with the colleges and professional bodies. I plan to work with them in preparing guidance to their members on the operation of this Bill. I will be meeting with them in the near future to commence this process.

In conclusion, I wish to thank the Chairman and his fellow committee members for the opportunity to address them today. I would like to wish them well with their work and look forward to the committee's report. I am at the committee's disposal for any questions or clarifications that members may wish to raise.

Chairman: Thank you, Dr. Holohan. As agreed, there will now be an opportunity for questions and answers. This session will end at 11 a.m. Time will be allocated as 70% for members of the committee and 30% for non-members. I will indicate when the members' time is up. I now call on Deputy Billy Kelleher. I ask members to stand when they are addressing the committee, rather than sitting down.

Deputy Billy Kelleher: I will pose questions rather than expressing opinions. In the context of an interruption to a pregnancy, a termination or an abortion - whichever terminology one wants to use - is there, or will there be, an obligation under this legislation, coupled with Article 40.3.3° of the Constitution, to vindicate the life of the unborn at whatever stage? In other words, if there is an interruption to a pregnancy for emergency medical reasons, non-emergency medical reasons or in the context of assessment for self-destruction, is there always an obligation

on the medical practitioners who will be carrying out that termination to make every effort to deliver the child alive and make every effort thereafter to sustain the child's life? I would like to get clarity on that matter.

In the context of the panel for assessment for self-destruction or suicide - the words sound very callous at times - we will have an obstetrician and two psychiatrists. I want to get a flavour of how Dr. Holohan would see this particular panel working. Will this just be a panel that will make the assessment and adjudication as to whether the woman's life is at serious risk because she is pregnant, or will there be a patient-professional relationship with the psychiatrists and obstetrician when they are assessing the woman for that? In other words, do they just decide to assess her, make their decision and move on, or is there a type of patient-professional relationship on the panels themselves?

Head 11 concerns reporting to the Minister. We do not expect all that information to be made public, including names, addresses, hospital locations and the professionals who carry it out, but will there be an overarching reporting process that will be available to the public concerning the number of terminations, in broad outline?

Deputy Caoimhghín Ó Caoláin: In dealing with the heads of the Bill it is most unfortunate that the Minister has not remained for questions on these matters. I wish to ask a number of questions nonetheless. As regards the five obligations of the State, as laid out in the expert group's report, could Dr. Holohan give us his view as to whether this draft legislation fulfils these obligations? I am speaking of each of the five as laid out in the expert group's report. Does Dr. Holohan believe that the draft legislation before us fulfils all of those obligations?

As regards head 4 - the risk of loss of life from self-destruction - the requirement is that one obstetrician-gynaecologist must be employed at that location and two psychiatrists, one of whom shall be attached to an institution where such a procedure is carried out. What is the situation concerning the lead? Who is the lead person concerning that combination of expertise - that is, the obstetrician-gynaecologist and psychiatrists? It must have some structure. What is Dr. Holohan's understanding of the lead practitioner in that regard and what is the situation regarding conscientious objection which may present regarding one or other of the psychiatrists, and particularly where the requirement is that one of the psychiatrists would be attached to an institution where such a procedure is carried out?

Regarding the certification where a non-emergency situation - a medical condition - would arise, the requirement is that two medical practitioners can certify. One must be an obstetrician-gynaecologist, another could be, as the legislation provides, a psychiatrist. It also provides for others with "specialist division" registration. What other areas of specialist division expertise would Dr. Holohan envisage? There is a significant list there. Depending on what circumstances might they apply?

With three minutes it is very difficult; my time is almost up. I suggest that in head 2, "Risk of loss of life from physical illness", it may be a requirement to revisit the words "an", "a" and "that" in the construction of the provisions. It is open to a number of interpretations as to the requirement of the obstetrician-gynaecologist being attached to an appropriate location. It goes on to say "that location" and "a location". It is open to interpretation as to exactly what is being required. This process is to try to inform how to better prepare the legislation so that it is fit for purpose.

Deputy Mattie McGrath: I, too, welcome our guests today but express my deep dismay

that the Minister is not staying with us. We were informed only yesterday by e-mail at 4.30 p.m. It is typical of the way this has been handled and I am very disappointed. In the absence of the Minister, can our guests provide specific examples indicating how the heads of the Bill were influenced by the evidence presented at this committee during the hearings held last January, especially regarding the unanimous evidence presented at these hearings clearly indicating that abortion is not a treatment for suicidal ideation and that it is impossible to determine that a person is suicidal?

As the Minister has left, this may be very unfair, but we have to ask the following question. I heard the Minister interviewed on the radio recently and he indicated that a child who survived a termination and whose mother did not want to parent the child, him or her, that this child will be put into State care. Yet the heads of the Bill which we are discussing here today make no provision for this eventuality whatsoever. Why?

Chairman: I remind members that the Minister of State at the Department of Health, Deputy White, will be here at the end of our session to reply to the three days of hearings, so the Minister and the Government will be here at the very end as well.

Senator Martin Conway: Well done, Chairman.

Dr. Tony Holohan: I will try to answer those questions as quickly as I can. If I could describe how I think the panel might work in practice it might help in answering Deputy Kelleher's second question. The likelihood, and by no means the only scenario that could arise, is whereby a GP, for example, who is visited by a pregnant woman who is expressing suicidal ideation, and who has concerns, may make a referral to a consultant psychiatrist for his or her expert assessment. That psychiatrist may well then form a reasonable view that there is a genuine risk to her life, if he or she believes that to be the case. The psychiatrist would then seek the opinion or involvement of a second psychiatrist to essentially corroborate that view. If the view further extends to a potential requirement for an intervention such as a termination, they would then have to consult with or engage an obstetrician. That would be the likely mechanism through which one would end up with three different doctors coming together to assess. It is not a panel remote from the individual.

This is very much about treating a woman whose life is at risk or where there is a belief that there is a real and substantial risk to her life. We are placing a framework around the care the doctors who are caring for her will provide. This is a medical service the woman is receiving, not a remote panel. This is very much the group of doctors who are involved in caring for and looking after that woman in that situation. The requirement for reporting will give rise to an ability on our part to produce some form of annualised reporting of numbers, potential indications and so on. It will be open and available to us to have the information upon which we can make reports that people can use to assess the impact of the legislation.

On Deputy Kelleher's first question, arising from the Constitution there is a clear duty upon doctors to make every effort to save the life of an unborn child where that is reasonable, feasible and practicable. That is enshrined in current Medical Council guidelines. While I would not in any sense seek to direct the council in the guidelines it would set out, I would expect that the council will, when any new legislation is prepared in this area, seek to update and change its guidance to set out that form of expectation. There may well be room then for colleges, for example, to set out what that means in practice. Without my saying this is what will happen, this will be very much open to obstetricians. It might well be set out that there would be a requirement for a certain form of imaging to take place as part of the foetal assessment process. That

brings detail to what would be required to make an assessment of and take steps to vindicate the right to life of the unborn child.

To answer Deputy Ó Caoláin's first question, yes, we believe they fulfil the conditions set out in the expert group report. My answer to Deputy Kelleher's question may help to answer Deputy Ó Caoláin's question on head 4. I would see the initial psychiatrist as the person who would be primarily looking after that individual person, but I would like to think, as I said in my opening statement, that the colleges would begin to set out guidance on the detail of medical practice that will arise to give effect to the services that will be governed by this broad framework of legislation.

Deputy Ó Caoláin raised the question of conscientious objection. That is provided for in Medical Council guidelines. Am I not answering his question there?

Deputy Caoimhghín Ó Caoláin: The requirement is that one of the psychiatrists would be attached to an institution where the procedure is carried out. What if the situation presented where that person, the only person then available, was a conscientious objector? It is not beyond the bounds of possibility.

Dr. Tony Holohan: Yes, there are some technical issues to which the Minister alluded, that we will be looking at in the context of these linkages between doctors and locations of practice. That is the first part of the answer to that question. The other part is that doctors who raise a conscientious objection are not free of obligation to the individual in that situation. They must make appropriate arrangements to ensure there is an appropriate onward referral. They cannot simply step away from the care of that woman. The woman in that situation where the doctor has a legitimate conscientious objection will not find herself in a situation where there is nobody to care for her. That is the intent of this legislation but we will be looking at some of those technicalities to which the Minister alluded.

Regarding the other areas from a physical health point of view, the likely areas are various aspects of oncology, cardiology and renal medicine, and these are by no means common necessarily. Those would be the dominant physical specialists who could be involved, although I understand the College of Physicians will make a detailed presentation that will go into much more detail on that subject.

I am not taking comprehensive enough notes. Could Deputy Ó Caoláin remind me of his question regarding the "Risk of loss of life" under head 2? I apologise.

Deputy Caoimhghín Ó Caoláin: I referenced what I believe to be a need to revisit the construction of that. I drew attention to the words "an", "a" and "that. I think it creates a spaghetti junction of possibilities and needs to be much more precise.

Dr. Tony Holohan: The Deputy is quite correct. That is something we accept and will look at. In the spirit of what the Minister said about looking at some of these technicalities that will improve the operation of the legislation, that is, in a sense, what these hearings are about.

Deputy Mattie McGrath asked about abortion and suicidal ideation. I understand that the College of Psychiatrists of Ireland will make a statement and present itself for questioning, as will a number of other psychiatrists. There are widely held and sometimes conflicting views among psychiatrists. The Supreme Court judgment in the X case has created a requirement for us to make provision for this situation, which is what we have done.

As to the issue of a child requiring care, we already have appropriate arrangements for children where other arrangements - for example, normal parenting and so forth - do not provide such care. This legislation neither adds to nor takes away from that situation.

Chairman: Members' time ends at 10.44 a.m. and nine members have expressed an interest. Non-members have also indicated. Members should keep their questions tight, as we will end this session at 10.44 a.m. I call Senators Burke and Walsh and Deputy Naughten, in that order.

Senator Colm Burke: I welcome the delegation. I have two questions. First, section 1(*b*) in head 4 calls for an obstetrician and two psychiatrists. A question arises as to whether an obstetrician is competent to make a decision on a psychiatric issue. For example, the evidence of an obstetrician on a psychiatric issue would not be accepted in the High Court. Should two psychiatrists make the decision and only involve the obstetrician after the decision is made?

Second, what if the expectant mother is an infant? For example, in all matters of personal injury involving infants, the courts must approve a settlement. There is no indication in the heads that the court must sign off on the decision where it is an infant who is pregnant. This is a technical issue, but it may arise at some point.

Senator Jim Walsh: My questions will relate to head 4, the proposals in respect of suicide. Clear evidence was given to the committee at our last hearings and, despite Dr. Holohan's comments, was unanimous. All of the psychiatrists, including those who were pro-choice, stated that it was almost impossible to diagnose suicidal ideation. According to a study in Britain, such a diagnosis was accurate in only 3% of cases, with 97% false positives. In January, the committee received a submission from St. Patrick's University Hospital, whose staff are the recognised experts in this field. It clearly stated that mental health professionals were unable to predict suicide and that no test or clinical assessment was valid or reliable in that regard. It also stated that no evidence in the literature or from its own work indicated that the termination of pregnancy was an effective treatment for any mental health disorder or difficulty.

Dr. Holohan will accept that no psychiatric evidence was presented to the court in the X case. I am sure he will acknowledge that, in the interim, there have been significant advances in medical science that inform our knowledge today and indicate that abortion is not a treatment. The Minister stated that our hearings informed the compilation of the heads, but why did he and his Department ignore this medical evidence?

Deputy Denis Naughten: I thank the witnesses for their evidence. Regarding head 6, the Minister and Dr. Holohan referred to how the formal review pathway was in addition to, rather than in substitution for, a woman's seeking a second opinion. If so, and I believe it should be the case, does it mean that a woman who is unsatisfied with the first decision can, instead of going through the appeals process, search for two other consultants until she gets a determination that suits her? How will the system work in reality?

On a related point - namely, suicidal ideation and self-destruction - two psychiatrists are required to make a determination of a risk of suicide. The review process also involves two psychiatrists. This country has only three perinatal psychiatrists. In January, the committee heard evidence that no service was available to women outside Dublin. The majority of women with suicidal ideation during pregnancy want to give birth to healthy babies. Will we spread limited resources thinly and concentrate on a small cohort to the neglect of women who have serious mental health issues? Will the witnesses assure members of the committee that

adequate resources will be provided to treat those women with suicidal ideation who want to continue their pregnancies?

In Dr. Rhona Mahony's evidence to the committee in January, she asked whether a "substantial risk to life during pregnancy" was "a 10%, a 50%, an 80% or a 1% risk of dying". I do not see in the heads of the Bill an answer to that question. Perhaps the witnesses can provide an answer for us.

Dr. Tony Holohan: Senator Colm Burke asked about provision for an obstetrician and two psychiatrists. It is not proposed by any stretch that the obstetrician has expertise or a function in assessing suicidal ideation. That is not the reason for the obstetrician's being a part of the certification process. The Supreme Court test requires that, first, the criterion of a real and substantial risk to the life of the woman be satisfied and, second, the termination is necessary to save her life. This assessment can be made only by an obstetrician. As the Minister stated, it requires, in part, an assessment of the foetus's viability and such matters.

The obstetrician might be the person who carries out a necessary termination. It would not be workable if this process of certification of necessity did not involve the person carrying out the termination. Therefore, we require two psychiatrists, for the purpose of creating greater certainty around some of the uncertainties to which we referred that arise in the assessment of suicidal ideation, and an obstetrician for those reasons that I have just indicated. They all form part of the process of certification. We are not in any sense suggesting that obstetricians have miraculously found a capacity to assess suicidal ideation.

I presume the Senator was referring to a minor rather than an infant.

Senator Colm Burke: I am sorry; yes. I was referring to the X case, which involved a 14 year old.

Dr. Tony Holohan: That situation will be governed by the existing law on minors and so on. This legislation does not seek to change that. Whatever arrangements might pertain to a child who is pregnant at that age, whether she is in care or not, are enshrined in existing legislation and we do not seek to change it.

Senator Walsh mentioned the uncertainty in the diagnosis of suicidal ideation. I must point out that psychiatry is a clinical science, one that is based on scientific method and endeavour. It is not a hocus-pocus assessment. There is a genuine clinical method and evaluation. The simple assertion that there is uncertainty in that clinical evaluation in no way negates the science behind the practice of psychiatry.

Deputy Naughten asked about the formal review panel. We view it as something that is activated by the woman if she receives a decision from the initial process with which she is not satisfied, which will mainly be a decision in the negative. If she is unhappy with the decision that a termination is necessary, she has the right to withdraw her consent, which addresses that particular scenario. The review is essentially a rerun of the initial process, in that three doctors will take over her care and have the duty of care responsibilities to the woman to which I referred in the context of the initial assessment. It will, therefore, be only activated at the request of the woman and in practice will arise only where the woman gets a judgment with which she is not satisfied.

Regarding the question of perinatal psychiatrists, we do not believe it is necessary that suicidal ideation in pregnancy be assessed only by perinatal psychiatrists. The assessment of

suicidal ideation is well within the scope and sphere of competence of general and child and adolescent psychiatrists of which there are more than sufficient in numbers relative to the likely rarity of these circumstances such that it is not going to cause any difficulty in either access to services or resources and so forth. It will not be the case that only perinatal psychiatrists can be involved in the assessment of women who might express suicidal ideation during pregnancy.

Deputy Denis Naughten: In January Dr. Rhona O'Mahony asked if a substantial risk to life during pregnancy was a 10%, a 50%, an 80% or a 1% risk of dying. I do not see an answer to that in the heads of the Bill. Will Dr. Tony Holohan provide us with an answer to that?

Dr. Tony Holohan: I am certainly not going to put a percentage on it. It is a real and substantial risk. Doctors would evaluate that risk and it would be upheld in the eyes of their peers if there were to be an examination of that particular decision. If a doctor is making a clinical decision, as is the case with any other aspect of medical practice, he or she must make it in such a way that the decision, the care, the interventions and so on are likely to meet a standard that would be upheld by their peers. I do not think we want to put a precise numerical definition on it. I do not think the Deputy would be surprised for me to say that.

Deputy Catherine Byrne: I thank the delegation for attending the committee this morning, particularly the Minister. What about the treatment of women who are suicidal and decide to continue with the pregnancy? Will there be a process to help them along? Could the delegation explain what that treatment might involve?

Many people have asked me about the proposed head 4. When someone presents herself as suicidal, what will be the process for assessing her and how long will it take? Will it be hours, weeks or months before a decision is made on when the termination of the unborn will happen?

Senator Jillian van Turnhout: Under head 1 on interpretation of reasonable opinion, why does it not also include for the life of the pregnant woman? If it were, it would give more of the equal esteem that is in Article 40.3.3° of the Constitution.

Regarding heads 2 and 4, is there a reason there is no clause requiring consultation with the pregnant woman? We are ensuring consultations are taking place but not actually with the pregnant woman.

Under head 4 also, is there a reason there is not a clear and reasonable time limit for a decision, given the physical and mental strain under which the pregnant woman might be? There should be a statutory requirement for the assessment, which I would suggest should be seven days. I have similar concerns regarding head 6.

Regarding head 19 and the scope of offence, I believe it is a broad scope of an offence for the criminalisation of any act with the intent to destroy human life. Has the Minister considered being more clear and precise about the activities that would be subject to criminal proceedings?

Deputy Robert Dowds: I welcome our guests. If I understand correctly, fatal foetal abnormality is not covered by the legislation. Is there any way this Bill could be amended to include the possibility of a termination in the case of a woman who has the misfortune of having a pregnancy where there is no chance of life for the foetus outside the womb? If not, is that because of the 1983 constitutional amendment?

Dr. Tony Holohan: In the case cited by Deputy Catherine Byrne, a pregnant woman presenting in that situation will be treated exactly as she is at the moment. Women are likely to

present to psychiatrists expressing suicidal ideation in pregnancy and they are cared for as things currently stand. Nothing in this legislation will change that or the duty of care of the doctors who attend these women. This legislation will have no implications for such cases.

On the suicidal process, I outlined earlier what I believe the process is likely to be. I gave a picture of what a routine scenario might be of how someone goes about accessing a service if they believe themselves to require a termination as a result of suicidal ideation.

Head 1 on the reasonable opinion makes specific emphasis on the whole question of the requirement to also assess the right to life of the pregnant woman. The reason we are here in the first instance is because of the real and substantial risk to the life of the mother. By definition, there is consultation taking place with the woman because we would not be in this situation unless there was consultation-----

Senator Jillian van Turnhout: Yet there is no statutory requirement.

Dr. Tony Holohan: I cannot see how it could practically occur that one could propose the procurement of a termination on a woman's behalf without consultation with the individual woman.

The time limit is in the legislation. There is a seven-day period for the Health Service Executive, HSE, to convene and a seven-day period within which it must actually make that assessment.

The length of time for the assessment will be dictated by the clinical circumstances. There may well be a situation of someone expressing suicidal ideation or indeed something arises from physical health point of view where time is much more of an issue than in other situations. One can have a real and substantial risk to life that need not be imminent in a physical health situation. The time period that should elapse will vary on clinical grounds and, therefore, should be the subject of the clinical guidance that needs to be developed by doctors that I spoke about in my opening statement.

It is not proposed that this legislation and the heads approved by the Government would cover the question of foetal abnormality. That is not to say that we at a personal level have enormous sympathy for women who find themselves in that situation.

Deputy Robert Dowds: Is that due to the 1983 constitutional amendment?

Dr. Tony Holohan: That is a component of it.

Deputy Peter Fitzpatrick: Over the past number of weeks both I and my constituency office have been completely inundated with questions and queries about this debate. As an elected representative of my constituency, I have given an undertaking to my constituents that I would raise their questions at this committee. Accordingly, the questions I am about to ask are on behalf of the people of Louth and east Meath. I thank the delegation for making itself available.

Does the definition of an appropriate location allow the HSE to enter into arrangements with organisations such as the Irish Family Planning Association, the Marie Stopes International and the Well Woman Centre in order to allow these organisations carry out abortions under the proposed legislation?

Will doctors and nurses who wish to have no part in abortions under head 4, either directly

or indirectly, be significantly protected in their professions and livelihoods?

Is the delegation satisfied that the proposed legislation will provide for the mandatory care of newly born children resulting from later stage termination in order to vindicate their equal rights in the Constitution?

Deputy Seamus Healy: Could Dr. Holohan clarify the question of non-viable fatal foetal abnormality? My understanding is that the Government in A, B and C *v*. Ireland referred to this matter and indicated that there was a belief that it was constitutional. Certainly, evidence presented to this committee in January was very strong in the belief that Article 40.3.3° covered this area. Could Dr. Holohan tell us whether this issue was considered, what the outcome of that consideration was and the reason this was excluded from the Bill?

In respect of appropriate location, the heads refer to health care facilities providing obstetric and mental health services. Does this mean that public hospitals where there are obstetric units but no inpatient acute psychiatric units are not covered as appropriate locations under the Bill? I agree with Senator van Turnhout regarding the repeal of sections 58 and 59 of the Offences Against the Person Act 1861. The penalties arising in the Bill from that appear to be excessive and further clarification is needed. Could Dr. Holohan comment on that?

Senator Ivana Bacik: I have three very brief questions relating to the need to ensure this legislation provides an accessible and effective procedure under the terms of the A, B and C *v.* Ireland judgment. Head 4 concerns the specific requirements in respect of the two psychiatrists, namely, that both should be employed at a centre registered by the Mental Health Commission and one should be attached to an institution where the procedure is carried out. Is that overly restrictive, particularly in view of the possibility that they will be dealing with minors, who ideally will have to see a child or adolescent psychiatrist, and the fact that the maternity hospitals in Dublin are not part of a general hospital with a big psychiatric department attached?

My second question relates to the review provided for in head 6. Seven days seems unduly long where a woman is seeking to vindicate her right to life. Could this practicably be reduced to three days?

In respect of head 19 and the criminalisation aspect, I share the concerns of others about the penalty and the overly broad wording. It falls foul of the Constitution in terms of creating a criminal offence that is too vague and broad in its current drafting. I also suggest that the woman concerned should not be criminalised. If we are looking at the Criminal Law (Suicide) Act 1993 as a model, given that the note to the head specifically refers to that Act, we can see that it does not criminalise the person who attempts suicide.

Deputy Mary Mitchell O'Connor: I want to address head 4. Members of the public fear that this head will open up the floodgates to abortion or will be the first step in opening up the floodgates. Could Dr. Holohan tell me how many women he expects to seek and be granted terminations of pregnancy under head 4? He gave details of likely processes in other areas today. Could he tell us whether the number will be less than ten? Is he talking about 20, or hundreds? What numbers does he expect to see?

Chairman: I will call on Dr. Holohan and then we will move on to non-members' time.

Dr. Tony Holohan: I will firstly deal with Deputy Fitzpatrick's questions. In respect of the definition of appropriate location, the intention is that the service be provided through all of the 19 public obstetric units in the country. It will not be possible under the heads as proposed for

organisations that are not governed - and I use that word loosely - by HIQA and its framework, which is the 2007 Act, to be involved in the provision of these services. Without going into the names of individual organisations, some of those mentioned by Deputy Fitzpatrick are not so governed as things stand.

In respect of the care of children, I think I answered the question earlier by saying that the same obligation arises. If there are children who require care, there are other pieces of legislation that govern the situation.

In respect of Deputy Healy's question on viability and gestational age, the legislation is silent on gestational age. I know there has been a substantial amount of media and public comment on that particular point. We believe the making of an assessment as to the viability of a pregnancy is best placed in the hands of the doctors who are making the assessment. It does not mean that we believe doctors - who have a duty, as I noted earlier, to vindicate the right to life of the unborn child - are going to engage in what might be termed late-term terminations. The situation that currently pertains is that doctors will see patients as things stand, where, perhaps as a consequence of suicidal ideation or some physical illness, it is necessary and indicated that a early delivery take place. That is something that happens in the here and now and perhaps gives rise to children being born at an earlier time than might otherwise be the case. This legislation does not change that situation in any way. Issues relating to assessment of the health and viability of the foetus are subject to change as obstetric and neonatal practice improve so it is appropriate and prudent that we would not enshrine specific time periods in the legislation but rather to leave it to doctors to make that assessment in the individual situation.

Chairman: Deputy Healy may speak regarding a point of clarification.

Deputy Seamus Healy: The point I was raising concerned fatal foetal abnormality.

Dr. Tony Holohan: I apologise if I misunderstood the Deputy's question. The test that arises in this situation relates to the risk, real and substantial, to the life of the mother. It does not relate to the health or potential viability of the foetus. That is the situation as provided for under the Constitution.

In respect of the question about whether the provisions relating to the two psychiatrists under head 4 may be overly restrictive, the intention is to create a situation whereby this service can be accessed, perhaps through a GP or direct referral from an obstetrician in all of the 19 obstetric units in the country. If we need to look at aspects of how things have currently been framed in terms of their impact, the Minister has indicated that we will do that. That is the intention.

I take the point about Senator Bacik's preference for a three-day period over a seven-day period. There can sometimes be practical difficulties in convening groups of people over holiday weekends and periods so the seven-day period is very much an outer limit as opposed to a minimum period.

Senator Bacik echoed a point made earlier about head 19, and we take that point. Again, it is something we can look at in the context of drafting.

In respect of head 4, I will not get into giving what I think will be the likely number of terminations that will occur as a consequence of the Bill. My general expectation is that it is not likely to be significant. We have made provision for the grounds of suicide because it arises as a consequence of the constitutional position and the Supreme Court judgment and because it

would be impossible to rule out the possibility of suicidal ideation and a risk to a woman's life as a consequence of self-destruction that could only be averted through termination. Removing this provision entirely would be based on a belief that it could never arise. I would not expect it to be a very widespread or common occurrence but I would not say that it would never happen and I will not put a number on it.

Chairman: Deputy Healy indicated that he wished to speak. I ask him to be brief because he has already spoken twice.

Deputy Seamus Healy: In respect of the reply to the question regarding appropriate facilities, the heads refer to health care facilities providing obstetric and mental health services. There are obstetric units in the country where mental health services are not provided.

Dr. Tony Holohan: To clarify, every inpatient obstetric unit where women are looked after and where antenatal mental health issues such as antenatal and postnatal depression arise are capable of providing a mental health service. There is no obstetric unit in which a woman might find herself in which access to a mental health service is not possible. It is our intention that all of the public obstetric units where such services could be provided would also be capable of providing mental health services. That is the policy intent of the heads of the Bill. There may well be little aspects, technicalities, that we can look at to achieve that policy intention.

Chairman: We now move on to non-committee members' time and already there are seven speakers for a 15 minute slot. I will add time at the end to allow for the overlap. Members should try to be brief rather than speak at length. I call Deputies Joe McHugh, Billy Timmins and Michael Creed in that order.

Deputy Joe McHugh: I want to raise two items in respect of head 4 concerning mental health. I think a better explanation is needed for the different ranges and definition of mental illness. I refer to the definitions of real, serious, long-lasting and permanent and specifically within that category schizophrenia and recurrent psychotic depression. That is one level. Public concern focuses on a different level, that of a person presenting at a GP's surgery saying she is suicidal, with the corollary that there will be a termination. That is the fear and concern among the public and the opening of floodgates as Deputy Mitchell O'Connor pointed out. Can we please highlight better the pathways that are and will be available to women who present saying that they have just harmed themselves or are about to do so, or threatening suicide, be they counselling, help or support, the better to manage the crisis? That conversation is not being held at the moment and I ask that this be done in a better way, even in the explanatory memorandum of this legislation to avert terminations where possible.

In respect of heads 19 to 20, the Offences against the Person Act 1861 was already mentioned. Under the changes with respect to criminal prosecution, what are the consequences of accessing abortive pills over the Internet, within the first trimester?

Deputy Billy Timmins: I cannot think of a more appropriate or important place for the Minister of Health to be this morning than this Chamber.

Members: Hear, hear.

Deputy Billy Timmins: His name is on the witness list.

Chairman: The Deputy missed my remarks at the beginning. The Minister of State will reply at the end of the three day discussion on behalf of the Government.

Deputy Billy Timmins: I was here and I heard those remarks but they do not give me any consolation.

My points are aimed at the Minister but maybe the Minister of State or Dr. Holohan can answer them. Dr. Holohan stated that the guiding principles which underpin the legislation derived from the work of the expert group. It is very important that the origin of the principles has a sound foundation. For the past few months I have been trying to get some information through parliamentary questions and the parliamentary party but I have not been able to access it. I want clarification on the terms of reference of the expert group and the paragraph on page 8 of that report where Mr. Justice Ryan states:

> The only brief that the Minister gave this Group was to deal with the requirements of the European Court of Human Rights judgment and to advise the Government on how to give effect to existing constitutional provisions.

That appears to contradict the terms of reference if it is the only brief the Minister gave this group. I want to know whether the Minister briefed the chairman of the group separately or did anyone brief him or has the judge misinterpreted his terms of reference? I sought to have Mr. Justice Ryan come before the committee but he was not one of those chosen. It is important to clarify that point.

In addition, based on responses to parliamentary questions that I tabled, it appears that nominations to that group were sought from various bodies but those forwarded by the Irish College of General Practitioners, the Institute of Obstetricians and Gynaecologists and the College of Psychiatry were not the ones accepted. I would like clarification on that because I may be incorrect, although in the case of the College of Psychiatry the nominees certainly were not in the group because I heard Dr. McCarthy say in interview that the college's nominee was not picked. Why were these nominees not picked? Who was picked instead and who nominated those people?

We were told that the purpose of these hearings is to inform the legislation. I sat through the hearings in January and the clear message that came through to me was that termination is not a treatment for suicidal intent. Dr. Holohan said that would be very rare. From the evidence we received, it seems that the ratio for this is 1:500,000. Weighed against that, the assessment can be inaccurate in 97% of cases and termination is not a treatment for suicidal intent, yet head 4 puts this into the legislation. Is there any point in our listening to evidence presented at these hearings when the legislation does not reflect what happened at the hearings or are we just going through a charade?

Do we have any statistics on minors in the care of the HSE who come before the court and go abroad for terminations on the grounds of suicidal intent? Those statistics must be available somewhere and, if so, are they accessible?

With regard to the issue of conscientious objection, if, for example, staff in a hospital in Ballinasloe or Tralee or wherever decide that they will avail of this clause, where does that tie-in with the fact that the hospital cannot avail of that facility? If all the staff oppose it, what is the solution to meet the requirements of the legislation as proposed?

Deputy Michael Creed: I have two questions for our guests this morning. Deputy Mitchell O'Connor referred to opening the floodgates and that is a genuine fear of people who are probably not prisoners of either extreme in this debate. There is a provision under heads 10 and 11 for an accountability structure to give the Minister an anonymised version of numbers

of applications, etc., but there is no role envisaged in the heads for the Houses of the Oireachtas to be informed, consulted or asked for their opinion on this information. Can Dr. Holohan tell me whether there is resistance at any level in his Department to bolstering and enhancing that review mechanism and involving the Houses of the Oireachtas? Section 18 of the Offences against the State Act 1998, for example, provides that the relevant section "ceases to be in operation" on and from a particular date "unless a resolution has been passed by each House of the Oireachtas resolving that that section should continue in operation". Would it not be appropriate, in order to allay the floodgates fear, to put a structured review mechanism into the legislation to ensure its continued operation, particularly in respect of head 4 making provision for termination on the grounds of suicidal intent? I heard the witnesses say that termination is not an appropriate treatment for suicidal intent. I note Dr. Holohan's comments about the numbers which I hope are correct but we do not know. We are fallible so we may get it wrong. Given the fears about the appropriateness of the treatment and the international experience which shows that people in good faith introduced legislation to cover mental health grounds that was subsequently exploited, would such a review not be appropriate? I would like to hear Dr. Holohan's comments on that point.

Article 40.3.3° refers to the equal right to life of the mother and child. Under heads 4 and 6 there is provision for an application for a termination on the grounds of suicidal ideation and under head 6 the pregnant mother is entitled to an appeals process if her original application is not granted. Given that Article 40.3.3° provides for an equal right to life, would it not be an appropriate provision, under either or both heads but particularly head 6, that some authorised officer of the State – I have suggested elsewhere that this might be Dr. Holohan – would be empowered to appeal a decision, also to that body, if the right to a termination was granted because all of this has to tie-in with Article 40.3.3° and the equal right to life? Would consideration be given to that in the final draft of the legislation?

Chairman: There are four more speakers in this slot but first I will call Dr. Holohan.

Dr.Tony Holohan: In response to Deputy McHugh's first question, the issue is the risk to life that arises through self-destruction and not through any other category. I take the point that perhaps more can be done to highlight the available pathways that exist to deal in the hear and now with women who express suicidal ideation during pregnancy. That is something on which perhaps we can all collectively do a better job. It is something that I am more than happy to take up with the college of obstetricians and the college of psychiatry to see if we can make more clear those arrangements that currently exist and will continue to exist into the future, and in which I have expressed confidence in terms of how they allow doctors to deal with patients who express suicidal ideation or have any other mental issues in pregnancy.

Deputy Timmins made some remarks on the terms of reference and on the nominations and process around the expert group. We have confidence both in the chair and in how he carried out the work that he did. The nominations were made on a confidential basis by the various different bodies, although I know that some have made their nominations public. We have moved to a position now where we have a set of heads of a Bill based on that work. We have confidence in the work that was undertaken by the expert group under the chairmanship of Mr. Justice Ryan.

Deputy Timmins asked in regard to the numbers under the care of the HSE. We do not maintain numbers in regard to that point, therefore, I am not in a position to answer that question. I think the scenario Deputy Timmins painted regarding the conscientious objector is one where all practitioners in a given setting might conscientiously object. I guess that is a theoreti-

cal problem and I would see it as one. It is unlikely to become a practical problem and in that situation there will still be a duty on the provider, which would be the HSE or perhaps one of the voluntary institutions, to make arrangements to ensure that the woman - let us remind ourselves that this is a woman who is in a situation where there is a real and substantial risk to her life - has access to an appropriate service, even if that is not available at that particular location, but I rather doubt that this situation will arise in clinical practice.

Deputy Creed asked about accountability back to the Minister. I take the points he made. There certainly is not any resistance in the Department and I am not aware of any other pockets of resistance, as it were, to the proposal that the Oireachtas might have some particular role. This information will be available to us and to the Minister and we intend to report on it in public as part of the routine reporting we do of many things. I am not aware of any resistance to what the Deputy is proposing. That would allow us to make an ongoing evaluation of the impact of the legislation, which I think was the import behind his question.

Deputy Creed's final point related to the question of appeal. This is something we have explored and on which we have dealt with the Attorney General. The appeal mechanisms we provided for in the legislation provide for a right of appeal for a woman in a given situation where she is not happy with the determination that is made by the panel. The assessment that is undertaken by the clinicians requires them to have a regard to the equal right to life of the unborn foetus. We are not making provision for any other appeal mechanisms, through me or through anybody else, in the legislation.

Senator Rónán Mullen: I want to register my disquiet and this is no fault of the Chairman, but he has been put in charge of an express chair which is not at all satisfactory to the purposes we have to achieve. It certainly illustrates the difference between the notion of a hearing and an inquiry.

I did not quite understand the answer that Dr. Holohan gave in regard to a review in terms of the equal right to life of the unborn. Given that the unborn is a constitutionally protected actor, why is there not the requirement that there would be a voice, an advocate for the unborn, to test whether the initial certification is even necessary by the definitions provided?

Dr. Holohan referred to the third principle, that termination of pregnancy is always a medical intervention. Is there any other example he can give where doctors are called on to make a certification of a procedure in the absence of any evidence-base, particularly where it has such far-reaching consequences, fatal and final consequences, for a constitutionally protected actor? It was clear that there is no evidence that abortion is a treatment for suicidal ideation. There was unanimity on that point at the hearings.

Dr. Holohan suggests that the only reason that we have head 4 is that the Supreme Court requires that we make provision for this, but surely he is aware of the separation of powers and that it remains the prerogative of the Oireachtas, of the Legislature, not to activate an interpretation of the Constitution by the Supreme Court where it would consider that to do so would be dangerous and unjust. It was for that reason that we did not have legislation and why the former Taoiseach, John Bruton, said he would not legislate for the X case because it would have the effect of bringing abortion into Ireland. That is a legal point but I am sure it is one on which Dr. Holohan has taken advice.

I also note that Dr. Holohan said that the numbers were quite likely not to be significant. Will he accept, however, that the consequences will be very significant for whatever children

are involved? I refer in particular to head 4.

The subjective nature of the psychiatric assessment is one Dr. Holohan acknowledged in his presentation. Given that subjective nature, has he had any regard to the experience of other jurisdictions such as California and New Zealand where similar apparently extremely tight grounds were set up in the area of mental health - with we should note suicidal ideation being an even more subjective issue to assess - and where it was noted, even by the Californian Supreme Court, that it was surprising the extent of abortions that took place on foot of that?

Will Dr. Holohan accept that, in reality, the only checks and balances he is talking about is that there will be two psychiatrists and that the obstetrician will have no role in disputing whether the abortion is necessary to end the real and substantial risk and will have a role only in the mechanics of carrying out the abortion and other related physical issues? Therefore, the only check and balance will be one psychiatrist backed up by another, two people who have a psychiatric qualification in an area that is subjective.

Deputy Peter Mathews: I thank Dr. Holohan for his presentation. I want to go straight to the heart of this matter. We are here to uphold the Constitution which provides for the equal right and value of lives of mothers and children. Two points in the discussions this morning come to mind. The first is a question raised, in the first instance, by Deputy Mattie McGrath, which has not been adequately answered. I will read it again. Deputy McGrath asked can the Minister provide specific examples indicating how the heads of the Bill were influenced by the evidence presented to this committee during the hearings held in January, especially in regard to the unanimous evidence presented at those hearings indicating that abortion is not a treatment for suicidal ideation or intent and that it is impossible to determine with any degree the probability that a person is in fact suicidal. There are other aspects to the scheme of arrangement with which I am not happy. Words are not being used correctly. I refer, for instance, to the risk to the life of the mother as opposed to the health, there is no opposition between the life and the health, it is "as distinct from".

On a careful, robust and rigorous reading of the document Dr. Holohan produced, I do not believe one would understand the impression it gives. I believe that the discipline of rigorous thought and rigorous appraisal has been lost in this debate and the consequences for Ireland, its people, its mothers and its daughters are far too important to be racing into this. We have to be very clear. It is very clear, even from Dr. Holohan's paper, that the medical profession, with its current peer reviews and peer checks and balances, is carrying on very well with a duty of care - that word "care" coming from the words "heart", "core" - not measurement, rulers or calibration, but care and intent.

Deputy Timmins is correct in his comments about the base and foundation of the expert group and so on. One cannot have a sound building on bad foundations.

Senator Labhrás Ó Murchú: It would have been helpful if the Minister could have remained to answer some questions on the contribution he made. Clarity is what we have all been focused on in this debate in recent times. The hearings are about the heads of the Bill. I ask for clarification on three points which have been touched on. Is Dr. Holohan happy that the rights of the unborn child are given sufficient weight in the heads of the Bill? Is there sufficient clarity for the medical profession in that regard?

We accept that medical procedures and best practice must be evidence-based. Is Dr. Holohan happy that this is the case in the heads of the Bill when it comes to suicidal ideation?

The Minister is on record as saying that where a child survives and where the mother does not wish to parent the child, the child will be placed in State care. Is Dr. Holohan happy that this issue is covered in the heads of the Bill? If it is not covered, does he not believe it is a serious omission?

Deputy Terence Flanagan: What physical changes to infrastructure will be made in Irish hospitals in the light of this cultural shift, if abortion is introduced. What changes to work practices will be involved? What method of abortion will be used in these instances, as there are different methods that can be used? Has HIQA been involved in departmental discussions on the provision of abortions in Irish hospitals? Like previous speakers, I am concerned. I attended the committee hearings in January. Will Dr. Holohan provide specific examples to indicate how the heads of the Bill were influenced by the evidence given at the January hearings?

Deputy Peadar Tóibín: We are being told this legislation is not really new. Is there a precedent in legislation to deal with damage done to another human being as a result of treatment for suicidality? Is the Bill a new legal departure for the State?

Head 4 refers to the viability of the unborn child. Will the Bill provide for a definition of viability?

I refer to the issue of women disabled by symphysiotomy. How will the State provide for children who suffer a disability as a result of being born prematurely? Will they be able to sue the State for any disability they suffer?

Senator Paul Bradford: I welcome our visitors. I express my disappointment that the Minister is not here. I find this bizarre.

I want to take up the question raised by my colleague, Deputy Billy Timmins, which Dr. Holohan may not have had time to answer. It is a very important question relating to the expert group. We are here because of the decisions taken by the expert group, of which Dr. Holohan was a member. The expert group was given three terms of reference, which gave it a broad spectrum of decision-making powers, yet in its report as presented by Mr. Justice Ryan, it is indicated that the Minister had provided only one briefing for the group in which the solution or solutions the group could offer were confined. I ask Dr. Holohan to clarify the position. I have tried to clarify it directly with the Minister at the parliamentary party meeting. Apparently, there has been a parliamentary question. Was the expert group advised or briefed on the type of solution it would bring forward? The terms of reference are broad, yet we have been advised of this briefing by the Minister that the answer would have to be within the confines of the X case judgment. It is very important that we know. We are debating the heads of the Bill because of the expert group's report. I am worried that the expert group's hands were tied in order to bring about a pre-designed answer. Dr. Holohan sat at the table. I want him to tell me that this is not the case and then to explain why these remarks are included in the report from Mr. Justice Ryan about that briefing.

Dr. Tony Holohan: Because of the number of questions asked, I am happy to be interrupted, if I skip some of them. It is not a deliberate attempt to avoid answering some of the questions asked.

On the appeals mechanism, we are presenting a set of heads which are based on the advice we sought and received from the Attorney General. That is the reason we make provision for appeal in certain circumstances and not in others. It is very much based on the advice received

from the Attorney General.

Reference was made to suicidal ideation, in particular, and the consequences being so significant, particularly in relation to head 4. I maintain that the consequences for an unborn foetus, whether the risk to the life of the mother is physical or due to mental health reasons, are exactly the same.

Senator Jim Walsh: One is evidence-based, the other is not.

Chairman: I am sorry, Senator, but we have one Chairperson - me, until the committee wants to get rid of me. The Senator's help is noted by the Chair.

Dr. Tony Holohan: I stand over what I said in my opening statement that psychiatry is a clinical science based on scientific method and research. It is not some form of hocus-pocus that operates without evidence.

(Interruptions).

Chairman: I will chair the meeting and decide who is the next speaker.

Dr. Tony Holohan: Deputy Mathews made reference to the unanimity of the evidence. I did not sit in the Chamber, but I had the opportunity to go through all of the various submissions made by the different parties. The point has been made by a number of speakers this morning that on that occasion the committee was presented with a unanimous view with regard to suicidal ideation and self-destruction. That is not my reading of the evidence presented to the committee.

(Interruptions).

Chairman: One speaker, please.

Dr. Tony Holohan: Although it was attributed to me that I had simply said it was only as a consequence of the Supreme Court situation that we were making this provision, there is a second reason, that we simply cannot say the circumstance of a real and substantial risk to a woman's life could never occur as a consequence of suicidal ideation. That is the reason that provision is included in the heads of the Bill. I did say I do not believe it would be prevalent or very common, but I could not say it would never occur.

(Interruptions).

Senator Jim Walsh: Is it a treatable-----

Chairman: Please respect the witness, Senator Walsh. You have spoken already and were allowed to make an intervention. You are not helping.

Dr. Tony Holohan: A remark was made about my use of the words, "as opposed to the health". That language came from the Supreme Court's decision; it is not, in fact, used in the heads of the Bill.

(Interruptions).

Chairman: One speaker, please.

Dr. Tony Holohan: I was simply using the phrase presented by the Supreme Court in its judgment.

A question was asked about rigorous and thorough appraisal, but I do not quite remember its import.

Deputy Peter Mathews: It was the point made by Deputy Billy Timmins on the foundation and the setting up of the expert group, the mandate-----

Dr. Tony Holohan: I am happy to deal with that question and Senator Bradford raised the same point. I know that the expert group and its chairman had an opportunity to address this committee. We have taken our direction from the Government's decision with regard to the heads of the Bill. As I said earlier, I stand over and have confidence in the work carried out by the expert group. The terms of reference were framed at the time to make it clear that some of the potential public discussion around changes to the Constitution was outside the terms of reference of the expert group, at least for the work of and purpose of the expert group.

Senator Ó Murchú sought clarification with regard to whether sufficient weight was being given. I must ask the Senator to clarify his first question. I have written down my answer, but I am not clear on the Senator's question.

Senator Labhrás Ó Murchú: I asked Dr. Holohan for clarity on whether the rights of the unborn child were given sufficient weight in the heads of the Bill and if there was sufficient clarity for the medical profession in that regard. Questions were asked previously but I just want to get clarity on that point.

Dr. Tony Holohan: There is sufficient weight and, as I said earlier, we took advice from the Attorney General on that point and what the obligations were, in a general principle sense, on doctors in that situation. As I said earlier, it is clear there is a need for more detailed guidance - profession-specific guidance and specialty-specific guidance - for doctors to interpret what that might actually mean in the day-to-day practice of medicine. For example, obstetricians might determine that it requires a foetal ultrasound at a particular point in time and so on. I would simply leave it to the colleges to work out-----

Senator Labhrás Ó Murchú: Would it be helpful to expand on that in the heads, or in the legislation?

Dr. Tony Holohan: No, I think it would be most unsafe for us to expand on what the requirements of medical practice would be. Based on my confidence in the profession and in the colleges, it is appropriate and reasonable that we leave matters of professional practice and guidance to the doctors themselves.

Deputy Terence Flanagan referred to the type of abortion, and I think some points were made earlier - I may have forgotten to cover this particular point - on the procurement of abortion services by way of Internet access and so on. The legislation does not deal in any way with the method through which termination is effected. All forms of termination, however effected, will be covered by the legislation. It does not talk about obstetric interventions necessarily, or surgical interventions. HIQA, along with a number of other organisations, as part of our ongoing preparatory work, were involved in discussions.

Deputy Terence Flanagan: I had asked about the work practice changes and infrastructural changes in Irish hospitals.

(Interruptions).

Chairman: I chair the meeting.

Deputy Mattie McGrath: He asked to be reminded.

Chairman: We do not need a fourth official yet. If we do, I will ask the Deputy.

Deputy Mattie McGrath: I am not saying that but he asked to be reminded if he-----

Chairman: I appreciate that.

Dr. Tony Holohan: Deputy Tóibín mentioned the assessment of suicidality and the question of viability.

Deputy Peadar Tóibín: The first question was whether there was a precedence for damage being done to another human being as a treatment for suicide in legislation in this State. The second question was about defining viability and what rights a child would have if the State was to disable the child by bringing him or her to term as a premature child.

Dr. Tony Holohan: In regard to the first question, I am not aware of any such provision. On the question of viability, I dealt with that, in part, earlier on. We are not seeking to define an age beyond which, or below which, the provisions of this legislation would or would not apply, rather we are entrusting it to the assessments the obstetricians, in particular, will make as to whether viability has been arrived at. It is very difficult, as I am sure the Deputy is aware, to define that in time terms alone. Sometimes viability can relate to the weight and other aspects of the health of a given foetus. Viability may be arrived at a week or two earlier in the case of some foetuses. It would be unsafe for us to seek to define something which, as I mentioned earlier, is likely to shift as a consequence of the developments in the different relevant specialties.

Deputy Peadar Tóibín: What about the disability of child?

Dr. Tony Holohan: That is interesting because this kind of allows me to deal with a certain misunderstanding which might be out there as to what this legislation is likely to give rise to. As things stand, and without this legislation, a woman who expresses suicidal ideation and who is pregnant can attend a psychiatrist or an obstetrician seeking help and a decision or a determination can be made by those two individuals in consultation with one another that early delivery is necessary. That is already the situation. As things stand, we may well have - numbers of which I cannot answer - women who have earlier than otherwise would be necessary deliveries as a consequence of the expression of suicidal ideation. This legislation does not create that circumstance.

The Deputy's question relates to the disability that arises as a result of that. That is something that arises in the here and now, and the operation of the legislation will make that no more or no less prevalent than it might already be.

Senator Rónán Mullen: My question was whether there was any evidence base, or any example where doctors are called on to make a certification in the absence an evidence base. Dr. Holohan is saying that it was established that there is unanimity that abortion is not a treat-

ment for suicidal ideation. He is questioning that by saying there are conflicting views among psychiatrists, but it is a conflicting view in the absence of evidence. Is there any other situation where doctors are called on to make a certification in the absence of an existing evidence base, because this is all being presented to us as medicine?

Dr. Tony Holohan: I believe it is medicine and I do not accept the Senator's implied assertion that the practice of certain parts of medicine are without an evidence base, nor do I accept his assertion that there is unanimity around the view that self-destruction cannot be a ground upon which termination might indeed necessary.

Senator Jim Walsh: Is Dr. Holohan saying abortion is a treatment for suicidality? That is the key question.

Chairman: I thank Senator Walsh for his intervention.

Senator Jim Walsh: It is a very simple question.

Chairman: I thank Senator Walsh. I appreciate him speaking again but he spoke already.

Senator Jim Walsh: Dr. Holohan has not clarified whether it is a treatment or not.

Chairman: I will adjudicate. I thank Senator Walsh for his assistance. I appreciate his help.

Senator Paul Bradford: I respectfully ask that we get an answer to a question asked by Deputy Timmins, Deputy Mathews, myself and many others in the Dáil Chamber and at very various parliamentary party meetings about the guiding terms and the various interventions at expert group level, because I take what has been said that we are debating this report-----

Senator Ivana Bacik: On a point of order, the committee decided that the questions would be directed to the heads of the Bill, and many of us have respected that today.

Chairman: Could we all take a collective deep breath, be calm and be respectful of one another?

Senator Paul Bradford: All I am asking is for a truthful response in regard to the expert group, its terms of reference and the comment by the chairperson in his report on what he described as the only instruction-----

Chairman: Dr. Holohan has replied to the question and we are dealing with the heads of the Bill.

Senator Paul Bradford: He has not replied to the question.

(Interruptions).

Chairman: I appreciate Senator Walsh's help in trying to chair the meeting.

Senator Jim Walsh: Is abortion regarded by Dr. Holohan as an appropriate treatment for suicidality?

Chairman: Will Senator Walsh please resume his seat?

Senator Jim Walsh: I am only asking for Dr. Holohan's view.

Chairman: Will Senator Walsh resume his seat?

Senator Jim Walsh: Everybody else who came in said it was not.

Chairman: I thank Senator Walsh for his help in trying to chair the meeting. Will he resume his seat?

Senator Jim Walsh: I am trying to get the information.

Dr. Tony Holohan: What I am happy to say is that what we are providing for in this set of heads is a set of circumstances in which a woman who has a genuine, real and substantial risk to her life can receive a service by doctors who can operate with certainty as to their protections under the law in acting in the interests of that woman who, because of the risk to her life, will be in a situation where she has recourse to and dependence on that treatment. We must have a situation where doctors who operate in that environment, in the best interests of the woman who has a real and substantial risk to her life, do what is necessary to provide for that.

Chairman: We have reached the end of this session. I thank members for their contributions. In particular, I thank the Minister, Dr. Holohan, Dr. McLoughlin and Ms Luddy.

Deputy Mattie McGrath: On a point of order, the Minister did not answer any questions. The Chairman thanked him for answering questions but he did not answer any. He ran out of the Chamber.

Chairman: Will Deputy McGrath resume his seat?

Deputy Mattie McGrath: It is a farce. The Minister ran out of the Chamber.

Chairman: I thank Deputy McGrath.

Deputy Mattie McGrath: The Chairman is making it an even bigger farce by condoning that. If he wants to be fair and impartial, he should ask the Minister to reply to some questions.

Chairman: I thank Deputy McGrath. As I said at the beginning, the Minister of State, Deputy Alex White, will reply on behalf of the Government at the end.

Deputy Mattie McGrath: It is a joke.

Chairman: We will resume at 11.45 a.m.

Sitting suspended at 11.30 a.m. and resumed at 11.45 a.m.

Regulatory and Representative Bodies

Chairman: I apologise to witnesses for the delay and thank them for coming in. I remind members of the committee, witnesses and those in the Gallery, be they members of the media or members of the public, to ensure their mobile telephones are switched off for the duration of the meeting as they interfere with the broadcasting equipment even when they are on silent mode. They also interfere with the sound coming through headphones to members of staff.

The witnesses are very welcome to our second of the sessions on the heads of the protection of life during pregnancy Bill which the joint committee will be holding. I welcome repre-

sentatives from the Institute of Obstetricians and Gynaecologists, the Irish College of General Practitioners, the Irish Medical Council, the Irish Medical Organisation and the Royal College of Physicians of Ireland. They are all very welcome. I remind members and witnesses that the balance will be 20/30 and the Chair will be very strict about adhering to it during this session. I remind members of the need for balance and calm in the discussion we are having and of the requirements of respect and tolerance.

I remind members and witnesses that witnesses 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 on a particular matter and they continue to do so, 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 the proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise nor 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 to the effect that they should not criticise, comment on or make charges against any person or persons outside the House or to an official either by name or in such a way as to make him or her identifiable.

I ask Professor Kieran Murphy of the Irish Medical Council to begin.

Professor Kieran Murphy: On behalf of the Irish Medical Council, or IMC, I welcome the opportunity to provide the Joint Committee on Health and Children with views to assist it in formulating its report to Government on the heads of the protection of life during pregnancy Bill 2013. The IMC is a statutory body with responsibility for the regulation of doctors in Ireland. Its purpose is to protect the public by promoting and ensuring the highest standards among doctors. In the interests of patient safety and the protection of the public, the IMC has been vested by the Oireachtas with responsibility to ensure that only those doctors with the necessary education, training and skills are registered to practice in the State. The IMC also specifies standards of practice for doctors in the areas of professional conduct and ethics. The IMC provides principles-based guidance to doctors on matters relating to conduct and ethics in its *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*. The seventh edition of the guide was published in 2009, following extensive consultation with doctors, the general public, medical schools, post-graduate medical training bodies, Departments, employers and a range of other stakeholders.

While doctors are expected to adhere to the IMC's guide in their professional practice, it is important to note that it is not a legal code. In drafting its ethical guidance, the IMC sought to incorporate and reference relevant legislation to ensure that doctors would be aware of the legal framework within which they operate. The guide is a principles-based document which must be relevant to each of the approximately 18,000 doctors registered to practice in Ireland, regardless of specialty, interest or discipline. It covers issues as diverse consent, confidentiality, end-of-life care, clinical trials, prescribing practices and referral of patients. It has been designed to support doctors in decision-making with regard to conduct and ethics and to complement other sources of clinical guidance developed by professional bodies, expert groups, the HSE and others. While the IMC's guidance sets out the principles which are the cornerstone of each doctor's practice, it is the role of expert bodies and employers to devise procedures and protocols for use by doctors in day-to-day practice.

The IMC has a number of general comments on certain matters arising in relation to the heads of the protection of life during pregnancy Bill in respect of which provision must be made

in primary legislation or by way of regulations.

The Medical Council is of the opinion that the process underlying the certification of the decision regarding termination of pregnancy should be the same for grounds of risk of loss of life from physical illness and risk of loss of life from self-destruction. Accordingly, the council is of the opinion that head 2 and head 4 should be merged into a single head. In circumstances in which the pregnant woman's capacity to consent is or may be impaired, the council believes it is not clear from the draft heads how a decision regarding termination of pregnancy will be made and how the woman will be enabled and supported in participating in this decision. The opinions of all registered medical practitioners certifying a procedure that will end unborn human life must be recorded in writing. The council expresses concern about the ability of the pregnant woman to access treatment by the required registered medical practitioners as currently outlined under heads 2 and 4 in all areas of the country. Processes for a monitoring system should incorporate appropriate requirements to preserve the confidentiality of the patient and the certifying practitioners. All processes for an appeal mechanism, either by way of High Court appeal or judicial review, should be incorporated where the pregnant woman is not satisfied with the decision.

The council provides the following responses to the heads. In view of the time constraints today, I will provide an overview of the main points contained in the council's submission. In regard to head 1, the Medical Council has no specific comment on the provisions. The council is of the view that it is in the public interest that doctors have legal clarity when making clinical decisions.

In regard to head 2, the Medical Council is of the opinion that head 2 should be merged with head 4 into a single head. The text in subhead 2(1)(*a*) should be amended to read: "that procedure is carried out by a registered medical practitioner registered in the Specialist Division in the relevant specialty at an appropriate location" to ensure the registered medical practitioner has completed specialist training recognised by the council. The text in subhead 2(1)(*b*) should be amended to read:

> (*b*) two medical practitioners, registered on the Specialist Division of the register of medical practitioners established under section 43(2)(*b*) of the Medical Practitioners Act 2007 under a relevant specialty, have, in accordance with this head, jointly certified in good faith that -
>
> (i) There is a real and substantial risk of loss of the pregnant woman's life, and
>
> (ii) In their reasonable opinion this risk can be averted only by that medical procedure.

The amended head 2(1)(*b*) thereby renders head 2(2) redundant. Where the clinical decision is made to proceed with a termination of pregnancy, if neither of these registered medical practitioners is an obstetrician, at least one of the two registered medical practitioners shall then consult with an obstetrician employed at the appropriate location.

In regard to head 3, the Medical Council is of the opinion that the text in subhead 3(1)(*a*) should be amended to read "registered medical practitioner" to ensure it defines a medical practitioner who is registered with the Medical Council. The text in subhead 3(1)(*b*) should be amended to read "immediate real and substantial risk" in line with drafting in other heads. The text in subhead 3(1) should be amended to include a provision that, in forming his or

her opinion, the registered medical practitioner should consult with another registered medical practitioner where practicable.

In regard to head 4, the Medical Council is of the opinion that head 4 should be merged with head 2 into a single head. The text in subhead 4(1)(*a*) should be amended to specify that the procedure should be undertaken by a registered medical practitioner registered in the specialist division in the relevant specialty. The text in subhead 4(1)(*b*) should be amended to read:

> two psychiatrists, have, in accordance with this head, jointly certified in good faith that -
>
> (i) there is a real and substantial risk of loss of the pregnant woman's life by way of self-destruction, and
>
> (ii) in their reasonable opinion this risk can be averted only by that medical procedure.

Where the clinical decision is made to proceed with a termination of pregnancy, at least one of the two certifying psychiatrists shall then consult with an obstetrician employed at the appropriate location. Not all psychiatrists work in centres registered by the Mental Health Commission, as referenced in head 4(1)(*b*). It is not clear why one of the certifying psychiatrists must be attached to a location where such a procedure is carried out. The majority of psychiatrists are not attached to such institutions.

In regard to head 5, the Medical Council is of the opinion that the formal framework developed to record a medical opinion should be independent, accessible, transparent and timely, and preserve the confidentiality of the pregnant woman.

In regard to head 6, the Medical Council is of the opinion that the text in subhead 1 should be amended to read "registered medical practitioner" rather than "medical practitioner." Subhead 6(1) does not make clear which registered medical practitioner is vested with the duty to inform the woman of the formal review option. Criteria in subhead 6(1) have not been set out to ensure that information is conveyed to the woman in an effective, accessible and timely manner. A timeframe has not been set out in subhead 6(7) for notification of the outcome of the committee's review to the woman who made the application, and, if applicable, the person who made the application on her behalf, and the executive. The council is of the view that subheads 5 and 6 are not necessary as these provisions are adequately covered under heads 7 and 8.

In regard to head 7, reflecting the council's recommendation that heads 2 and 4 be merged, the Medical Council is of the opinion that head 7 and head 8 should also be merged and the processes from head 8 adopted in the legislation. The text in subhead 7(1) should be amended to read: "in the case of a pregnant woman who believes there may be a real and substantial risk of loss of her life, a committee established by an authorised person shall consist of two medical practitioners registered on the Specialist Division of the register of medical practitioners established under section 43(2)(*b*) of the Medical Practitioners Act 2007 under a relevant speciality". The text in subhead 7(1) should be further amended to include an additional sentence: "Where the clinical decision is made to proceed with a termination of pregnancy, if neither of these registered medical practitioners is an obstetrician, at least one of the two registered medical practitioners shall then consult with an obstetrician employed at the appropriate location." A timeframe has not been set out in subhead 7(4) for notification to the woman who made the application and, if applicable, the person who made the application on her behalf, and the executive, of the outcome of the committee's review. The text in subhead 7(6) should be amended

to read: "The procedures set out in this Head are without prejudice to Head 3, which shall apply where there is an immediate risk of loss of the life of the pregnant woman, and therefore the provision of Head 3 shall apply irrespective of review procedures which are in train."

In regard to head 8 specifically, the Medical Council is of the opinion that the text in subhead 8(1) should be amended to read: "in the case of a pregnant woman who believes there may be a real and substantial risk of loss of her life, a committee established by an authorised person shall consist of two medical practitioners registered on the Specialist Division of the register of medical practitioners established under section 43(2)(*b*) of the Medical Practitioners Act 2007 under a relevant speciality". The text in head 8(3) should be amended to include a further sentence: "Where the clinical decision is made to proceed with a termination of pregnancy, if neither of these registered medical practitioners is an obstetrician, at least one of the two registered medical practitioners shall then consult with an obstetrician employed at the appropriate location". It is not clear in subhead 8(1) why one of the certifying psychiatrists must be attached to a location where such a procedure is carried out. The majority of psychiatrists are not attached to such institutions. Not all psychiatrists work in centres registered by the Mental Health Commission.

As referenced in our submission on head 7, there is no time limit set in subhead 8(4) for notification to the woman who made the application and, if applicable, the person who made the application on her behalf, and the executive, of the outcome of the committee's review. In regard to head 9, the opinion of the Medical Council is that the text in subheads 8(1) and 8(2) should be amended to read "registered medical practitioner" rather than "medical practitioner". A subhead should be inserted to enable the committee to have access to legal expertise on a formal basis.

In regard to head 10, the Medical Council is of the opinion that the formal framework developed to support the collation of information on the workings of the formal medical review process should be independent, accessible, transparent and timely, and preserve the confidentiality of the pregnant woman.

In regard to head 12, the Medical Council is of the opinion that subheads 8(1) and 8(4) are largely consistent with the Medical Council's 2009 "Guide to Professional Conduct and Ethics for Registered Medical Practitioners", which states:

> 10.1 As a doctor you must not allow your personal moral standards to influence your treatment of patients.
>
> 10.2 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.

The Medical Council suggests head 12 be expanded to ensure the holding of a conscientious objection does not absolve the registered medical practitioner from his or her responsibility to a patient in emergency circumstances. The view of the council is that the right to conscientious objection must be balanced against the right of the patient, particularly in the case of a medical emergency. The Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners states: "10.3 Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances". The text of subhead (1) should be amended to specifically include the term "conscientious objection". It is not clear whether subhead (1) applies exclusively to the carrying out of the procedure or whether it also applies to involvement by certifying registered medical practitioners in the assessment of risk, the certification process

and the review process. Subhead (2), as drafted, is unclear.

With regard to heads 14,15 and 16, the Medical Council is of the opinion that the underlying principles in the development of regulations should ensure procedures developed are independent, accessible, transparent, timely and preserve the confidentiality of the pregnant woman.

With regard to head 19, the Medical Council is of the opinion that subhead (1) should be modified to read as follows: "It shall be an offence for a person to do any act with the intent to destroy unborn human life other than in accordance with the provisions of Heads 2, 3, and 4 of this Bill".

We are grateful for the opportunity to engage with the committee on this important issue and commend both the Chairman and the committee for seeking a range of expert views as part of the process. If our future input can provide support at later stages, we will engage with the Department of Health to assist in its processes.

Chairman: I also welcome Ms Caroline Spillane, chief executive officer of the Medical Council. I call Professor Harrison, Institute of Obstetricians and Gynaecologists. I welcome him and ask him to introduce his colleagues.

Professor Robert Harrison: I am chairman of the Institute of Obstetricians and Gynaecologists. Professor Fionnuala McAuliffe will give our presentation and will be ably backed up by Dr. Cathy Allen and Dr. Meabh Ní Bhuinneain. They are both doctors in the area and as they are in practice, they will be able to answer and help with any of the questions raised.

Professor Fionnuala McAuliffe: The Institute of Obstetricians and Gynaecologists at the Royal College of Physicians of Ireland is the body that officially represents and advises on obstetrical and gynaecological opinion, professional standards, patient care, education and research in Ireland. As such, the IOG has a compelling interest in the contents of the final Bill. We have a responsibility to ensure it will be the best way to protect women's' health and lives, and also allow for the necessary flexibility to cater for future advances in obstetrics.

Maternal health services in Ireland are among the best in the world and pregnant women and their families should be reassured that they are receiving the very best of care during pregnancy. Recent accurate figures have been collected in Ireland in the past three years which show that approximately one woman per 12,000 pregnancies dies in pregnancy. This low rate compares very well with that in the United Kingdom and the rest of Europe. However, we are never complacent and it is our absolute priority to ensure pregnant women receive the very best of care. To maintain these high standards and improve on them, we need to continue to adequately resource maternity services. The situation where termination of pregnancy or delivery of a very premature baby is required in order to avert a substantial threat to the life of the mother is rare, although these situations do occur. The heads of the Bill provide a process that can be accessed to deal with this rare clinical situation when there is a concern about maternal life. This process will require underpinning with robust multidisciplinary guidelines from the Department of Health and the HSE; input will be required from the Royal College of Physicians, the Royal College of Surgeons, the College of Psychiatrists of Ireland, the College of Anaesthetists of Ireland, the Irish College of General Practitioners, An Bord Altranais, the Irish Nurses and Midwives Organisation to mention a few. Robust Medical Council guidelines will also be required.

At all times we remain acutely aware of the potential negative consequences for the unborn when cessation of pregnancy is necessary to protect maternal life. We highlight the fact that

enormous additional challenges to clinical management arise when termination is being considered in gestations approaching foetal viability but still extreme prematurity. In current practice, all efforts are exhausted within medical margins of safety to prolong the pregnancy in the foetal interest. Additionally, once the baby reaches a stage when it can survive, it is current practice that every effort is made to support the life of the baby after birth, if medically appropriate. We do not see this Bill in any way providing for late terminations, nor the destruction of the baby and our members would not support this. These are complex difficult cases and a multidisciplinary team approach is required. However, obstetricians are the experienced clinicians in the care of pregnant women and should be central to the assessment of sick pregnant women and any decision-making process when there is a substantial risk to the mother's life.

In this submission we represent the majority view within obstetrics and gynaecology in Ireland following a planned, structured consultative process. In preparation of this opinion on the heads of the Bill we used the content of our positional paper from January 2013, the final text of which had been approved by the institute and circulated to all of our members. Following a request for an opinion on the protection of life during pregnancy Bill, an initial draft was considered and discussed in detail by the executive of the institute and the final text was approved at a meeting on 7 May. The final version has been circulated to all members. In addition, direct contact was made with representatives of all maternity units for comments directly on this document. The response overall was supportive of the institute's written submission.

A number of areas require amendment and the following are the main points. Our full opinion is contained in the written submission. We propose adding a definition of "termination" under head 1. When there is a real and substantive threat to the life of a pregnant woman, the gestation at which the pregnancy is interrupted is the critical factor influencing outcome for the unborn. We suggest restricting the use of the term "termination" to situations where there is no chance of survival after birth such as when a pregnancy is ended before a foetus is viable. The definition of "obstetrician-gynaecologist" for pragmatic reasons will need to be expanded to include those acting in the role of consultant obstetrician-gynaecologist who may be on the general medical register rather than in the specialist division. All Government approved general hospitals, including the 19 maternity hospitals, will need to be regarded as suitable venues to provide these procedures, as necessary. Pregnant women with a severe illness requiring specialised inpatient treatment are often cared for in a general hospital setting with access to coronary care and intensive care units. General hospitals, therefore, must be included. Failure to make these two changes could result in delays in accessing life saving treatment in pregnancy and it is the institute's opinion that they must be made.

Under head 2, in non-emergency situations, whatever the indication, two obstetricians-gynaecologists must be involved in the decision-making process; one obstetrician would be required to examine the patient and sign the documentation and the support of a second obstetrical opinion sought. In addition, where the condition warrants but only then, other consultants on their own specialist register form a team assessment.

With regard to head 3, we accept that, although consultation between two obstetricians-gynaecologists is desirable in the acute emergency case, this may not always be possible and a single opinion would suffice. It is the institute's view that emergency procedures should only be carried out in a hospital setting and I suggest changing the term "health facility" to "hospital setting".

Head 4 concerns the risk of loss of life from self-destruction. The Institute of Obstetricians and Gynaecologists does not differentiate in terms of logistical arrangements between physical

or mental reasons for considering a termination. One obstetrician would be required to examine the patient and sign the documentation, and the support of a second obstetrical opinion would have to be sought. We accept there is a need for two psychiatrists, however, as it would be their expertise that the obstetricians would rely upon to determine whether suicidal ideation is true intent and poses a real and substantive risk to the life of the mother.

On heads 6 to 11, inclusive, we support the review process and would like to emphasise the importance of accurate documentation and regular auditing of cases.

Head 12 pertains to conscientious objection. We endorse the current Medical Council Guidelines of 2009, 10.1 to 10.3, inclusive, regarding the options and responsibilities for clinicians with a conscientious objection to participating in certain clinical treatments.

Head 14 concerns regulations. The Institute of Obstetricians and Gynaecologists supports the legislative option of legislation plus regulations, suggested by the expert group on the judgment on A, B and C *v*. Ireland. We believe this option best addresses the need to protect women as well as health care professionals involved. The regulation aspect of this would allow the necessary flexibility to incorporate future developments in the area of obstetrics.

We ask the Minister to ensure, when developing regulations with the Department of Health, that they are initiated without delay so that robust, safe guidelines of practice can be enacted promptly by the HSE and the Department of Health on this issue. This will necessitate appropriate funding and infrastructural provision. Any changes to regulations, in our view, should be put before the Oireachtas before enactment. Our full opinion on the heads of the Bill is contained in the written submission from the Institute of Obstetricians and Gynaecologists. We would appreciate it if careful attention were paid to it.

The location should include all Government-approved hospitals. The definition of "obstetrician and gynaecologist" should be expanded, and detailed multidisciplinary guidelines should be generated. We are grateful for the opportunity to present to the joint committee the views of the institute. We request that obstetricians have an input into the final Bill as we are the doctors most intimately connected with this issue and who will need to deliver the service.

Chairman: Our next speaker, representing the Irish College of General Practitioners, is Dr. Margaret O'Riordan, medical director. She is very welcome. She has ten minutes.

Dr. Margaret O'Riordan: Deputy Buttimer, members of the Joint Committee on Health and Children, ladies and gentlemen, I am thankful for the invitation to the Irish College of General Practitioners to present on the protection of life during pregnancy Bill. This is an extremely important Bill. The college welcomes the opportunity to be involved in the legislative discussions.

The general practitioner has a key role in supporting women during pregnancy. By way of introduction, I am a general practitioner and medical director of the Irish College of General Practitioners. I am accompanied by Dr. Seamus Cryan, president of the Irish College of General Practitioners, Dr. Darach O'Ciardha, chair of communications, and Mr. Kieran Ryan, chief executive officer.

Established in 1984, the Irish College of General Practitioners is responsible for postgraduate specialist medical education, training and research in the specialty of general practice. The college also provides an extensive range of practice management services focused on the effect of organisation of general practice. The college has a national advisory role in relation to

clinical standards and it interacts regularly with the number of bodies, including the Medical Council, the Department of Health, the Department of Children and Youth Affairs, the Health Service Executive and the Health Information and Quality Authority, among others.

As a membership organisation, the Irish College of General Practitioners is responsible for providing continuing medical education for established general practitioners, who number more than 2,500 at present. The mission of the college is to serve the patient and its members, general practitioners, by encouraging and maintaining the highest standards of general medical practice. The core values of the college are quality, equity, access and service to the patient. The college has provided guidance for its members on the management of crisis pregnancy since 1995 and the latest guidance is available on open access on the college's website.

At this point I would like to clarify that I am representing the specialty of general practice. Individual general practitioners have diverse views on this issue.

In the majority of cases, a termination of pregnancy is a decision taken as a last resort and in great distress. The college believes that the structures, resources and systems to support women during a crisis pregnancy should be enhanced. There is a need to improve access to social supports, counselling and psychology services. Perinatal psychiatry should be a priority for the Government in supporting women in crisis pregnancy.

The general practitioner is usually the first point of contact a pregnant woman has with the health service. The general practitioner has a key role in supporting women during pregnancy. All pregnant women are entitled to free antenatal care under the mother and infant scheme.

Current obstetric practice does not place a patient in the care of an obstetrician until 16 to 20 weeks gestation. General practitioner care is immediately available to every pregnant woman, and general practitioners routinely play a supportive role to women through the provision of antenatal and postnatal care. The general practitioner has knowledge of the woman's past medical and psychological health and of her social supports. In many instances, this knowledge extends over a number of years. General practitioners view every patient as an individual and care for them in their unique circumstances. Therefore, the general practitioner has a vital role in the assessment of risk. This role is supported by the expert group's report, which suggested "it may be appropriate that general practitioners are consulted as a matter of best practice in the course of the diagnostic process. This would provide access to their knowledge of the patient and establish continuity of care for the woman after the treatment has been delivered".

Consultation with a general practitioner should take place only with the woman's consent, and the importance of confidentiality should be emphasised in all aspects of the Bill. The current heads of the Bill could be strengthened in this regard. The legislation should not be enacted until a specific, well-defined referral pathway is in place with appropriate professional support. General practitioners will usually be the first persons to whom a woman with a crisis pregnancy presents, and they will need to know exactly how to refer the woman in a timely manner. The general practitioner has an important ongoing role as patient advocate and in providing non-judgmental support to women who have been involved in this process, regardless of whether they have had a termination.

The Irish College of General Practitioners recommends that the Department of Health commission an independent guideline consortium to develop evidence-based national clinical guidelines to underpin implementation of the legislation. Following the guidance provided by the national clinical effectiveness committee, this process should involve health care professionals

and patients in the guideline development process and employ internationally agreed standards of guideline development methodology. The Irish College of General Practitioners has experience in this area and is willing to take an active role in the development of these guidelines.

Chairman: I thank Dr. Margaret O'Riordan. Our next speaker is Dr. Matthew Sadlier, president of the Irish Medical Organisation. He is joined by Ms Vanessa Hetherington, policy executive. They are very welcome. Dr. Sadlier has ten minutes.

Dr. Matthew Sadlier: I thank the Chairman, Deputies and Senators. On behalf of the Irish Medical Organisation, which represents more than 5,000 doctors of all craft groups and specialties in the country, I thank the committee for inviting us to address it today. I know that everyone here agrees that the matters before this committee are of enormous importance and sensitivity for people throughout the country and deal with issues on which people have very strong, and often very opposing, views.

Within the Irish Medical Organisation, we have debated the issue of abortion on a number of occasions, and when we have done so, we have found that the diversity of opinion that is found in the wider community is reflected among our own members. Our official position on this dates back 20 years to 1993 and states that the Irish Medical Organisation endorses the principle of respect for all human life, both born and unborn, and that it rejects abortion. More recently, at our recent annual general meeting in April, the issue was debated in a number of motions, but our policy did not change.

However, the Irish Medical Organisation accepts that whatever our policy position might be, our members operate within a legal framework. Therefore, without turning our backs on the formal policy position we have adopted, we have an obligation to engage in the debate about the legal framework that is being established. We understand that it is the role of the people through referenda and Deputies and Senators through the Oireachtas to frame the laws under which this country operates. Furthermore, we accept that the Government is now moving to introduce a legislative framework on this issue.

In that context we have a number of general concerns regarding the legislation: that the patient's health and welfare is of paramount importance; the legislation must provide adequate clarity and protection to health care professionals who must operate under it; the legislation must be practical and realistic for application in a hospital and health care environment; the legislation must be sufficiently resourced; where issues of morals are concerned, such as in abortion, the laws must provide adequate flexibility to ensure that an individual can abstain from engaging in an activity which he or she may deem, in conscience, to be immoral without jeopardising the right of the relevant patients to all the facilities and treatments for which the law provides.

I will give a brief summary of our issues in respect of each head of the Bill. In head 1, we believe the term "reasonable opinion" should be replaced by the term "opinion" and the term "unborn" replaced by the more medical term "foetus". In head 2, the opinion of two medical practitioners is required to certify jointly that there is a real and substantial risk to the life of the mother and where the risk can only be averted by the termination of the pregnancy. Where a pregnant woman presents with a physical condition that poses a real and substantial risk to her life, clear clinical guidelines are required in order to identify, monitor and treat such patients. While such cases are rare, public obstetric units must be appropriately resourced to ensure that patients are adequately cared for according to clinical guidelines and that no delay to life saving procedures arises due to under-resourcing. A system should be in place to allow medical

practitioners to declare a conscientious objection and protocols must be in place to deal with situations of conscientious objection as they arise.

Medical practitioners who have no conscientious objection must receive appropriate training either during postgraduate training or as part of compulsory CPD programmes organised and resourced by the State. The health and welfare of the patient is paramount and therefore women must be provided with appropriate follow-on care, both physical and psychological, following any termination.

Head 3 deals with the risk of loss of life from physical illness in a medical emergency. Again, such cases are likely to be rare and clear clinical guidelines must be in place. Patients must be attended by a practitioner that has no conscientious objection and is appropriately trained to perform such procedures. Patient consent must be obtained where possible - we will deal with the issue of consent later in our submission. Women must be provided with appropriate follow-on care, both physical and psychological.

Head 4 refers to the risk of loss of life from self-destruction. Under that head the opinion of three medical practitioners - one obstetrician-gynaecologist and two psychiatrists - is required to certify jointly that there is a real and substantial risk to the life of the mother and where the risk can only be averted by the termination of the pregnancy. Imposing a requirement for three doctors may cause unnecessary delay and is in excess of the maximum of two doctors recommended by the expert group. It also adds an extra burden of resources an already stretched services.

Obstetricians should not be required to certify risk of loss of the pregnant woman's life by way of self destruction. This should be done by two psychiatrists in consultation with the woman's general practitioner. The Bill requires the psychiatrists to be employed in an institution registered with the Mental Health Commission. We believe this is an unnecessary specification. Specialists are required to be registered with the Medical Council and this should be the only stipulation. Such cases again are likely to be rare and, again, clear clinical guidelines must be put in place. Patients must be attended by specialists who have declared no conscientious objection. As it stands, mental health services throughout the country are significantly under-resourced. Adequate resources must be provided to ensure that patients at imminent risk of suicide receive appropriate psychiatric care. Additional resources must be provided to ensure that there is no drop off in existing services as clinicians are tending reviews specified under this Bill.

Regarding head 5, medical opinion to be in the form and manner prescribed by the Minister, we believe the medical opinion should be given in the form and manner prescribed through clinical guidelines established by the relevant professional colleges, not by the Minister.

The issue of mental capacity is relevant to the Bill in a number of areas. Given the importance of this legislation and that decisions may be contentious, it is important that the legislation removes the potential for ambiguity and gives a clear definition of the criteria for determining capacity to make a medical decision. It is quite possible that in many of the cases that will occur the woman will lack capacity temporarily either due to a mental health problem or physical illness. The legislation should also clearly state what should be done in cases where a woman is found not to have the capacity to make a medical decision. Also, the legislation should define at what age a woman has the legal capacity to ask for a termination as there is ambiguity regarding the Non-Fatal Offences Against the Person Act 1997, which defines the age to give consent for medical treatment at 16 years, and the Mental Health Act 2001, which defines the age of medi-

cal consent in mental health issues at 18 years.

Head 6 deals with formal medical review panels. Under this head the HSE is to establish and maintain a panel of medical practitioners for the purpose of review. Practitioners who declare a conscientious objection must be excluded from such panels.

Regarding head 7 and head 8, the establishment and convening of a review committee and the review procedures combined may take up to 14 days. This is an unacceptable delay. During this time there is a risk that the patient's health could deteriorate significantly. Resources must be put in place to ensure that patients are adequately cared for and receive appropriate support during the period of the review. The opinion of the review committee should be made in accordance with appropriate clinical guidelines.

Head 11 and head 12 detail that the reviews and medical procedures permitted and carried out under this Bill are to be notified to the Minister. This seems unnecessarily prescriptive. The HIPE, hospital in-patient enquiry, data currently records the numbers and types of procedures carried out in acute hospitals and the Medical Council is the body authorised to investigate complaints relating to the performance of individual medical practitioners. Patient confidentiality must be guaranteed and patient anonymity is welcomed in the heads of the Bill. There must be no possibility of identification of the women in respect of whom the termination was carried out. To protect both the patients and the medical practitioners involved and to avoid sensationalist media reporting of such procedures, the names of medical practitioners involved should not be publicised.

Finally, head 12 deals with conscientious objection. Recent debate at the IMO's annual general meeting shows that there are a number of physicians who object strongly to the termination of pregnancy on moral and ethical grounds and the IMO welcomes the provision for conscientious objection under head 12. However, patients who present with life threatening illness must be reassured that they will receive adequate care and the necessary termination to protect maternal life. Clear protocols must be in place to ensure appropriate and timely referral of patients to other colleagues in the case of conscientious objection.

Chairman: Thank you, Dr. Sadlier. The final witness to give a presentation is from the Royal College of Physicians of Ireland. I welcome Professor John Crowe, who has ten minutes to make his presentation.

Professor John Crowe: I represent the Royal College of Physicians of Ireland, the body responsible for postgraduate training in all medical specialties - paediatrics, pathology, public health, occupational health and obstetrics and gynaecology. We thank the Joint Committee on Health and Children for the invitation to make a submission on the recently published heads of the Protection of Life During Pregnancy Bill 2013.

To discuss the Bill and to prepare a submission, a meeting was convened of Fellows from the relevant specialties within the Royal College of Physicians of Ireland as well as the chairman of the RCPI Institute of Obstetricians and Gynaecologists, Professor Robert Harrison, and Professor Fionnuala McAuliffe. Professor Harrison presented to the meeting the institute's submission to the Joint Committee on Health and Children. The institute's submission represents a majority view from institute members on the draft heads of the Bill. Our meeting considered the heads of the Bill, the institute's submission and the involvement of consultant physicians in the very rare clinical instances where a decision is required to terminate the pregnancy of a woman whose illness during pregnancy poses a real and substantial risk to her life. The rec-

ommendations of that meeting were conveyed to the 32 members of the council of the Royal College of Physicians of Ireland. The council fully supports the submission of the constituent institute, the Institute of Obstetricians and Gynaecologists, with the following additions.

Head 2 relates to risk of loss of life from physical illness, not being a risk of self destruction.

We believe that in addition to the support of a second obstetrical opinion, and where the patient's condition warrants the opinion of another medical practitioner from a different specialist register, two specialist opinions from that register should be involved.

We accept that while only one specialist is required to examine the patient, the opinion of an additional independent specialist should be sought. In an elective situation, and where practical and in conformity with best practice, a multidisciplinary team would consider a decision to terminate pregnancy. It should be noted that in modern clinical practice generally it is considered appropriate in complex or difficult cases, regardless of whether the patient is pregnant, for a specialist to seek a second opinion and, where practical, to have the issue discussed within a multidisciplinary team. That is modern medicine. Clearly, in emergency situations this may not be practical and we agree with the content relating to emergency situations under head 3.

In conclusion, it is important to recognise that legislation should not seek to define treatment pathways that are more appropriately and safely dealt with through professional judgment in a given clinical situation. Doctors seek to treat patients in line with best clinical practice which is continually evolving. The guidelines for the operation of the legislation will be complex and will require the input of the relevant professional bodies. The Royal College of Physicians is prepared to participate with the Department of Health and the HSE in the development of guidelines on the operation of the legislation. I thank the Chairman.

Chairman: We will now move to members' time, which will comprise 70 minutes, and non-members' time, which will comprise 30 minutes. The time will be adhered to strictly and I will end the discussion at the end of each session, irrespective of who has or has not spoken and replied. There will be no ambiguity; that has been agreed by the committee.

Deputy Billy Kelleher: I thank the Chairman and welcome the witnesses. We have a very short period of time so I will try to be brief. I have questions rather than opinions, and would welcome hearing opinions on my questions.

In terms of GPs having conscientious objections, should there be an obligation on a GP, when a patient arrives at a surgery and has reason to believe there is a substantial risk to her life because of pregnancy, to inform her of his or her conscientious objection to a termination of pregnancy in the context of a threat to life by suicide or physical health grounds? According to the Bill, when a woman presents to the panel or review group comprising an obstetrician and two psychiatrists, there is a provision whereby a GP can be informed if she so wishes but, equally, the GP is not informed if she declines. Who will provide aftercare treatment for a woman who goes before a panel which deems that her life is at real and substantial risk for physical or mental reasons? If the woman does not want her GP to be made aware of that, where in the Bill should there be some obligation for aftercare to be provided without her GP being informed of the termination? Clearly, a certain amount of aftercare would be required in that context.

I refer to the comments of Professor McAuliffe. We need clarity. An issue which has been spoken about around the country is foetuses on the cusp of viability. Does an obstetrician, in making a decision about an intervention for physical or mental reasons to save the life of the

mother, take into account the viability of the foetus? If he or she can delay intervention for a number of days or weeks without further threat to the life of the mother, is that taken into account? I refer to the two patient approach which has often been spoken about. Is foetal viability of secondary consideration? Many people are agitated and confused about current medical practice. Article 40.3.3° is quite clear and specific in that there is an obligation to make every effort to vindicate the life of the child. I ask the witnesses to elaborate on current medical practice in maternity units throughout the country.

I note the comments of Professor Murphy. The IMO guidelines in 2009 included the risk of suicide as grounds for termination in the State. Is that based on clinical evidence or is it because of the legal obligations under the current Constitution, as interpreted by the X case? Do our maternity hospitals currently have the physical and personnel capacity to implement the Bill if it is passed with the current heads?

Deputy Caoimhghín Ó Caoláin: I thank each of the witnesses. Unfortunately, the time allowed will not allow us to question each of them and elaborate but their contributions are very valuable.

I ask Professor McAuliffe to answer a question on the risk of loss of life due to physical illness. She talked about two medical practitioners, one of whom shall be an obstetrician or gynaecologist who must be employed at a specific location. How will this work in practice? I ask her to assure me that this could not mean that a woman might be examined in two locations, one being that where the procedure could be carried out. Surely it is about bringing the necessary professional expertise to the woman. The IMO presentation made a number of points in regard to patient confidentiality. Would the Institute of Obstetricians and Gynaecologists agree it is something which should be addressed?

Head 3, the risk of loss of life from physical illness in a medical emergency, allows one medical practitioner to carry out a termination in an emergency at any location. I note from its presentation that the institute views that such emergency procedures should only be carried out in a hospital setting. I ask the witnesses to elaborate on that. Would they take the view that, while the Bill provides for any registered medical practitioner to carry out such a procedure, such a person should be somebody who is registered on a specialist division? I would like further clarification, if possible, on that.

I may be open to correction, but from my preparation for this committee I note that, in regard to the requirement for notification to the Minister, notification of all emergency terminations will be sent to the Minister. As the Bill is currently drafted, that does not require the involvement of an obstetrician or gynaecologist. Should the same apply in regard to non-emergency situations such as physical or general illnesses and the risk to life as a result of mental illness and the associated possible risk of self harm or self termination?

Would the institute envisage there would be oversight and a review of notified terminations carried out? Would an effort be made to at least confirm the efficacy of the decisions taken and to win the widest possible public confidence for them? For some considerable time that will be an issue and focus. It would be desirable and helpful if that were to be the case.

I refer to Professor Murphy and the Irish Medical Council. Deputy Kelleher made reference to the guide to professional conduct and ethics. My sense of the guide in the 2009 publication - the witnesses can tell me if I am wrong - is that its wording does not change by the passage of this Bill. Detail regarding the outworking will require revisitation, but the specific guide on

how and when it is permissible for an intervention that results in termination would not change.

Deputy Seamus Healy: Several contributors referred to the provisions regarding appropriate locations, which refer to public obstetric units where there is a mental health facility. The witnesses have indicated a preference that this be broadened to include public hospitals in general. Will they elaborate on this? Will they comment on the availability of medical personnel to operate the system as outlined under the heads, particularly in smaller hospitals in locations throughout the country? Will Professor Murphy elaborate on the issue of conscientious objection?

Chairman: I invite the witnesses to respond to that group of questions.

Professor Fionnuala McAuliffe: Deputy Billy Kelleher asked about after care. We must bear in mind that we are talking about rare clinical cases where a mother's life is in danger or there is a risk of loss of life. It would be a small number of cases and we would offer follow-up in the hospital setting. These are patients with complex medical disorders or perhaps life-threatening obstetrical emergency conditions. As such, they would always be offered after care in the hospital setting. It would be rather unusual for such patients not to inform their GPs of what had transpired, given that, as I said, they are patients with complex medical disorders of which their GPs would usually be aware. They would require long-term follow-up care for that medical disorder, whether it be mental or physical. It would be unusual for the GP not to be aware of the patient's situation. We would always follow up with the patient in the hospital in the first instance.

On the important issue of viability, Article 40.3.3° remains in the Constitution. We are committed to the health and life of mother and baby. It sometimes happens that we have a very sick mother around the time of viability, in which case every effort is made to prolong the pregnancy to allow the baby to get to a stage where there is some chance of survival. If we feel prolonging the pregnancy could jeopardise the mother, where, for example, she might develop overwhelming infection, uncontrollable blood pressure, seizures or life-threatening bleeding, we would have no option but to terminate the pregnancy or, depending on the gestation, deliver the baby pre-term. We work very hard with the family and each other to promote foetal viability in order that the baby will get to a stage where it can survive. After the baby is born, intensive care would be offered. if medically appropriate. That is current standard medical practice.

Deputy Billy Kelleher also asked whether we had capacity for this Bill. To reiterate, we are talking about rare medical disorders and small numbers of cases. We already look after such cases. The Bill merely provides a legal framework for our current clinical practice. I do not anticipate large numbers of patients suddenly becoming suitable for these procedures where previously we have seen only very small numbers. However, it is important to note that we have approximately half the number of obstetricians per head of population in Ireland as there are in the United Kingdom; therefore, we are dreadfully under-resourced and would welcome improved resourcing.

Deputy Caoimhghín Ó Caoláin asked how many obstetricians would be required to examine the patient. Again, we are talking about complex medical disorders where multidisciplinary teams are required. In current medical practice it is often the case that more than one obstetrician would assess such a patient in order to achieve a consensus view. However, if a colleague felt there was no option but to terminate the pregnancy, we are not saying two obstetricians would be required to examine the patient but that a second obstetrical opinion be sought just to underpin the approach. In complex cases such as these there is always consultation with more

than one person and often with a very large team. We would want the obstetrician who examines the patient to seek support, which could be in the form of a telephone conversation, for instance, or a case review. We are totally supportive of patient confidentiality at all times and there would no difference in such cases.

In regard to head 3, the Bill refers to a health facility and talks about locations other than those recognised. We are concerned that emergency treatment should only be offered in a hospital setting, not in a clinic or an outpatient setting such as a GP's surgery. These are emergency life-saving procedures and it is our view that they should only be carried out in a hospital setting.

The specialist division of obstetrics and gynaecology came into being in 2005 or thereabouts. Consultants appointed prior to that time will be on the general medical register but may not be in the specialist division. This means that a number of very experienced consultants who are very capable of making patient assessments are not in the specialist division. For this reason, we have asked that the provision be expanded to include an obstetrician or gynaecologist acting in the consultant role who is in the general division only. Otherwise, the concern is that patients who present requiring emergency treatment might not be able to receive it if the consultant who sees them is not on the specialist register. This is an historic issue that will be resolved over time. In the meantime, however, we have several experienced obstetricians who are not on the specialist register.

In terms of notification of cases, we are totally supportive of the requirement for audit and documentation. In fact, within our own hospitals these cases are already recorded and discussed. I suggest this matter is best dealt with in guidelines, with these unusual cases being reviewed, say, on an annual basis. Members may be aware that the National Perinatal Epidemiology Centre is collecting data on cases of severe maternal morbidity. This means that many of the cases are already captured in a national context.

Deputy Seamus Healy referred to the provisions regarding appropriate locations. In our previous submission we explained in detail that we were talking about patients who were medically very unwell and needed access to specialist physicians, coronary care units and intensive care units. Many of our maternity units are not co-located. The units in the three Dublin maternity hospitals and one in Limerick, for example, are stand-alone units. The patients to whom we are referring are usually cared for in hospitals with a general intensive care unit and coronary care unit. It is imperative, therefore, that general hospitals are able to carry out these procedures. That is where these patients will be treated because they are too ill to be looked after in a stand-alone maternity unit.

The Deputy also asked about the availability of personnel throughout the country. There are 19 maternity units in this country providing high quality maternity care. They are also providing emergency care, which would include termination of pregnancy. That is current practice. What the legislation does is put a framework around it.

I will defer to my colleague, Dr. Méabh Ní Bhuinneáin, to provide detail on the smaller units.

Dr. Méabh Ní Bhuinneáin: The smaller units in this country are not small by international standards. In fact, there are no single-handed or dual-handed practices in operation at this time. All of the facilities are delivering more than 1,000 babies per annum and, in total, 20,000 mothers receive their care, including emergency care, in these units every year. Consultant-

provided care is delivered in all 19 units on a 24-7 basis. There is a three-tier on-call system, involving a registrar, a senior house officer and a consultant. There are systems to support obstetric emergency provision in the cases to which Professor McAuliffe has alluded, where there is haemorrhage, bleeding, infection or uncontrollable high blood pressure and, in the case of complications of miscarriage, where a foetal heartbeat may still be present. There is the to provide that at this point in time.

The smaller units will be affected more by the logistics of implementing the services, but the networks and governance established through Medical Council best practice and ethical practice and through college governance will ensure a woman has access, regardless of which maternity unit she attends. For maternal survival, access to a unit that can save her life is essential. The timeliness of moving to a city unit and bypassing a rural unit could certainly confound maternal survival possibility.

Dr. Margaret O'Riordan: In response to Deputy Billy Kelleher's questions, the Medical Council guidelines are very clear in regard to conscientious objection. A general practitioner would have to inform a patient if he or she had a conscientious objection.

In regard to the follow-up of patients, the Deputy has hit on a very important point. Sometimes in these circumstances we forget the long-term consequences. In the immediate aftermath of an event there is much focus on and a need for follow-up in a hospital scenario, and in the long term there is a need for a general practitioner. It would commonly be found by GPs, for example, that a woman who has suffered a miscarriage feels an impact on the date she was expecting to have the baby. It is then that she needs support, as much as she needs such support immediately after the event. We must first and foremost respect a patient's autonomy, and patients have the right to choose a general practitioner. That goes without saying. In the second instance we must focus on support for women in the long term after these events.

Professor Kieran Murphy: I will take Deputy Healy's question first, as he asked for an elaboration on the Medical Council's position with regard to conscientious objection. Perhaps it might be helpful for Deputies and Senators if I outline the current guidance. Before doing so it may be worthwhile for me to articulate how the Medical Council came to produce such guidance. Approximately every five years, the council completely revises its ethical guidance, doing so in a way that engages a range of stakeholders. We engage with members of the profession, employers and patient groups. We want to ensure that the guidance we produce to assist doctors will be useful and informed by our engagement with stakeholders. It is also important to say that the guidance produced by the Medical Council is a principle-based document, meaning it cannot deal with every day-to-day eventuality; it deals with principles rather than operational day-to-day matters.

The guidance, as mentioned earlier, follows on from legislation. As legislators, Deputies and Senators are tasked with ensuring that appropriate legislation is in place. Once the legislation is in place, it is the task of the Medical Council to draft guidance based on the legislation. As we heard from the Chief Medical Officer this morning, once the new legislation has been passed, he intends to work with a range of stakeholders, including the professional bodies and the Medical Council, to ensure that the subsequent regulations will implement what is passed by legislators.

Deputy Healy asked a specific question on conscientious objection, so I will outline the current Medical Council guidance on the issue. There are a number of points taken from the guide to professional conduct and ethics for registered medical practitioners, and members may recall

that during our submission in January, we circulated copies of the guide. We have not done so this time because we assume they have seen it already. If Members wish to see copies of the guide afterwards, we would be very happy to circulate them. With regard to conscientious objection, the guidance is as follows:

> 10.1 As a doctor, you must not allow your personal moral standards to influence your treatment of patients.
>
> 10.2 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.

That addresses the point made by Deputy Kelleher, which was also addressed by Dr. O'Riordan in her response. The council wishes to see this particular head extended in regard to the Medical Council's third point in the guidance, "10.3 Conscientious objection does not absolve you from responsibility to a patient in emergency circumstances." As we noted in our submission, the Medical Council suggests that head 12 should be expanded to ensure that the holding of a conscientious objection does not absolve the registered medical practitioner of responsibility to a patient in emergency circumstances. The view of the council is that the right to conscientious objection must be balanced against the right of the patient, particularly in the case of a medical emergency.

I will take the questions from Deputies Kelleher and Ó Caoláin together as they relate to the Medical Council guidance on abortion. It might be helpful for Deputies and Senators for me to outline the current guidance provided by the Medical Council to doctors on abortion. The guide states:

> 21.1 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.

To address Deputy Kelleher's point, the council formulates its guidance based on the current legal position. The council drafted its guidance in the light of the Supreme Court judgment. The guide continues:

> 21.2 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.
>
> 21.3 You have a duty to provide care, support and follow-up services for women who have an abortion abroad.
>
> 21.4 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.

It is worthwhile restating that this guidance was drafted and published by the council after extensive consultation with a range of stakeholders, particularly the Institute of Obstetricians and Gynaecologists. As I stated earlier, we ensured that this guidance would target to the doctors

faced with these decisions and be useful in ensuring that doctors had the appropriate guidance.

Deputy Ó Caoláin asked if Medical Council guidance would change. We are engaged in a process today that will lead to the subsequent development of legislation, and nobody can predict at this stage how the legislation will look. Once the legislation is passed, the Medical Council will examine it and reconsider its advice based on the eventual legislation.

Ms Spillane wishes to make a point on specialist division of the register.

Ms Caroline Spillane: Deputies Kelleher and Healy raised questions about the number of doctors. It might be helpful for the committee to understand that there are currently 18,000 doctors registered with the Medical Council across five divisions. Approximately 7,000 doctors are registered in the specialist division of the medical register, which indicates that doctors have been educated and trained to the highest possible standards in that particular specialty. The register is quite a dynamic listing and there are currently 481 doctors in the specialist division with the specialty of psychiatry, with 236 doctors registered in the specialty of obstetrics and gynaecology.

Dr. Matthew Sadlier: I will make two points, although they are not in answer to a specific question, because most of those have been answered. I echo my colleague's comments on resources, as Ireland is significantly under-resourced per head of population with regard to the number of specialists compared to most European and other developed nations. Systems are already under stress and the expectation is that this legislation will not add a significant extra workload. Systems are already under severe strain.

With regard to the sites mentioned in head 1 of the Bill, particularly the interpretation of "appropriate location", the Irish hospital network contains interlocking and stand-alone units, with specialties in certain hospitals. Very few hospitals or health care facilities in the country have a broad range of medical specialties, so they rely on specialists coming from other locations, particularly when they are outside the larger urban centres. The definition as contained in the Bill is probably a little too prescriptive and takes in only a small number of facilities that could provide all those services.

Chairman: Eleven speakers have indicated a wish to contribute and we may not get to all of them. I apologise, but this session is to end at 1.42 p.m.

Deputy Ciara Conway: I thank our guests for their very interesting presentations on the heads of the Bill. My first question is for Dr. O'Riordan on GP practice. It is great that she is present today because she is correct that for most women who are pregnant their first point of contact, be it a crisis pregnancy or a planned one, is with their local GP. It is important, therefore, that she is present. To ensure that as a country we are compliant with international human rights law and that women can exercise their right under the Constitution, the legislation must guarantee a clear referral pathway and timeframes for terminations that can take place, in particular under head 2. Is that something Dr. O'Riordan would agree that we need to include under head 2? Should the legislation state that the Minister shall make regulations regarding timely and appropriate referral pathways from primary to tertiary care, but also including self-referral? GPs will probably know more than others the time delays that can be experienced by people trying to get access to specialist services. That should be integral to the legislation. The evidence also shows that if there is a time delay in a woman getting access to treatment it could have lifelong detrimental consequences for her.

My second question is for Dr. Sadlier. In the submission under head 10 he refers to it being overly prescriptive in terms of the review of practice. Are we not in the aftermath of a situation where because no reviews were carried out on obstetric practices in a particular hospital in this country that women have to suffer lifelong consequences? We cannot discount that. Is it Dr. Sadlier's view that the Irish Medical Organisation came to the conclusion because there is a chilling effect and because of the criminalisation sanctions it places on doctors? Is that the concern of the organisation when it refers to the potential review process being overly prescriptive?

Senator Jillian van Turnhout: The witnesses are all very welcome. I will not duplicate questions already asked. I was very interested to hear the Irish Medical Council propose that heads 2 and 4 should be merged. That was the conclusion to which I came following the January hearings. I went in with a different opinion but having listened to the submissions I questioned why we were differentiating. I am interested in hearing the views of the members of other bodies on how they feel about the differentiations that are being made.

Deputy Conway has made several points about time limits. I am not a medical practitioner and I do not know the answer, which is why I ask the question. The Medical Council made a distinction between registered medical practitioners and medical practitioners. What are the consequences of including the word "registered"? Who are we excluding?

Conscientious objection is something everyone can understand and appreciate but should we consider a requirement that as a general rule a practitioner would declare his or her conscientious objection rather than waiting until a situation got to a certain point? How do we ensure that hospitals would have an adequate number of medical professionals who have not declared a conscientious objection?

Deputy Catherine Byrne: I thank the panel for their expertise, observations and suggested amendments. In practical terms one must consider the situation of where a woman goes if she finds herself pregnant. Where does one go, who does one contact and how does one make the initial contact? I put the question to the GPs. Senator van Turnhout asked one of the questions I wished to ask. Do general practitioners believe that as the first port of call the information must come from them or their surgeries?

Professor Fionnuala McAuliffe: I will respond on whether we should merge heads 2 and 4. The view of the institute is that no differentiation should be made between whether the risk of loss of life is mental or physical. It is our preference that the situations would be taken together. One must remember that these are rare, clinical conditions where two senior doctors consider there is significant risk of life to the mother which can only be averted by termination of pregnancy.

In terms of doctors who are conscientious objectors, in a large number of these cases we are talking about emergency situations and the practice and care currently being delivered around the country. We do not have any difficulty with the provision of emergency care around the country. We would defer to the Medical Council in terms of conscientious objection for non-emergency cases.

Dr. Margaret O'Riordan: In response to Deputy Conway's question, we must remember that this is a very small group of women where there is a real and substantive risk to the life of the mother. Therefore, the need for the referral path may not occur very often in the average GP practice. That is all the more reason it should be clearly defined and timely when we need to avail of the referral pathway.

To answer Deputy Byrne's question, the situation is no different from any other situation and it is normal practice for patients to approach the health service through their general practitioners. In the vast majority of instances it is through the general practitioners in the first place.

Professor Kieran Murphy: With regard, first, to Senator van Turnhout's question, I am very pleased that she agrees with the Medical Council position that heads 2 and 4 should be merged. As Professor McAuliffe has outlined, that is also the position of the Institute of Obstetricians and Gynaecologists.

On Senator van Turnhout's question on the difference between a registered practitioner and a non-registered practitioner, the Medical Practitioners Act, which regulates the profession, specifies that all doctors have to be registered. If one practises in this country and one is not registered, it is a criminal offence. It is very important for the legislation that it makes reference to the fact that all doctors working in this country must be registered.

To reply to Senator van Turnhout's question on conscientious objection, the Medical Council guidance on conscientious objection, item 10.2, specifically says that one must explain to the patient if one has a conscientious objection and make the names of other doctors available to them. This is an important provision because it protects the woman and ensures that she is able to access the most appropriate treatment for her. Care should not be dependent on any moral value the practitioner might hold.

Dr. Matthew Sadlier: To answer Deputy Conway's question specifically, what we feel is unnecessarily prescriptive is the administrative element of head 10. Medical procedures carried out in hospitals are already reported to the Health Service Executive and to the Department, and it is proposed that we would put them into a separate report. Head 4 relates to mental health issues, which are already a stigmatised issue to be reported. We will not stand over practitioners not practising to the highest standards. The Medical Council is the body to investigate any difficulties or complaints against practitioners. It is too prescriptive to separate it out from the procedures of clinical audit and HIPE data already being sent into hospitals and from the procedures of the Medical Council or other professional bodies around practice and is creating another level of administration and unnecessary bureaucracy.

On Senator van Turnhout's question on conscientious objectors, as the representative body for doctors we would be insistent that our concerns regarding the use of information on whether a doctor is a conscientious objector would not become a stigmatising or discriminatory element in the interview and recruitment process to posts within hospitals.

Deputy Peter Fitzpatrick: I thank the witnesses very much for making themselves available. My first question is whether doctors and nurses who wish to have no part in abortions under head 4, either directly or indirectly, will be protected in their profession and livelihood?

In the case of a patient who is suicidal but not mentally ill, is it ethical for a doctor to decide to end the life of one patient – the unborn – in order to change the condition of pregnancy for a second patient where no illness exists? The explanatory note under head 4 recognises the absence of clinical markers in accurately assessing suicidal intent. Is it ethical, therefore, for doctors to partake in such a process under head 4 that ends the life of one patient, the unborn, and implements a life-changing decision for the other in ending her pregnancy?

Are the witnesses satisfied that the proposed legislation will provide for mandatory care for newly born children resulting from later stage terminations in order to vindicate their equal

right to life in the court decision?

Senator Colm Burke: I thank the witnesses for their detailed and constructive submissions. Professor Murphy of the Irish Medical Council spoke about a proposed amendment to head 4, an issue I mentioned this morning. He suggests two psychiatrists should sign off and then consult the obstetrician, whereas the head proposes that the three sign off. He obviously has very strong views on the matter and I know some obstetricians have questions about signing off on a psychiatric issue. I ask the professor to clarify this.

The Irish Medical Council's submission refers to the need for access to legal support. I ask Professor Murphy to expand on this, in particular the legal support provided for an expectant mother under 18 years.

I understand there are 236 names on the obstetrics-gynaecology specialist register. How many practising consultants are there in the 19 hospitals? Some 12 maternity units have only three obstetricians-gynaecologists practising in them. Particularly at weekends, do these units need more structured support from the bigger units than they already receive?

Senator Ivana Bacik: I thank the witnesses for their very informative presentations. I have some specific questions aimed at ensuring women have access to effective procedures, whereby their constitutional right to life could be vindicated in the very rare cases we are discussing, as we have all said. There is a proposal to merge heads 2 and 4 which makes sense. Is the Institute of Obstetricians and Gynaecologists suggesting two obstetricians should certify risk, as well as an additional doctor in the case of a physical risk, or an additional two psychiatrists in the case of risk of suicide? That seems unduly cumbersome and would render the process less accessible and effective for women. I believe Professor McAuliffe said the second opinion would be more informal rather than formal extra certification or examination.

The Irish Medical Council and the Irish Medical Organisation suggest the requirement that psychiatrists be attached to specific institutions is too restrictive. Particularly in the specialist maternity hospitals in Dublin which will not have large psychiatric departments attached, is it practical to ask that psychiatrists be attached to specific places or should it be a more general point that they should be consultant psychiatrists? What exactly do they mean?

Heads 6, 7 and 8 provide for a review procedure. The IMO and the ICGP have raised some very practical and important points about access for a woman to a review and the obstacles that might apply. Do they believe the time limit is unduly onerous? The IMO's submission points out that a 14 day delay - seven days and seven days - may be provided for and suggests a six day delay - three days and three days - might be better.

I do not believe any of the witnesses addressed head 1 on the definition of the unborn. Do they believe that definition should include a non-viable foetus - a foetus with no prospect of life - where, for example, the foetal heartbeat has stopped? In these circumstances should an obstetrician be legally permitted to deliver the foetus where there is no longer the prospect of life beyond the womb?

Professor Fionnuala McAuliffe: In response to Deputy Peter Fitzpatrick, it is fair to say the lack of evidence on the role of termination in the treatment of suicidal pregnant women is an ethical concern for our members. However, we need to remember that we are talking about pregnant women, in respect of whom after consultation two senior obstetricians, plus or minus physicians or psychiatrists, feel there is a significant risk to her life which can only be averted

by termination of pregnancy or early delivery of the baby. We are talking about a small number of cases of very sick women who need access to life-saving treatment. The general view of the institute - the majority view - is that we will not differentiate between causes of risk to life, whether they be mental or physical.

The Deputy asked if it was ethical to perform a termination for a suicidal woman. Again, we are down to the expert assessment of two psychiatrists, plus an obstetrician. The Deputy needs to remember what we are talking about. We are talking about risk of threat to the life of the mother which can only be averted by termination of pregnancy. Therefore, we are talking about very serious conditions and we are talking about small numbers of cases. These are issues that we will resolve using a multidisciplinary approach.

There was a question about late terminations which I addressed in my opening submission. There is no question of late terminations in the Bill, as far as the institute is concerned. If the baby is delivered before viability, it will die unfortunately - that is a very sad consequence. If the baby is born after viability, every effort will be made to support its life. I hope that is clear.

Senator Colm Burke asked about the role of the obstetrician in suicidal cases. As obstetricians, we need to be centrally involved in any decision in terms of termination of pregnancy or early delivery of the baby because we are the experts in pregnancy and can assess it. There could be other comorbidities in the patient who is suicidal. There could be comorbidities that need to be assessed. She needs to be assessed for her health to assess whether she is even suitable for any procedure or process. Therefore, we in the institute strongly believe one obstetrician should examine the patient and sign the documentation, but he or she should seek a supportive second opinion - at least one. It is normal practice that there be multiple opinions, but we are stipulating that one obstetrician in all of these cases, regardless of the cause of risk to life, examine the patient and sign the documentation but seek the support of a second opinion.

In terms of the smaller units, we envisage that networks would be available. As the Senator knows, earlier this week proposed networks were published. It would be good clinical practice for smaller units. There are informal networks where people will refer to certain hospitals. I often receive telephone calls from my colleagues outside Dublin. I am happy to receive a telephone call at any time of the day or night and any day, including weekends. Therefore, we are there to support each other. I would certainly favour having a more structured referral pathway for all complex pregnancy disorders.

Senator Ivana Bacik mentioned location. The Institute of Obstetricians and Gynaecologists believes this should be available in all Government-approved hospitals which would include the 19 maternity units because these women are sick and need to have access to the appropriate medical care, whether it be psychiatric care or a coronary care unit or an intensive care unit. We believe very strongly that it needs to be opened up outside these maternity units. It needs to include Government-approved general hospitals.

In terms of the unborn, if a foetal heartbeat is absent, that is a miscarriage. There is no ethical dilemma that I am aware of around this. If a foetal heartbeat is absent, unfortunately, the baby has died and either the patient will miscarry naturally or we can give her medication or perform a procedure to speed up the process.

Dr. Margaret O'Riordan: I endorse all the answers Professor McAuliffe has given to the questions asked. On the question addressed to the ICGP of access to the review panel and the 14 day period, yes, that would be of concern. Bearing in mind that this is a real and substantial

risk to the life of the mother, if it is a real and substantial risk to the life of the mother, it implies that it is an emergency. Particularly in the case of suicide and the analysis of suicide one would have to wonder about having to wait for 14 days. Obviously in that scenario, we would have to take the psychiatrist's opinion into account but 14 days seems to be a long time.

Professor Kieran Murphy: I will deal with Deputy Peter Fitzpatrick's questions first. He raised issues regarding the guidance on conscientious objection and also the guidance on abortion. As I previously read the detailed guidance for doctors, I do not propose to waste the members' time by going over the issue again. I have dealt with that issue previously.

The Deputy's point about the absence of markers for suicide is most appropriately put to representatives of the College of Psychiatrists of Ireland who will be before the committee on Monday. Senator Burke asked for the rationale as to why the Irish Medical Council proposes heads 2 and 4 should be merged. The council clearly emphasises the significant role of the obstetrician in the process. It is the obstetrician who will perform the procedure so he or she must have a central role in the process. The issue for the council relates to ensuring all doctors work in their particular scope of practice. To deal with physical health under head 2, if a cardiac problem arises and it is judged by a cardiologist that there is a real and substantial risk to the life of the mother and the only intervention to save the woman's life is a termination it may be appropriate, and this would be up to the clinicians involved, that the two people best placed to make the decisions are cardiologists, but not necessarily so. It may very well be that one of the two is an obstetrician. If this is the case an obstetrician will be involved in the certification in the first part at least.

Head 4 relates to assessment of suicide risk. The council is concerned to ensure doctors work within their scope of practice. In the assessment of risk of, as the draft heads of the Bill state, a threat of self-destruction, the council's view is that psychiatrists are best placed to make the assessment. If the psychiatrists agree there is a real and substantial risk to the life of the mother and that the only way it can be dealt with is by a procedure of termination then, as the Irish Medical Council put in its submission, these psychiatrists should consult with the obstetrician. It is very important that Deputies and Senators understand the council's view is that obstetricians have a central role in the process but doctors must work within their scope of practice to ensure the safety of the woman is protected at all times.

Senator Burke also raised the issue of age of consent. In my verbal submission I did not make this point because of time but I will mention it now. In our written submission we state in circumstances where the pregnant woman's capacity to consent is, or may be, impaired it is not clear from the draft heads how a decision regarding termination of pregnancy will be made and how the woman will be enabled and supported to participate in this decision. Furthermore we state the draft heads do not make reference to the legal age of consent for minors. Specifically it is not clear who will have decision-making authority in circumstances where the pregnant woman is under 16 years of age. In accordance with national policy, the council believes the voice of the young person should be considered and appropriate provisions should be made.

I hope I have addressed the questions asked by Senator Bacik on heads 2 and 4. We address her final question in our submission, but it is worth stating again that it is very clear only a very small minority of psychiatrists are attached to the appropriate locations. Importantly, not all psychiatrists are employed in institutions which are registered with the Mental Health Commission. Ms Spillane wishes to make a further point on one of the questions.

Ms Caroline Spillane: Senator Burke asked about the total number of practising consul-

tants at present. As I stated previously, 18,000 doctors are on the medical register, the vast majority of whom work full time in this country. There are 7,000 doctors on the specialist division of the register. The register holds information about the area of specialty in which doctors operate but not the posts they hold. This information is held locally by employers such as the HSE.

Dr. Matthew Sadlier: On conscientious objection, if legislation is passed it is meaningful only if it has sufficient resources and mechanisms to action what it contains. It is very much the responsibility of employers to have a system in place which includes professionals who do not have a conscientious objection, thus protecting those who do from engaging in practices with which they have a difficulty.

With regard to the time limit, 14 days seems to be quite long given that a pregnancy is a time-limited entity. Although provision is made for emergency cases it would be expected that most cases are urgent as opposed to routine. We do not have an opinion on an alternative specific number of days.

Professor Murphy dealt with the question on various services in various hospitals. Services are divided among various sites with one hospital providing a specialty to another so a network of referral processes and cover between individual sites will be required.

Deputy Mattie McGrath: I welcome our guests. If two consultant psychiatrists agree a patient is suicidal and this constitutes a real and substantial threat to her life which can be averted only by the termination of her pregnancy, do the witnesses envisage any situation in which they would disagree with them? The heads of the Bill provide for a situation in which a physically healthy woman carrying a perfectly healthy baby of 20 weeks gestation could be determined to qualify for a termination of pregnancy on the grounds her life was at risk due to the threat of suicide. This baby is viable albeit extremely premature, and the heads require everything possible be done to vindicate the baby's right to life. What exactly would the witnesses do in this situation?

My next question is for the Irish College of General Practitioners, ICGP. At its recent AGM the ICGP voted that the Government should introduce clarity in the law founded on evidence-based medical guidelines where there are real and substantial risks to the life of the mother. How does it reconcile the position it outlined today with this mandate?

I understand new Medical Council office-holders will soon begin their term of office. Is it not possible and likely this new council will revise the ethical guidelines relating to the care of pregnant women? Is it not the case the witnesses have no means of predicting what form this revision is likely to take? In light of the heads of the Bill, is it possible the council's ethical guidelines could be amended to remove the requirement to make every effort to preserve the life of the baby?

Deputy Denis Naughten: From the evidence given by the Irish Medical Council and the Institute of Obstetricians and Gynaecologists their firm position is that what they would like to see is regulations supported by primary legislation rather than the structure proposed under the various heads. Will the witnesses clarify this?

With regard to conscientious objection, what happens if in smaller units all three existing consultants decide they are not prepared to get involved in these procedures? Does this mean for any new posts created people's personal opinions would have to be determined before they could be recruited?

I have a question for Professor McAuliffe. She mentioned the destruction of the baby in her evidence. Does she believe there needs to be clarification in the legislation with regard to destruction versus induction? Will she comment on the evidence given earlier by Dr. Tony Holohan who stated early deliveries may have been carried out in this country on the grounds of suicidal ideation. Does Professor McAuliffe have any evidence of this?

Dr. O'Riordan made the point in her evidence that there needs to be more resourcing of perinatal psychiatry but Dr. Tony Holohan stated there was no need for additional resources in this area in that a perinatal psychiatrist will not necessarily be involved in these additional assessments. The point was made that the current obstetric practice is that referrals would be made between 16 and 20 weeks. Is it not the case that referrals are being made later now because of delays in obtaining an appointment with an obstetrician? How will that affect determinations concerning a termination? Would it require earlier referrals and, on foot of that, additional resources to facilitate that?

Senator Jim Walsh: I wish to put my questions first to the Irish Medical Council representatives. Why do they feel the desire to merge heads 2 and 4? Deputy Kelleher referred to the guidelines which cover the risk of suicide. I assume the IMC monitors its guidelines, so what do the records show with regard to terminations for suicidality since 1992? Also in that regard, does the IMC have records on women who subsequently committed suicide because of post-abortion trauma? Those statistics would be of interest and value to us.

I welcome some of the comments in the report of the Institute of Obstetricians and Gynaecologists. Its representatives said they "remain acutely aware of the potential negative consequences for the unborn and in current practice all efforts are exhausted within medical margins of safety to prolong the pregnancy in the foetal interest". In practice, under this legislation, how will the requirement to make those reasonable efforts for the life of the baby actually work? In other words, if the baby is born around the viability period of 22 or 23 weeks, what will effectively happen in practice?

With regard to premature deliveries, can the IOG representatives tell us the potential complications and risks to the baby? I have heard stories that, for example, with early deliveries at 23, 24 or 25 weeks there could be a 50% risk of cerebral palsy. We had a submission from obstetricians and gynaecologists back in January who said that "the psychiatric grounds for abortion on the basis of suicide risk appear non-existent in the view of the experts in this field. An obstetrician, the doctor with responsibility to patients, faced with terminating a normal pregnancy on grounds of suicide risk, will be placed in an impossibly conflicted situation where there is no benefit to the mother". Do the IOG representatives share that view, or what is their opinion be in that regard?

Chairman: The Senator is over his time.

Senator Jim Walsh: As regards a mother presenting at 17, 18, 19 or 20 weeks - just short of viability - what is the IOG's view with regard to the need for medical psychiatric treatment for that lady over a number of weeks to carry her through, as one would do with any other patient who was not pregnant, to the stage where she could safely deliver that baby? I would put that question to the IMO as well, whose representatives have commented on the need for proper psychiatric care for patients who are pregnant and feel suicidal.

Senator John Crown: In the legally ambiguous landscape of Irish abortion law, where our Constitution, as interpreted by our Supreme Court at least once and by our people five times

in referendums, is in direct conflict with our Statute Book, we have heard testimony here in the January hearings that Irish doctors will perform abortions where the life of the mother is threatened and where the only safeguard for her life is a termination to the pregnancy. We have heard that there are approximately 30 such terminations per year. We have also heard evidence that suggests that suicidality is at most a vanishingly rare cause. It may never have occurred in Ireland, although there is some dispute about this. There is also some dispute as to whether it is ever necessary. However, in theory it could be. As I have said, we are legally prevented from excluding suicidality by two specific questions put to the people in referendums.

It is frequently being mentioned here that best medical evidence is not at the moment suggesting that suicidality is ever needed as a ground for termination. There has been some dispute about this and many have stated that it would occasionally be needed. However, this committee is not drawing up guidelines for medical practice - doctors do that. They live within those guidelines and practise according to the best evidence which is available. I would ask our various experts, especially the obstetricians here, to provide some research for those who somehow, for reasons I am not quite certain I understand, believe that the evidence base of medicine will change if this law is introduced, which allows for the theoretical possibility of suicidality as a necessity for abortion, to reassure these legislators that that in fact is not the case, and that doctors confronted with an individual patient will still have access to the best evidence base and will make the best decision for that patient who is in their charge at that time.

I cannot let this moment pass without paying tribute to Professor Desmond Carney, who is one of the fathers of Irish oncology. He is one of my role models in joining this specialty and he has probably saved the lives of more Irish women than nearly anybody else in this country. Thank you, Des, for all you have done for us.

Chairman: He has a lot to answer for, for you. I thank Senator Crown for that. I now call Professor McAuliffe. We have seven minutes left in this slot for replies.

Professor Fionnuala McAuliffe: Deputy Mattie McGrath was wondering if an obstetrician would disagree with two psychiatrists. Just to reiterate, these are rare situations involving complex medical disorders. We take a multidisciplinary team approach. No individual doctor, or two doctors by themselves, will make these decisions. However, it is our opinion in the institute that if two experienced doctors feel, in good faith, that there is a risk to a woman's life that can only be averted by termination of pregnancy, and if it is our assessment also, then we would be in agreement with that decision.

There were a couple of questions about viability, and Senator Walsh and Deputy Mattie McGrath also discussed this. Foetal viability changes over time. When I first started in medicine the earliest point of viability was 28 weeks. It is now about 23 or 24 weeks, so it is changing all the time. Therefore I would favour not putting gestational age into the law, because it changes. At present, foetal viability is 23 or 24 weeks, so if a baby is delivered at 20 weeks' gestation, there is unfortunately no chance of survival.

If we have to intervene in a pregnancy - for example, if a woman has overwhelming infection or there is some other life-threatening maternal cause at 20 weeks - if we could extend that pregnancy to 24, 25 or 26 weeks, of course we would. Every effort would be made and every effort is made. Regardless of what this Bill shows when it comes to fruition, we will continue our current practice of trying to get every pregnancy to a stage at which the baby will survive, but we have to do that if it is medically safe. If the mother died while we were waiting for that time, that would be a disappointing situation. We work together with our neonatal colleagues

in multidisciplinary teams to try to advance gestational age.

With regard to Deputy Naughten's question, our institute's opinion is that we favour legislation plus regulation.

In terms of destruction, to reiterate, if a pregnancy needs to be ended before viability, the baby is delivered and it will die, unfortunately. If it is after the point of viability, the baby will survive.

I was asked if I was aware of any cases of suicidal ideation requiring early delivery. I cannot say that I am particularly aware of it without a review of cases. If a pregnant woman is sick and needs medication, we work together to get a plan in place. Sometimes that may involve pre-term delivery, but we have to take the mother and foetal longevity and life together. We do that every day.

A general point has come up with a lot of the questions. The institute's view is that this Bill will just put a legal framework around current practice. We do not see any significant changes to current practice. It will just give us a legal framework for current practice, so we do not see big changes to how we approach the equal rights to life of a mother and a baby in pregnancy.

The average gestation at which a pregnant woman presents to hospital is generally about 15 to 18 weeks. If she is identified as having a medical disorder she will be seen much earlier. There are medical clinics available at all tertiary referral centres and patients can be seen there from as early as four or five weeks. We often see patients with medical disorders much earlier on. The patients we are talking about will be identified as having medical disorders by the general practitioner and will be referred to us. It is our experience that general practitioners appropriately refer patients in a timely manner.

As regards our opinion on suicide, it is a very rare situation in which a woman is suicidal and the only option is to terminate the pregnancy to avert the risk to life. This is a very rare situation. We have not seen this case, so we know that these cases are very rare. Of course, that does not mean that is not possible or would not happen. Therefore, it is the institute's preference to put heads 2 and 4 together, as they both relate to risk of loss of life. I ask Dr. Ní Bhuinneáin to briefly address Deputy Naughten's question about what happens if three consultant obstetricians have conscientious objections in a smaller unit. I am not talking about emergency treatment.

Dr. Méabh Ní Bhuinneáin: Emergency treatment excluded, the smaller hospitals are networked - now formally, previously informally. If it turns out that there are three conscientious objectors in one unit, the network and institutions will have to decide, where care is delivered, if it is safe and timely to hold that decision to treat until the woman can be transferred. If it is not safe and timely to hold the decision to treat, under current Medical Council standards, even conscientious objectors must provide care, because guideline 10.1 is essential - one must not allow one's moral standard to determine the care provided to the woman.

A Member: So a transfer would be involved?

Dr. Méabh Ní Bhuinneáin: Yes.

Dr. Margaret O'Riordan: In response to Deputy Mattie McGrath, I made it quite clear in my opening statement that the ICGP supports guidelines to implement this legislation. In response to Deputy Naughten, the ICGP holds that there is a need for more resourcing for peri-

natal psychiatry. This is in the context of women suffering from mental health disorders when they are pregnant, not just in the context of the heads of this Bill. On the need for earlier referrals, GPs generally refer pregnant women as soon as they present. As Professor McAuliffe has explained, on receiving that letter women usually get an appointment when they are between 16 and 20 weeks or 15 and 18 weeks pregnant, depending on where they are in the country. If there is a need for a woman to be seen sooner we will of course put that in the referral letter and she will be prioritised on that basis.

Chairman: As we are over time, could Professor Murphy be brief in his response, please?

Professor Kieran Murphy: I will try. Deputy Mattie McGrath raises an important point, which is what happens if there is not agreement. It is very important that the members, as legislators, put the interests of the woman at the centre of all they do, which is what the Irish Medical Council does in all its own actions. If there is a disagreement and the woman is unhappy with the outcome of the process, there is a review mechanism within the draft heads of Bill which allows for an appeal process. The council is very supportive of this and would go further. In our submission earlier this morning I outlined that we believe there should be a further appeal process enshrined in the legislation to allow a woman to access an appropriate treatment if she feels this is what she wants to do.

On Deputy Mattie McGrath's comments on the new Medical Council, clearly, as an outgoing member of the current Medical Council, I cannot possibly comment on what the new Medical Council might do. Regarding what Deputy Naughten said, as the Taoiseach and our Minister for Health have said, it is important for doctors to have legal clarity when making clinical decisions. Consequently, it is the Members' role, as legislators, to ensure they can provide that legal clarity to doctors. Once that legal clarity is provided it will be up to other organisations - such as the colleges and the Medical Council, co-ordinated by the Department of Health - to ensure that the guidelines developed based on the legislation are appropriate to ensure that the woman, who is at the centre of all this, is protected.

Regarding the questions from Senator Walsh, I have already dealt with the rationale for a merger of heads 2 and 4. The principle underlying the council's submission is that we want to ensure all women have equal access to a process that will save their lives. That is all I will say, given the time.

Dr. Matthew Sadlier: I will try to be as quick as possible. In response to Deputy Naughten's comment regarding employment of staff, we would be very opposed to a doctor's status of conscientious objection being a criterion in whether he or she attains a post in a facility. We would view that as similar to discrimination based upon religious, gender or other grounds. The other question that was directed towards us was Senator Walsh's question on proper psychiatric care. We would envisage that at all stages in this procedure - before the decision is made, during the decision and after the decision, whichever way it goes - all women involved in this would receive the maximum and best evidence-based medical and psychological care, including their family members if necessary. We included this in our submission to emphasise the need for adequate resources, because the health services are struggling and the mental health services are struggling more than most of the others.

Chairman: We now have 30 minutes for non-members. We have five speakers who have indicated so I will be very tight on time.

Deputy Terence Flanagan: The ICGP's submission asked how doctors who are willing

to refer patients requesting a termination will be identified. Do they propose that there be a register of doctors who have no objection in principle to the direct and intentional killing of an unborn baby?

Professor McAuliffe distinguishes between terminations and pre-term delivery. What exactly does she mean by "termination"?

I have some questions for the Irish Medical Council. In taking a stand in favour of the Government's proposed legislation, I presume, as an evidence-based organisation, the council's members have had extensive discussions on the studies questioning whether abortion can be a treatment for suicidal ideation. Could they share with the committee the details of those discussions and indicate which studies supported the contention that abortion can be a treatment for suicidal ideation? In their comments on head 5, the witnesses expressed a preference for clinical guidelines established by the relevant professional colleges over prescription from the Minister. Would it be fair to say they fear legislation could be overly prescriptive and could tie the hands of medical professionals? In their comments on head 6 they suggest that "practitioners who declare a conscientious objection must be excluded from review panels". Is it the IMO's position that doctors should be screened for pro-life values and excluded on that basis, or that review panels should be made up exclusively of doctors who have no principled objection to the direct killing of an unborn baby? To be intellectually consistent as well as being fair in terms of the equal right to life of the unborn child, should practitioners who declare support for general abortion rights be excluded from panels determining whether abortion is an appropriate treatment for a threat of self-destruction?

Senator Paul Bradford: I welcome all the guests. I get confused about who is who in the medical world. I have a very straightforward question for Dr. Sadlier of the Irish Medical Organisation. Notwithstanding the fact that we all have to work within whatever is, or may be, the law, could he confirm that the official position of his organisation, as per its recent conference, is one of opposition to this piece of legislation, yes or no?

I have a question for Professor Murphy of the Irish Medical Council. The Medical Council guidelines are quite interesting. They are referred to from time to time when constituents on all sides of the argument meet us. The Medical Council guidelines prescribe that abortion is legal arising from the X case where there is risk to the life of the mother, including the risk of suicide. Interestingly, the guidelines go on to demand of practitioners that such a risk must be evidence-based. I trust that over the course of the years since those guidelines have been passed, such risk has been examined and determined. Could he inform us of the result of that examination of risk?

Professor McAuliffe and Dr. O'Riordan, who made very interesting contributions, both strongly expressed a view that they hoped the proposed legislation would be dealing with very rare cases. The reason we are here, when we remove all the waffle, is the political dispute over head 4 and the risk of suicide.

When we remove all of the waffle, we are here because of the political dispute over head 4 on the risk of suicide. The constitutional amendment, per the Supreme Court, allows the right of abortion where the threat of suicide can only be resolved by abortion, not where it is just one possible treatment. Has any member of the panel or any of their colleagues encountered a case in which an abortion was the only treatment for a threatened suicide?

Deputy Peadar Tóibín: Much divides Members in the Houses, but much also joins them

together. We all agree that mothers need more supports to help them to make the right choices for themselves and their children.

This morning, Dr. Holohan stated - I hope that I am citing him correctly - that this Bill was a significant change from the *status quo*. There is no precedent for the treatment for suicidality to involve the damaging or ending or the life of another human being. Will the Institute of Obstetricians and Gynaecologists comment on this issue?

Someone might correct me if I am wrong, but Dr. Holohan made another comment. Currently, if a woman has suicidal ideation and the unborn child is viable, an intervention may occur in which the child is brought to term prematurely. Is this the witnesses' experience? What are the typical outcomes for the children?

Regarding the issue of predicting the number of people who will need these services, this legislation is another change in the *status quo*. Currently, decisions are based on objective medical markers. If I am correct, the Bill will introduce subjective markers, which are scientifically more difficult to base predictions on. The actual number of suicides predicted by psychiatrists is low.

Chairman: To allow for continuity in the replies, I will take Senator Mullen and Deputies Timmins and Mathews now. As we will conclude at 2.15 p.m., they will have three minutes each, although they will not need to take them. Two other Members have indicated.

Senator Rónán Mullen: We have not seen the full submission of the Institute of Obstetricians and Gynaecologists to which someone alluded. We have only seen today's speaking notes. Does the submission include any concerns of obstetricians and gynaecologists about their role in certifying or carrying out abortions, particularly on grounds of suicide? Dr. Sam Coulter-Smith, who will address the committee later, stated on radio today that asking obstetricians to get involved in the termination of pregnancies when there is little evidence to show that they are appropriate interventions creates a moral and ethical dilemma for doctors.

Chairman: The Senator should be careful about naming people who are not present to defend themselves.

Senator Rónán Mullen: I am quoting him for the record. I sense a certain discrepancy between that statement and a general nod of approval for the legislation. Is there more information in the submission that would enlighten us about the concerns that many doctors have?

Turning to the Irish College of General Practitioners, as I understand it-----

Chairman: I am sorry, but the witnesses present might not have heard the remarks to which the Senator is referring, so it would be unfair to ask them to comment. Does the Senator understand?

Senator Rónán Mullen: That is fair, but I assure them that I am quoting from a verbatim transcript.

Chairman: As Chair, I must be impartial and cannot take the Senator's word for everything.

Senator Rónán Mullen: Go raibh míle maith agat. Glacaim le do neodracht.

Will the Irish College of General Practitioners provide guidance regarding the motion that was most recently passed? As I understand it, a motion approving of the Government's leg-

islative proposal was amended in favour of a desire for evidence-based medical guidelines. I would appreciate clarity on this point. I would also like clarity from the Irish Medical Organisation, IMO, about what was passed at its most recent gatherings in respect of this issue.

Dr. Holohan made it clear that the right is not to have a life ended, but to have the pregnancy brought to an end. I am referring specifically to head 4. Senator Crown believes sincerely that this set of circumstances is rare to non-existent, if I have interpreted him correctly. Nonetheless, many doctors have a deep concern about this issue, possibly because they are conscious of the national and international politics of abortion. Since what is proposed is that psychiatrists, in the absence of an evidential basis, would nonetheless be in a position to certify that an abortion was the only means of dealing with suicidal ideation, and given the Government and Dr. Holohan's statement that the right is not to end a life, but to end an pregnancy, does it not by definition follow that the Irish Medical Council would a prefer a situation in which a person who has suicidal ideation would be protected to the end of her pregnancy? Regardless of whether one agrees with this approach politically, should it not follow that, by definition, the Irish Medical Council would recommend against any termination in the absence of evidence to the effect that an abortion is a treatment for suicidal ideation, given the fact that there is no right to end the life, *per se*, and in light of the fact that there is the possibility of protecting a person until the end of the pregnancy?

Deputy Billy Timmins: I wish to make a couple of brief points. Everyone present would support any measure that could provide clarity regarding the protection of the life of the mother, particularly the physical aspect. In terms of head 2 and setting aside head 4, however, where is the clarity in the Bill? Where is clarity lacking currently? Pages 7 and 11 read: "Due to the unpredictability and complexity of these rare medical cases it was felt not desirable to provide in legislation for a specific referral pathway." As is currently the case, it will be left to the medical practitioner, which was pointed out by Senator Crown. Time and again, I have heard the Government state that this Bill will improve clarity and protect the life of the mother, but in what respect will clarity improve?

Regarding the Irish Medical Council's guidelines, Professor Murphy mentioned that they reflect the current legal practice. Between 1992 and 2009, the guidelines were different, in that they maintained that the carrying out of an abortion was medical malpractice. This only changed 17 years after the X case. I may be wrong, but the guidelines changed in 2009 following the 2007 legislation, which put a majority of lay people on the council as opposed to medical people. How did the council operate between 1992 and 2009?

I have a brief question for the Irish College of General Practitioners and the Institute of Obstetricians and Gynaecologists. Were they required to nominate people to the expert group or did they have members on that group?

Deputy Peter Mathews: An awful lot of words have been exchanged in this discussion - professional and expert words and simple words. For clarity, simplicity is needed. One must declutter. I am afraid that we are falling into the professional vanity of confusing and obfuscating.

(Interruptions).

Chairman: Deputy Mathews without interruption, thank you.

Deputy Peter Mathews: The Constitution is clear. The doctors have stated that their guidelines give them the sound basis for doing their work. Women and children have been extremely well served.

Senator Paul Bradford: Hear, hear.

Deputy Peter Mathews: People have done their work dutifully and well. Where people have fallen short in their professional capabilities, there have been accidents.

Chairman: Does the Deputy have a question?

Deputy Peter Mathews: Yes. Why do the professionals not say clearly and simply that they know what to do if there is a threat to the life of the mother and that they can get on with it? No one has discussed the post-abortion recovery counselling that is needed for those poor, unfortunate girls and women who have gone to England to have abortions. Their voices have only been heard by a few of us. In fact, they asked to be present and to be heard, but were told that, because of arrangements, it was not possible. This is a screaming void.

Chairman: I call Professor McAuliffe. This session ends at 2.15 p.m.

Professor Fionnuala McAuliffe: Deputy Terence Flanagan asked for a definition of the word "termination". I provided such a definition in my submission this morning and it is also in the written submission. Termination refers to circumstances where there is no chance of survival after birth, such as when a pregnancy is ended before the foetus is viable. Pre-term delivery is delivery of a baby after viability.

Senator Bradford asked if we had ever seen a case of a woman whose only treatment was termination of pregnancy. We have not seen a case of a woman who was suicidal in pregnancy and the only treatment to avert the risk of life was termination of pregnancy. However, that is not to say that there could not be even one such case. We work very hard in obstetrics to save mothers' lives and even one death is an absolute tragedy. To say we have not seen one case does not mean we will not see one case.

Senator Jim Walsh: It is not about saving babies but about saving women only.

Chairman: I ask Senator Walsh to show respect to the witnesses by having the courtesy to allow them to reply. He had an opportunity to speak and he spoke well.

Professor Fionnuala McAuliffe: Deputy Peadar Tóibín asked about suicidal ideation and pre-term delivery. If a woman is psychiatrically unwell, she will receive medication. I have not been personally involved in any case of a suicidal ideation requiring pre-term delivery. I revert to Dr. Houlihan and whether he is aware of such cases.

As to what numbers we are anticipating, the view of the institute is that this legislation provides a legal framework for existing, current medical practice. We are facing pregnant women whose lives are threatened by the pregnant state and need either termination or pre-term delivery. This legislation provides a process for that so that we are not working in a legal vacuum or unsure as to whether a woman's life is in immediate danger or in danger down the line. It provides us with a legal framework for current medical practice. That is our stated view.

In terms of the lack of evidence, an issue raised by Senator Rónán Mullen, the institute acknowledges that there is a lack of evidence of the role of termination of pregnancy. This poses an ethical dilemma for our members. We went through a planned consultative process and we

represent the majority view within obstetrics and gynaecology in Ireland. Members will have an opportunity this afternoon to hear views from individuals and individual units, but the view presented in our submission is the majority view that emerged from a consultation process that involved consultation with the executive members and representatives of each of the 19 maternity units involved. Members are, therefore, hearing the majority view within the specialty this morning.

Deputy Timmins wondered about the clarity of the Bill. We believe it will give us a legal framework to allow us to carry out high quality medical care.

We received a request to put forward some names for the expert group and we participated in that process.

To respond to Deputy Mathews, the view of the institute is that we favour legislation plus regulation. Professor Robert Harrison will comment on our submission as I understand the committee did not receive a full written statement.

Professor Robert Harrison: I am slightly shocked and dismayed at this because I am the rapporteur. The statement was submitted last Wednesday within the legal timeframe.

Chairman: The members of the committee received the submission.

Senator Rónán Mullen: I understand that is not the case.

Chairman: That is the case.

Senator Rónán Mullen: I was informed by an official that it was not the case.

Chairman: My understanding is that members were to receive all written submissions in advance of the meeting today. That was the decision taken by the committee.

Senator Rónán Mullen: I was given to understand by one of the officials that was not the case.

Chairman: All I can do, as Chairman, is-----

Senator Rónán Mullen: Will the Chairman revert to us on the issue after lunch?

Chairman: No.

Senator Rónán Mullen: It is an important issue.

Chairman: Thank you, Senator.

Professor Robert Harrison: The submission was definitely sent and acknowledged before the deadline of 5 p.m., despite the institute only being given seven days' notice, which included a bank holiday.

Dr. Margaret O'Riordan: To respond to Senator Mullen, the submission raises the question as to how doctors who are willing to refer patients requesting terminations in these circumstances will be identified. That is a genuine question to which I do not have an answer. I am raising it because it is an important issue.

On the guidelines, we have clearly stated that we support guidelines to underpin the legislation.

To respond to Senator Bradford, I am not aware of any general practitioner colleagues who have encountered a case where a termination was the only treatment available. I will leave it at that.

Professor Kieran Murphy: With regard to the questions raised by Deputy Terence Flanagan, which largely related to the Medical Council's guidance, as I stated earlier, the Medical Council constructs and publishes its guidance following extensive consultation. We engaged with a range of different stakeholders, including the Institute of Obstetricians and Gynaecologists, to ensure the guidance we produced will be the most helpful guidance in assisting doctors in their day-to-day practice.

Senator Bradford made comments about the appropriateness of the use of non-scientific markers in the assessment of suicide. This morning, we heard the Chief Medical Officer describe psychiatry as a clinical science. It has also been noted that there are a number of markers that are associated with assessment of suicidal ideation and suicidal intent. I suggest that these questions would be more appropriately put to the College of Psychiatrists of Ireland which will come before the joint committee on Monday.

I regret that Senator Mullen does not appear to support some of the submissions of the Medical Council. It may be helpful for Deputies and Senators to understand the composition of the Medical Council. The council is a body of 25 people constituted under statute. We are the only medical regulatory authority in the world with a lay majority. Of the group of 25 people, 12 are doctors and 13 are laypersons. We very carefully consider these issues. Our primary role is to protect the public and this guides all the work we do. We take the publication of our guidance extremely seriously. We want it to be fit for purpose to ensure that doctors understand what they need in terms of how they should work. It is also important for patients to understand the standards we expect of our doctors and they should expect of their doctors. As I stated, I regret that Senator Mullen does not share the collective view of the Medical Council.

Senator Rónán Mullen: I asked a question rather than expressed regret.

Professor Kieran Murphy: Deputy Timmins also asked questions about our guidance. I hope I have addressed the issue of how the Medical Council constructs its guidance without having to go over it again.

To respond to Deputy Mathews, as I indicated earlier, it is extremely important, as the Taoiseach has said on numerous occasions and the Minister of Health agreed, that doctors have legal clarity when making clinical decisions. The role of legislators, I submit, is to ensure that they can provide doctors with that legal clarity. Once that legal clarity has been established, it will be up to professional bodies, including the Medical Council, to draft guidance that will assist in the implementation of this new legislation.

Dr. Matthew Sadlier: I will respond to three general questions asked by a number of speakers. On the issue of guidelines and legislation, we are more in favour of guidelines than legislation on technical-medical issues because, as has been noted before, medical evidence changes and guidelines will change more quicker than legislation. We do not want to end up in a position where medical evidence or procedures make something feasible but the law makes it illegal. That is the reason we would prefer guidelines to be developed by professional expert bodies, rather than having legislation in specific medical instances. This view is shared across all specialties.

Two speakers asked questions on the official position of the Irish Medical Organisation. At our recent annual general meeting, there was no change in the policy of the Irish Medical Organisation. A number of motions were proposed, all of which were defeated. As such, the policy remains as it has been since the last time a motion on this issue was approved. That motion, which was approved in 1993, states that the IMO endorses the principle of respect for all human life, born and unborn, and rejects abortion. That answers the question. Notwithstanding that, we are aware that we are democratic organisation operating in a democratic society. The laws of the land are made by referendum, the people and the Oireachtas and it is our job to represent our members within that legal framework. We will, therefore, engage on issues notwithstanding our own policy.

We welcome the fact that there is a provision for conscientious objectors and that doctors can object to engaging in this process and are not being forced to engage in a process to which they object, notwithstanding their obligations under the Medical Council ethical guidelines which Professor Murphy alluded to previously. If they agree to participate in this process, whatever morals and ethics they use to inform their decisions is a matter for them. Obviously, they are guided by the Medical Council guidelines and those of their own colleges and specialised information.

Chairman: Members should have received the submissions. That was agreed at the committee. If they have not received them, I will check it out afterwards. Deputy Tóibín said a question of his was not answered?

Deputy Peadar Tóibín: Yes. I have a heavy cold so I probably asked the question very badly. My question was addressed to Professor McAuliffe. She predicted that there would be a very low number of individuals who would need this type of treatment in the cases of suicidality. We heard at similar hearings here in January that prediction accuracy for suicide is about 3%. Given that the legislation identifies that objective medical markers will not be available to the decision makers but that subjective analysis will be available and the fact that in every other jurisdiction where similar legislation has come through, the experience has been quite different and there has been a very large increase in the number of people accessing this service with similar types of symptoms, it is very difficult to make that prediction that the numbers will be very low. Professor McAuliffe said earlier that the legislation is not really a change in the *status quo*. Dr. Holohan mentioned this morning that this legislation was without precedent in that it meant that a third party would be damaged or would lose their life as a result of the treatment for suicidality.

Professor Fionnuala McAuliffe: With regard to suicide, we would defer to our psychiatric colleagues regarding making an assessment. They are trained in assessing patients, as we all are as doctors in assessing medical risk. I understand the committee will have a full day on the psychiatric evidence on Monday so in terms of the prediction of suicide, we would defer to the specialists involved.

In respect of the numbers, limited termination of pregnancy is permitted in Northern Ireland where there is a lethal foetal abnormality, there is a risk of permanent damage to the health of the mother or there is a risk to the life of the mother. Northern Ireland has very small numbers of cases. There are approximately 40 cases every year in Northern Ireland so it has not seen huge numbers of cases or a big requirement for increasing capacity. I suspect that we would see very low numbers of cases as well.

Deputy Mattie McGrath: Could I get an answer to my question?

Chairman: This section is for non-members. The Deputy is a member of the committee.

Deputy Mattie McGrath: It is a waste of time.

Chairman: In respect of submissions, I will make it my business to talk to people afterwards to make sure submissions are given to members who were here this morning. We will now suspend until 2.45 p.m.

Sitting suspended at 2.15 p.m. and resumed at 2.45 p.m.

Obstetric Care Facilities - Larger Hospitals

Chairman: I welcome everyone to this afternoon's session. Is it agreed that we begin in public session? Agreed.

I remind members of the committee, witnesses and those in the Visitors Gallery, be they members of the media or members of the public, to ensure their mobile telephones are switched off for the duration of the meeting as they interfere with the broadcasting equipment even when they are on silent mode. It is particularly unfair to members of staff who have to wear headphones.

Over 500 submissions were received by the committee prior to today's meeting. Not all of them could be given to members. However, the submission referred to earlier this morning has been e-mailed to members. Any documentation, if it is made available by a delegation the day before the hearings, will be given to members in advance.

I acknowledge the presence in the Visitors Gallery of former Deputy, Ms Geraldine Kennedy, and former Ministers, Ms Gemma Hussey and Ms Nora Owen. I also acknowledge the presence this morning of Ms Mary Banotti. I thank those watching these proceedings on UPC or the Oireachtas live feed. It is very much appreciated that people are taking time to watch the proceedings of this committee.

With that said, we are in our third session of hearings to discuss the heads of the protection of life during pregnancy Bill 2013. I welcome Dr. Peter Boylan, Dr. Sam Coulter-Smith and Dr. Rhona Mahony. Before we begin I wish to remind you of the position regarding privilege. Witnesses are protected by absolute privilege in respect of the evidence they are to give to the committee. However, if you are directed by the committee to cease giving evidence in respect of a particular matter and you continue to do so, you are entitled thereafter only to a qualified privilege in respect of your evidence. You are directed to give only evidence connected with the subject matter of these proceedings and you are asked to respect the parliamentary practice to the effect that, where possible, you 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 or her identifiable. Members are reminded of the long-standing parliamentary practice or 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 either by name or in such a way as to make him or her identifiable. I remind all members that the witnesses are here voluntarily to give of their time and I hope we will all show respect to them and to each other in our language and in the way we behave in the Chamber. We are now ready for opening statements. I call on Dr. Boylan to make his opening remarks.

Dr. Peter Boylan: I have been a practising obstetrician and gynaecologist since 1975. Part of my training was undertaken in London and after I qualified I held an academic post in the United States for four years. Over many years I have been invited to give lectures and perform clinical practice reviews in the United Kingdom, the United States, Europe, Scandinavia, Singapore, Israel, Australia and New Zealand. All of this experience has given me wide opportunity to observe the practice of obstetrics as it relates to the issue under discussion, namely, the termination of pregnancy to save the life of the mother.

Ireland is in a unique position in that there is ready access to termination of pregnancy in the United Kingdom for residents of this State despite it being illegal here. It could be interpreted that the State has implicitly agreed to facilitate this access by way of the constitutional amendments of 1992 which guaranteed the right to access information regarding termination of pregnancy and guaranteed the right to travel to obtain a termination.

The situation in Ireland regarding termination of pregnancy where there is a real and substantial risk to the life of the mother remains unclear. As doctors, we are aware of the Supreme Court judgment in respect of the X case but we are left, in the absence of legislation and regulation, to attempt to interpret that judgment on an *ad hoc* basis when it comes to termination of pregnancy in order to save the life of the mother. Meanwhile, the Offences against the Person Act 1861 remains on the Statute Book. This is a wholly unsatisfactory and, I believe, unreasonable situation to expect doctors to operate in. It also places the woman in the highly unsatisfactory position whereby doctors caring for her are unsure about whether they may be breaking the law in cases where they believe they must intervene to save her life. For these reasons I welcome the intention to enact legislation to protect life in pregnancy.

Dr. Sam Coulter-Smith: My name is Dr. Sam Coulter-Smith. I am master of the Rotunda Hospital in Dublin. My submission to the committee today is based on my views and the views of my consultant colleagues at the Rotunda Hospital following consideration of the draft heads of the Bill. I thank the Chairman and members of the Joint Committee on Health and Children for giving me the opportunity to present these views on this important draft legislation.

I will start by making some general comments. I acknowledge the work that was done on this extremely difficult and contentious document and I commend those who drafted the text for avoiding the word "abortion" in the terminology. This is a positive move and ensures that those women who have to have a pregnancy terminated in an emergency situation are not stigmatised in any way and this should be welcomed.

In terms of where a termination of pregnancy can occur, there are two factors that need to be considered. I welcome the fact that the legislation provides for termination of pregnancy in an emergency situation in any of the 19 maternity units in the country. However, there are occasions when it may be necessary to terminate a pregnancy outside these institutions, for example, in Mount Carmel Hospital, which is a private, non-HSE institution delivering maternity care.

In addition, in each of the big maternity hospitals in Dublin there is no provision for intensive care. Therefore, our sickest patients from these units, some of whom will have been transferred from other units around the country for care, will be looked after in intensive care units in hospitals such as the Mater Misericordiae University Hospital, St. Vincent's University Hospital, St. James's Hospital and others. There may be occasions, therefore, when it is necessary to provide this type of emergency care, which is provided for within this legislation, to patients in these intensive care units, which are currently outside the draft legislation.

I will turn my attention now to the clinical scenarios that the heads of the Bill cover. The document broadly covers three clinical scenarios. First, when a woman's life is acutely at risk in an emergency situation due to a complication of pregnancy. Second, when the acuity of the situation may be less urgent but the severity of the situation relates to a co-morbidity such as cancer, significant heart disease or other illness. The third clinical scenario is where there is imminent risk of death from suicide or self-destruction.

In respect of the first two scenarios, the heads of the Bill provide clarity and appropriate protection for those giving care to pregnant women. This, in turn, should provide clarity and reassurance for all professionals, including medical, midwifery and nursing professionals, that their actions in giving best care to the mother are covered under the law. It should also provide reassurance for women and their families that the medical profession can act in their best interests during difficult, life-threatening situations, and this is to be welcomed. It is also important to note that there is no gestational limit applied to either of the first two scenarios and this, in my view, is appropriate. It is also important to note, and it is confirmed and reiterated in several areas within the draft document, that doctors must have regard to the protection and preservation of the unborn human life where practicable. This should provide appropriate reassurance for patients and their families in very difficult and distressing situations.

In respect of the first scenario where a woman's life is at risk in an acute emergency situation, it is now acceptable for one obstetrician to decide whether a termination of pregnancy is required to save a woman's life. It is good practice for an obstetrician in this situation to seek a second opinion from a colleague if it is possible to do so. However, in these difficult situations there will often be other consultants involved, such as a haematologist in the case of haemorrhage or a microbiologist in the case of infection. It is also likely that a consultant anaesthetist will be available and it would be appropriate for the consultant obstetrician to seek advice and to discuss the decision-making process with these colleagues.

In respect of loss of life from self-destruction there are a number of issues that need to be raised. First, this is an extraordinarily rare situation with the incidence of suicide in pregnancy of the order of one in 500,000 pregnancies as per United Kingdom figures. Second, our psychiatric colleagues tell us that there is currently no available evidence to show that termination of pregnancy is a treatment for suicidal ideation or intent and, as obstetricians, we are required to provide and practice evidence-based treatment.

Deputy Peter Mathews: Hear, hear.

Dr. Sam Coulter-Smith: It, therefore, creates an ethical dilemma for any obstetrician who has requested to perform a termination of pregnancy for the treatment of someone with either suicidal ideation or intent. Third, this legislation, I am sure, is designed to create clarity and reassurance for both health professionals and patients alike.

The fact that there is no gestational limit in respect of the third scenario relating to suicidality is a major ethical issue for obstetricians. I will illustrate this with two scenarios. First, let us consider the case of a patient who is 25 weeks' gestation. If she is deemed to be sufficiently suicidal to require a termination of pregnancy by one or more psychiatric colleagues, an obstetrician who is tasked with dealing with this situation is faced with an enormous ethical dilemma. Delivering a baby at 25 weeks' gestation could lead to death, due to extreme prematurity or it could lead to a child with cerebral palsy or with other significant developmental issues for the future. This outcome would be entirely iatrogenic and the responsibility of those clinicians who have agreed to be involved in the process. This is a source of serious concern for myself and

my colleagues.

Another clinical scenario which provides a difficult ethical dilemma is a situation whereby at a woman's 20 week anatomy scan a significant but non-lethal malformation is discovered. The patient, for a variety of reasons, may decide that she cannot continue with the pregnancy and it is causing her significant mental health issues with risk of suicide. The obstetrician is left in the unenviable position of, by law, having to look after the best interests of the baby but also the understanding of the mother's issues. It would, therefore, seem appropriate in a case where there is a risk of self-destruction that there is no gestational limit applied in this situation as this creates a major ethical dilemma for us. My overriding concern, however, in relation to the whole area of self-destruction and termination of pregnancy to prevent same, relates to the lack of evidence to show that termination is of any assistance in this scenario and that we as obstetricians and gynaecologists must be able to stand over the decisions we make as being based on good medical evidence.

In relation to the infrastructure and resources it is my view, and that of many of my colleagues, that the inclusion of suicidality within the legislation may, and I stress may, in the long term lead to an increased demand for termination in this country. We currently do not have any real understanding of how big that demand may be. Currently in excess of 5,000 women a year go from Ireland to the UK to have termination procedures performed. We cannot be certain how many of these women would decide to use this current legislation as a means of obtaining a termination in this country and even if unsuccessful in obtaining a termination in this country, a huge amount of time and resources will be spent on the assessment of these patients.

We currently have three sub-specialist psychiatrists with a special interest in mental health issues in pregnancy. These are part-time posts attached to each of the three Dublin maternity hospitals. Mental health issues in pregnancy are among the most common complications we see, affecting between 10% and 15% of our pregnant population. The impact of this very high incidence of mental health complications means that these services are overstretched and find it difficult to cope with their existing workload. Any increase in the workload of these services could put huge strain on the system and take it beyond breaking point.

Each of our Dublin maternity hospitals delivers approximately 9,000 women per year. The midwife to patient ratio is approximately half of what it should be, the consultant to patient ratio is also half of what it should be. We have seen an increase in the delivery rate in Dublin of about 30% over the past six years and this has put an enormous strain on the infrastructure of our hospitals. The increase in the number of women delivered is now leading to a huge increase in the demand for gynaecology services to the extent that waiting lists for routine gynaecology outpatient clinics are currently well over a year and growing. The combination of these factors means that it would be extremely difficult for us in the maternity hospitals to take on any additional service which would require input from staff in an outpatient setting in terms of assessment or in theatre time to cope with an increase in the number of termination procedures.

In conclusion, I welcome this draft legislation, particularly in the area of real and substantial risk to the life of the mother which pertains to physical illness. I think, however, that there are significant concerns in all areas of the medical profession in relation to this Bill when it comes to suicidality. Our overriding concern relates to the lack of evidence to show that termination of pregnancy is an appropriate treatment for women who are deemed to be at risk of suicide. As obstetricians we are expected to practise evidence-based interventions and first and foremost to do no harm. This legislation should help in providing clarity and reassurance to professionals and patients alike. To enact and underpin the idea that termination of pregnancy is a solution or

a treatment for a patient at risk of committing suicide when there is no evidence to support that intervention creates an ethical dilemma for our profession.

To make matters a little more difficult there is no gestational limit mentioned in the draft at which this termination might happen. This opens the possibility for iatrogenic prematurity with all the risks of infant morbidity and mortality. Who will be responsible for these interventions? I also confirm to the committee that we as a profession, and particularly in my hospital, have concerns about the potential for increased demand for termination services in this country as this may be an unintended consequence of this legislation in its current form.

Dr. Rhona Mahony: Chairman and members of the committee, I thank you for the opportunity to comment on the draft heads of the protection of life during pregnancy Bill. I am the master of the National Maternity Hospital. I am a practising obstetrician, having practised for 17 years, and am a specialist in foetal and maternal medicine. I have practised as a consultant at the National Maternity Hospital since 2008.

This Bill is about saving women's lives. Women sometimes die during pregnancy and it is my belief that everything possible must be done to prevent such a tragic outcome. Where there is a substantial risk to a woman's life during pregnancy there should be no hesitation to save her life. If she dies her baby will die too. Despite this fundamental imperative there remains today in Ireland a lack of clarity surrounding when termination of pregnancy is legally permissible. It could be argued that the State has gone to great lengths to avoid legislating for this reality, the reality of maternal death as a consequence of pregnancy. This is inexcusable.

Provision has been made in Ireland for women to access termination of pregnancy outside of this jurisdiction despite the fact that it remains a criminal offence in Ireland. I believe this Bill, which is restricted to circumstances where a pregnant woman is at risk of dying, sets out to provide clarity in a number of key areas which directly affect clinical obstetric practice. Despite the Supreme Court judgment in the X case which provides for termination of pregnancy when there is a real and substantial risk to a pregnant woman's life which may be ended or removed by ending the pregnancy, there remains today no legal framework through which this risk can be determined. This leaves doctors and their patients, women at risk of dying, legally vulnerable. This Bill addresses this issue.

The Offences Against the Person Act 1861, sections 58 and 59, means that abortion, termination of pregnancy, is a criminal offence in this country. This is addressed also by the Bill and provision is made to remove this which is necessary. At present there is no formal process through which a woman who perceives that she is at risk of dying can access opinion on whether termination of pregnancy is appropriate. I believe women deserve that consideration and this Bill addresses that issue. I therefore commend the Government on the decision to provide legal protection for women and their doctors in this very difficult, rare and complex circumstance when termination of pregnancy is necessary to save a woman's life.

Most importantly, I understand that according to this Bill the constitutional protection of the unborn is preserved where practicable. We must vindicate the life of the foetus where it is practicable. This obligation has underpinned my clinical practice over 17 years and will continue to do so. In current practice all efforts are exhausted within the medical margins of safety to prolong pregnancy in the foetal interest. When a foetus has reached a gestation where survival is possible, every effort is made to optimise that survival. This is regardless of the indication for termination of pregnancy which in this context will be to save a woman's life. In practical terms with current neonatal intensive care, neonatal survival is now possible from as early as

23 weeks' gestation. Every year in Holles Street we look after at least 20 babies who were born somewhere between 23 and 26 weeks' gestation. This is not strange to us.

I want to leave the committee in no doubt of the following: we do not destroy or kill foetuses. We deliver them and on occasion delivery in order to save a woman's life is required at gestation so early that very sadly foetal survival is not possible. In this context if a pregnant woman dies her baby will die too. It is my experience - and I am experienced in this area, I specialise in foetal and maternal medicine - the majority of women do not wish to lose their babies but they do not want to die. The indications for termination of pregnancy prior to foetal viability include situations such as infection, choreoamnionitis, blood pressure that we are unable to control, haemorrhage, treatment for some cancers and management of severe medical disorders in pregnancy such as heart disease. These situations are very complex and very rare. At the National Maternity Hospital, which is one of the busiest maternity hospitals in Europe, we have annually up to five cases.

Following the months of debate regarding the draft heads of this Bill one could be forgiven for thinking that this Bill is about the risk of suicide in pregnancy. It is not. It is about saving a woman's life regardless of whether that risk to life is physical or mental. Suicide is death just the same as death from infection chorioamnionitis; women are dead. A woman who is intent on suicide is indeed at risk of dying. She needs to be assessed appropriately, she needs to be believed and she needs expert psychiatric care.

The committee has already obtained my written submission in regard to each of the heads of the Bill and all my comments on those are set out in it. I think some practical amendments to them will need to be included. For example, in respect of the person carrying out the termination and the definition of obstetrician-gynaecologist, not all obstetricians and gynaecologists are on the specialist register. It is a technical point but it would be more pragmatic to refer to the term "obstetrician-gynaecologist".

The issue of location is also very important. We are a stand-alone maternity hospital in Dublin. When women become very ill we are often required to transfer our patients to a hospital that has a broader medical network where women can access a variety of areas of specialist care. Therefore, provision should be made to include all Government approved hospitals in the Bill.

I am pleased to note that conscientious objection is addressed in the Bill. I am also pleased to note that provision is made to remove the Offences Against the Person Act 1861.

Chairman: I thank Dr. Mahony. I call Deputy Kelleher.

Deputy Billy Kelleher: I welcome the three witnesses. There there are varying views in their three presentations. Large parts of legislation are quite agreeable to the vast majority of professionals and the broader public but the issue of self-destruction is something that divides Irish society. I wanted to get the varying views of our three witnesses on this. First and foremost, if there was no constitutional obligation because of the X case to bring forward legislation on self-destruction, should it be included in any event if one were introducing legislation in this area? In other words, do the witnesses believe there is the potential of a threat to one's life because of suicide and should it be legislated for, even if the X case was never heard in the first place?

The Irish Medical Council's guidelines of 2009 include suicide as a ground for a termina-

tion. I get the impression from Dr. Coulter-Smith that he believes there is never a reason to terminate a pregnancy because of the threat of self-destruction. I want to get clarity on that point.

In the broader context, what we are trying to do here, as Dr. Mahony has pointed out, is to bring forward legislation that saves the lives of women and gives clarity to the professionals who are dealing with them. There are varying views on how that should be done but the Government has decided to legislate. In that context, are the witnesses satisfied with the legislation before them in the practical terms in respect off making interventions to save the life of a woman and that it will not inhibit them in doing that and that it will give them protection? Are they satisfied it will not inhibit them in dealing with an emergency case, a non-emergency case or a case of self-destruction?

I wish to ask the witnesses a question that I have asked the previous witnesses and it is about an issue to which Dr. Mahony has referred. We need to get clarity on this issue, which I have already got, but I raise it for the benefit of the broader public who may be following the proceedings and others who have an interest in this matter. It is the area of foetal viability and when the foetus is on the cusp of viability. Obviously in emergency situations, a decision must be made there and then but in non-emergency situations or in a case of self-destruction, do obstetricians in the course of their duty in trying to save the life of the woman look at the viability of a foetus and believe that if they could extend the time of intervention it would give the foetus greater viability?

People have asked me to raise the issue of how a termination of a pregnancy is performed. It has been described as an interruption of pregnancy. In Britain there is an intention to destruct the foetus whereas the opposite is the case here. Every effort is made to save the foetus, regardless of gestational age. I would like to get clarity on that. Is a pregnancy terminated normally through inducement or caesarian section? I understand they would be the normal ways of inducing early pregnancy. I would like clarity on that issue. I met many members of the public in recent weeks and these are issues on which they would like certainty and the witnesses are the people best placed to give it to us.

Deputy Caoimhghín Ó Caoláin: I join the Chairman in welcoming our three guests. In relation to Dr. Peter Boylan's contribution, it should not strike one as strange that I would not have known that intensive care units did not exist in any of the three maternity hospitals in Dublin but it has come as a shock or certainly a surprise. It poses the question of whether these entities, as they are currently resourced and configured, have the capacity to provide for all situations that could present. It is not just about legislation; it is like all legislation here, it must be resourced. I take the opportunity to welcome Dr. Boylan's exposure of that deficiency, which I expect may have presented difficulties in the past, not only in the context of for what we are currently legislating.

A number of the contributions made this morning would complement and echo Dr. Boylan's points regarding a wider number of approved locations, other than the 19 designed, extending it to the general hospitals and he also made a case for the approved private hospital scenarios.

Dr. Boylan and Dr. Mahony referred to limitations regarding only obstetricians and gynaecologists who are in the specialist division. There is a number, whatever number that would be but it is an significant and important number, who would not be on the specialist register but on the general register of the Irish Medical Council. We welcome all these points and that light has been thrown on these because these are elements that can and hopefully will be addressed during the Bill's passage through Committee, Report and Final Stages.

I do not want to go over the area covered by my colleague, Deputy Kelleher. I note in Dr. Mahony's contribution her commendation of the Government for bringing forward the Bill. I presume the subtext of that is that she accepts that the five obligations of the State, as set out in the expert group report, are addressed here. She might elaborate on whether they are addressed to her satisfaction. I recall very well her stated concerns back in January regarding the Offences Against Person Act and sections 58 and 59 and we all join in welcoming the fact that this is now being addressed. I asked Dr. Holohan this morning if in is view, as chief medical officer, this complies with the obligations of the State, as set out in the expert group report. From her practitioner perspective, I would like Dr. Mahony's confirmation that is also her view.

Deputy Mattie McGrath: I welcome our guests. At the hearings of the committee in January Dr. Mahony dismissed the notion of performing late-term abortions in Irish hospitals. However, this Bill contains no term limits. While she told *The Irish Times* that babies who were viable would be kept alive, there seems to be a legal question about a potential liability which arises for doctors who deliberately induce a physically healthy child who was being carried by a physically healthy mother. Even if viability becomes a term limit for abortions, I would like an answer to the following scenario. A woman presents in the 20th week of her pregnancy. She is suicidal and requests an abortion and this is granted. The 20-week old baby is not viable outside the womb but the baby has been fully formed for many weeks. The baby is quite big, perhaps up to 10 inches long, reacts to her mother's voice, can feel pain and the mother can feel movement. What I would like to know is what procedure Dr. Mahony or any Irish doctor operating under this proposal undertakes at this point to end the life of the child? In the United Kingdom there are two methods used. Either a D and C is performed where the unborn baby is dismembered or the unborn baby is given an injection into the heart which causes it to have a fatal attack. Will either of these procedures be used in Irish hospitals? Are doctors in this country trained to perform these procedures?

I believe Dr. Sam Coulter-Smith made the point at the Medical Council recently that he had been forced to react to an *Irish Independent* headline in which he had been misquoted. I understand he has issues with the media.

Chairman: I am sorry, Deputy, but we are discussing the heads of the Bill. We are not discussing the *Irish Independent* , the *Irish Examiner* or *The Irish Times*. On the heads of the Bill, please.

Deputy Mattie McGrath: I believe Dr. Coulter-Smith has an issue with the media. Does he believe some elements of the media are covering the issue fairly?

Chairman: That is not relevant to our business today.

Deputy Mattie McGrath: It is all relevant, as far as I am concerned.

Chairman: It is not; we are dealing with the heads of the Bill.

Deputy Mattie McGrath: I have questions for Dr. Peter Boylan and Dr. Mahony. I understand they are related through marriage-----

Deputy Ciara Conway: On a point of order-----

Chairman: Thank you, Deputy; I am chairing the meeting.

Deputy Mattie McGrath: Good man.

Chairman: I am sorry, Deputy, but I ask you to withdraw that last remark.

Deputy Mattie McGrath: I have no intention of withdrawing it. I am concerned that-----

Chairman: As Chairman, I want to be fair to everyone.

(Interruptions).

Chairman: I want to be reasonable, objective and impartial. The Deputy's commentary has no relevance to the heads of the Bill.

Deputy Mattie McGrath: The disappearance of the Minister this morning had as much relevance as what I said.

Chairman: Please, Deputy.

Deputy Mattie McGrath: Given that the two doctors are leading advisers among the physicians in favour of the proposals made, is there a danger of group-think?

Dr. Peter Boylan: We are related by marriage but not that closely.

Deputy Robert Dowds: The experts only answer the questions to do with the heads of the Bill.

Chairman: They are well able to do so.

Dr. Peter Boylan: Deputy Billy Kelleher raised the issue of self-destruction or suicide in pregnancy. My expertise and that of obstetricians is in the area of obstetrics, not psychiatry. I understand the council of the College of Psychiatrists of Ireland has made a submission. It is the representative body of the more than 800 psychiatrists in the country. As an obstetrician, I am happy to defer to their expert opinion. If a woman is referred to me by a psychiatrist whose opinion I respect - an opinion which is not driven by ideology but by care for the woman, taking everything into account - and if that psychiatrist believes the only way she will be prevented from killing herself - it is her life I am talking about - is by terminating that pregnancy and if I trust the psychiatrist's opinion, I will terminate the pregnancy. If the mother dies through suicide, so too does the baby. This is about the protection of life in pregnancy. That is my comment in that regard.

I advise the committee that it should not really give much credence to evidence which is not expert in this area. I also advise it and perhaps the broader public and the Government in general not to be misled by bad science. Medicine and society are littered with examples of the damage bad science can cause. One of the most recent examples which will be fresh in people's minds is the evidence from the United Kingdom of the bad science about vaccination and a link with autism in children. The consequence of that bad science has been many children dying and many ending up mentally handicapped. If the committee plans to interpret scientific studies, I advise that members should make sure they are from a good reputable source and that they have been properly conducted. That is all I wish to say about suicide.

Dr. Sam Coulter-Smith will deal with the point raised about the Medical Council. I am very satisfied with the legislation proposed. I did not go through my commentary on the various heads of the Bill because I did not understand that was part of my opening presentation but, no doubt, it will arise during the course of the discussion. I am happy to deal with the individual

heads, if the committee wishes and there is time to do so.

Foetal viability is considered in all of our clinical decisions. This arises, for example, in the case of women with extremely severe hypertension. In that case if a mother has seizures, she may well die or she may effectively become brain dead or blind if we do not deliver the baby. We will deliver a baby at 23 weeks in order to save a mother's life. As I said, we cannot allow a woman who is pregnant to die in front of our eyes. We cannot allow her to get to a situation where she may kill herself. If she kills herself or she dies, the baby dies too.

Deputy Mattie McGrath and others asked about the method of termination. The majority of terminations of pregnancy will be done medically by induction of labour, certainly in the early stages of pregnancy. We do not at any stage set out to destroy life. The Bill is about the protection of life in pregnancy; it is not about the destruction of life in pregnancy. The concept that Irish obstetricians would involve themselves in dismemberment of a living foetus is, frankly, on the extreme end of I am not sure what, but it is on a very extreme edge of opinion and not one that would be shared by us.

In reply to Deputy Caoimhghín Ó Caoláin, there are no intensive care units in the three Dublin maternity hospitals. That is one of the reasons we need relocation in order to be located close to general hospitals with intensive care facilities. Despite this, we have very good working relationships with the general hospitals. Holles Street Hospital has a very good relationship with St. Vincent's Hospital. We transfer women to St. Vincent's Hospital when they are very ill and require intensive care. It is not entirely satisfactory because they have to be put in an ambulance, sometimes on a ventilator, and transported. We deliver babies in St. Vincent's Hospital on occasion when we believe the mother will be at risk, particularly in a case of a severe form of placenta previa where there can be dangerous bleeding. There is that precedent, but it would be much better if we were co-located. When the Deputy is in government, no doubt he will accelerate that process.

On the question about designated hospitals, I make the point in my submission that because of the way things will happen in emergencies all Government-approved hospitals in the State should be designated rather than just the maternity hospitals or maternity units in general hospitals. Things can happen very fast. One cannot have a situation in Mount Carmel Hospital, for example, where a woman is going to die if she does not have a termination of pregnancy, but she is put in an ambulance and dies on the way to a designated hospital. It is a minor point, but it should be considered by the committee when reviewing the Bill.

On the specialist register question, some of the more senior colleagues are not on the specialist register, even though they have been consultant obstetricians for many years. This is a result of historical reasons because a specialist register was introduced by the Medical Council in 2005 and some specialists have not bothered to put themselves on the register. That is a minor matter.

Everyone in this room will be aware of the relative shortage of specialists in the country. We have the lowest ratio of specialists per head of population in the European Union. On occasions such as at weekends and holiday times, particularly in smaller hospitals around the country, there is a dependence on locum consultants who may be registrars and who are in an acting up capacity. They are not on the specialist register. That point needs to be taken into account when the committee is considering alterations to the Bill.

Dr. Mahony will answer the question about the expert group. I think I have dealt with all

the questions raised.

Dr. Sam Coulter-Smith: On the question of whether we should legislate for suicide, even in the absence of the X case, my view is that this legislation is required to protect doctors and give reassurance to mothers and their families that when a woman's life is at risk for whatever reason, doctors are duty bound to look after the baby, if at all practicable. When there is no option but to terminate a pregnancy, then that is what they should be covered to do.

We are not mentioning cancer or heart disease; I am not sure whether we should be mentioning suicide. I think there is an issue there. It widens the problem by including suicidality - risk of self-destruction - but my understanding is that we have been told by the European court that this is what we must do. I suppose what I am trying to do here is trying to point out the issues for obstetricians if suicidality is included in its present form.

In regard to whether we look at the viability of the baby, of course we do. If we are lucky enough to be in a situation where a woman who becomes unwell is 37 or 38 weeks pregnant, then we terminate the pregnancy by induction of labour or by caesarian section, depending on the situation. If bringing her pregnancy to a conclusion happens at 27 or 28 weeks, then those babies have a very good chance of survival given the standard of intensive care we have for those babies in this country. As Dr. Mahony rightly said, we have babies surviving in all our maternity hospitals from 23 weeks on but before 23 weeks, these babies unfortunately do not survive. I am not sure if that answers the question in totality.

Dr. Boylan mentioned methods of termination and I would be entirely in agreement with him. I am glad the committee has picked up on the fact that none of three biggest maternity hospitals in the country have access to intensive care on-site. This is a big issue for us. We transfer patients not on a daily basis but certainly on a weekly and a monthly basis to our sister hospitals. These are our sickest patients and we should have access to intensive care facilities on-site - not five minutes away by ambulance but actually plugged in and in the right way, and in hospitals designed in the right way so that we can look after our sickest patients appropriately.

There was a question about what does one do with a patient who is suicidal at 20 weeks. I think one gets a psychiatrist to see her. The psychiatrist will take a view on the best method to manage that. If, in extremely rare circumstances, termination of pregnancy is what is required in that situation, then a discussion will have to be had with obstetric colleagues as to how that should be best achieved. I echo the comments Dr. Mahony and Dr. Boylan made in regard to the specialist register. That is an important area which needs to be covered in this legislation.

Dr. Rhona Mahony: I will answer the questions Deputy Kelleher raised. If the X case did not exist, would we still legislate for suicide? Suicide is death. We are legislating here for the substantial risk to life. If one commits suicide, one dies so, inherently, when someone plans to take their life, they are at risk of dying. I make no distinction between medical and physical risk to life. I am not talking about mental health disorder but about the intent to commit suicide which can occur without a history of mental disorder.

In terms of suicide and all the evidence we talk about, the incidence of suicide is about one in 500,000. There is no evidence. When a condition is that rare, it is impossible to perform adequate research or studies which inform one because the condition and the outcome are so rare. If one was to truly examine the issue of suicide, one would have to take a group of women who planned to kill themselves and randomise them to termination of pregnancy to prevent them from killing themselves or to not being allowed have termination of pregnancy. I suggest

that studies should never be done. What we do instead is we defer to our psychiatric colleagues who are expert in the assessment of suicide ideation and they use their clinical experience and acumen.

Does the legislation do what we wish and does it give us clarity? I think it does in a number of key areas. It now gives us a framework in which we can define a substantial risk to life. That is supported by the law and that is one of the key issues. It also addresses the issue of the 1861 Offences Against the Person Act which hangs over us with that chilling effect. In addition, and very importantly, it gives women, if they feel they are going to die or are at risk of dying, a process through which they can determine whether termination of pregnancy is appropriate. That is very important.

I have said a lot already about the threshold of viability and I am concerned that this message still does not seem to be getting across. When we deliver babies, we do our utmost to protect and vindicate that baby's life. We are mandated to do that; we must do that and we wish to do it. I have no desire to see late termination of pregnancy coming into this country. That would be an affront to me. I spend a great deal of time in my own medical practice trying to look after both the mother and the baby but I am aware that if a mother dies, her baby dies too and we must prevent the unnecessary death of two people. Therefore, we will do our best to prolong the pregnancy until a baby is viable and again if a baby is born at that threshold of viability, every effort is exhausted to optimise that baby's chances of survival but one simply cannot allow a woman to die.

In terms of the scenario of delivering the 20-week old baby at the threshold of viability of a woman who has suicidal intent, that woman requires assessment by an experienced psychiatrist. In terms of the method, we do not kill babies; we do not destroy babies. We induce babies medically. Dilation and extraction at 18 to 20 weeks is a very dangerous procedure. We are not trying to kill women; we are trying to save their lives and so they will be induced medically - a medical induction of labour where, as Dr. Coulter-Smith has said, after viability is achieved and by whatever method is practicable.

I will address Deputy Ó Caoláin's issue. Again, I am echoing my colleagues on the whole issue of intensive care. The three Dublin maternity hospitals are quite unusual and unique in terms of obstetric care in that they stand-alone. This is not normal for an obstetric hospital and it means that not only are we deprived of intensive care facilities but we are deprived of a whole range of on-site medical facilities that would be very useful to us. For example, we transfer our tiny babies to access an MRI scanner because we do not have one on our site. We must transfer patients everyday for simple scans to see if they have a deep venous cloth in their legs. There is no doubt that co-location with an adult hospital is the way to go. It is not just me saying this, that is supported by an independent international recommendation in the KPMG report.

I refer to the technical issue on the wider number of hospitals. Sometimes we elect to deliver women in a general hospital because of the concurrent medical difficulty she might have. In addition, in an emergency, we cannot have a situation where we have to require to transfer a patient to an obstetric unit for determination of pregnancy. Therefore, it is very important that we include all Government-approved hospitals in this legislation.

Again, Dr. Boylan has covered the issue of specialist omission. This is a historic omission. Some doctors have simply not put themselves on to the specialist register, which began in 2005, so perhaps for the sake of safety we should use the term "obstetrician-gynaecologist". This again would cover the situation of locums.

I was asked about the recommendation of the European court in the case of A, B and C *v.* Ireland. Central to that is that we are now obliged to find a process for women through which they can see if they qualify for termination of pregnancy and, when that happens, whether they are able to access termination of pregnancy when their lives are at risk. Today all of this is restricted to when a woman is at risk of dying.

Again, I would say that this legislation gives us the protection we need to allow this happen. It addresses the issue of providing a process. It allows us to establish substantial risk in a way that is supported by the law and it gives a woman a process through which she can explore this risk when she perceives herself to be at risk of dying. In terms of suicidal intent, it is always a psychiatric assessment and we defer to our psychiatric colleagues in this.

Deputy Ciara Conway: I thank the witnesses for their presentations. I would like to ask Dr. Coulter-Smith about the point he raised in regard to the difficulties he and maybe some of his colleagues in his hospital face on the suicide issue. As I understand it, suicide is still among the top four causes of maternal death. Is that true? If it poses such a high risk, how could we fail to legislate for it? Suicidaility, particularly in a crisis pregnancy, tends to peak in the third month, and an unwanted pregnancy is a relevant risk factor. Risk management requires access to services. If we were to fail to legislate for that issue, we would be limiting access for those women who are suicidal. I have a simple question, which I put to each of the witnesses. Will the legislation save lives?

Deputy Peter Fitzpatrick: I thank the witnesses for making themselves available. My first question is for Dr. Boylan and Dr. Mahony. Will every effort be made to save a baby's life in every case where a pregnancy is terminated post-viability? Can Dr. Coulter-Smith explain the difference between abortion and necessary medical treatment which may result in the death of the baby? Are all three doctors satisfied that the proposed legislation will provide for mandatory care of newly born children resulting from later stage termination in order to vindicate the equal right to life?

Deputy Regina Doherty: I thank the three witnesses for attending. My questions are primarily for Dr. Sam Coulter-Smith. He referred earlier to the ethical dilemma with regard to suicidal intent. Does that ethical dilemma still exist personally or professionally if a patient in his hospital is prescribed a termination of pregnancy by her psychiatrist?

Dr. Coulter-Smith referred also to the ethical dilemma he would have about delivering very premature babies and the conditions which might arise thereafter. Who is currently responsible for delivering premature babies in circumstances, for example, of severe pre-eclampsia or other, what might be termed, medical conditions which give rise to a medical intervention?

I apologise if I am wrong, but I think Dr. Coulter-Smith mentioned in his presentation that he feels the introduction of the legislation could lead to an increase in abortions. Can he explain how and why he feels that?

Senator Colm Burke: I thank all of the witnesses for their contributions today. I want to raise an issue in relation to the submission by the Irish Medical Council this morning. The IMC is at variance with a proposal in the heads of the Bill. Its proposal is that the text in head 4(1)(*b*) should be amended to read:

> two psychiatrists, have, in accordance with this head, jointly certified in good faith that-
>
> (i) there is a real and substantial risk of loss of the pregnant woman's life by way of

self-destruction, and

(ii) in their reasonable opinion this risk can be averted only by that medical procedure.

The IMC is saying two psychiatrists should sign off on that and then there would be a consultation with an obstetrician. What is the view of the witnesses about that?

Do the witnesses feel that there is adequate protection in the heads of the Bill in relation to the decisions they have to make on a day-to-day basis, particularly where decisions are being made in respect of a person who is under 18 years of age?

One of the witnesses referred to the consultant-patient ratio in this country compared with others. It would be helpful if we could be given the figures comparing Ireland with one or two other countries. It is important to get that information out there given that we have a very high number of patients per consultant compared with other countries.

Deputy Denis Naughten: All three speakers this afternoon have said they do not destroy the foetus in the termination of a pregnancy. The legislation as proposed is silent on the issue, however. Do the witnesses believe there should be clarity regarding the procedure used to terminate the pregnancy? I do not mean that it should specify the means but rather that it might refer to destruction versus induction. It seems that induction is what we are talking about here whereas the legislation is silent on the matter.

Dr. Mahony in her evidence last January said that there was no definition of substantial risk to life during pregnancy in terms of whether it meant a 1%, 10%, 50% or 80% chance of dying. Is she satisfied that she has clarity in relation to that in the heads of the Bill before us?

Dr. Tony Holohan gave evidence this morning that there may have been women who have had early deliveries due to suicidal ideation. Can each of the witnesses say whether they are aware of women falling into that category in their three hospitals? If so, what numbers have been involved?

It is clear from the heads of the Bill that for a facility to provide services under the legislation, it must be a maternity hospital, it must have psychiatric support and it must have neonatal facilities. Few if any of those facilities exist in any location currently. Can the witnesses clarify whether such facilities exist or state what challenges there are to compliance with the legislation as it is proposed to be drafted? Do they believe psychiatric support should be perinatal or simply involve a psychiatrist?

Dr. Boylan mentioned quite correctly the issue of bad science. It is vital we have clarity on that. He might comment on the reports by Professor David Fergusson who has reviewed the evidence in this area and said there is no evidence to show that a termination on a mental health basis improves the quality of the mental health of the individual.

Dr. Rhona Mahony: Deputy Conway said suicide was among the top four causes of maternal death. It is very difficult to estimate the incidence of suicide. Occasionally, that verdict can be returned as an open verdict. According to the triennial report on all deaths in Ireland between 2009 and 2011, there were two cases of suicide and I understand there was an antenatal case of suicide last year. Suicide is extremely rare and the numbers can be difficult to estimate.

I was asked if legislation will save lives. Legislation will provide legal protection and flex-

ibility for doctors to do their job. I believe it will give doctors some peace and prevent hesitation where doctors are uncertain about whether they may act. Doctors will always try to save a life but at the moment what is wrong is that they do not have the necessary legal protection. That is really what the Bill is providing.

In terms of mandatory care for a late delivery, we care for all babies. I have to keep saying this. Once a baby is viable, we give that baby every support to survive, regardless of why the baby is born. If the baby requires support to survive, we do that. We will always vindicate the life of the foetus. That is not at issue.

I will allow Dr. Coulter-Smith to address the ethical dilemmas surrounding suicidal intent. In terms of the Irish Medical Council's proposal on head 4 and whether or not there are two psychiatrists, we must be clear that obstetricians and psychiatrists have very different roles. I am not qualified to assess suicidal intent or ideation. However, in a patient who may require termination of pregnancy because an expert psychiatrist feels she will kill herself, there are obstetrical considerations and, therefore, there must be a team involved. We work as a team, generally. These are rare, complex cases and it is very much our culture that we function as a team and include a broad range of disciplines. It was interesting that Senator Burke asked about the patient who is under 18 years of age. Of course, she is X. I interpret this head of Bill as legislating for the X case and would argue that it is X who is very vulnerable and who needs to be protected by the State. Let me just remind members about X - she is a 14 year old child who has been abused and raped and who is pregnant and wants to kill herself as a result of that pregnancy. She needs to be listened to, believed and protected.

I was asked about something I said when I presented in January about defining risk at 1%, 5% or 20%. The point is that two qualified specialist doctors in whatever field, such as an obstetrician and a cardiologist, an obstetrician and a liver doctor, or two obstetricians in the case of an obstetric intervention, can assess the patient's clinical case in its entirety and can come to a conclusion in a way that is supported, or will be supported, by law. It will be impossible to draw up a list of the reasons we can terminate a pregnancy because, invariably, that is impossible. Now we have a process supported by law, and I welcome that.

In terms of the legislation being silent, and the comment that there is no upper limit and that we can destroy foetuses, at the risk of repeating myself time and again, I understand that Article 40.3.3° still stands. Perhaps this needs to be clarified when the lawyers appear before the committee. I understand the 25th amendment still stands and I understand that, according to these provisions, where it is practicable, I am obliged to vindicate the life of the foetus. I have always practised in this way and I always will. I have no wish to kill babies but I want to make sure no woman under my care dies. If she dies, her baby will die too.

All 19 units are able to cope with routine obstetric emergencies and they are all able to give that comprehensive cover. In an emergency setting, all units are equipped to deal with that. When it comes to complicated medical cases, not all 19 units have that medical expertise. Indeed, the National Maternity Hospital, which is one of the busiest maternity hospitals in Europe, will often refer patients to St. Vincent's Hospital, for example, because of medical complications. We are well used to networking and it is normal medical practice to refer patients for opinion. We can obtain opinions over the phone and it is our culture to practise obtaining as much opinion as we can about the patient. We discuss patients quite often and we get as many opinions as we think we need. We are caring for women and we will obtain the opinions we need. We are well used to networking. This goes on all the time, day in, day out, in terms of psychiatric practice.

I am not a psychiatrist, but with regard to this business that there is no evidence that termination of pregnancy is a treatment for suicide, we are not talking about treating - we are talking about the risk to life. If members want to remove suicide from the legislation, in the X case, involving a 14 year old girl, is everyone in the room absolutely certain there was no way that X would kill herself and no way that she would die? In the case of a woman who does not want to be pregnant and who is so distressed by her pregnancy that she tells us that she wants to kill herself, can we all sit here and say we are absolutely certain she will not kill herself? I cannot.

Dr. Sam Coulter-Smith: I thank the Chairman. With regard to suicide and where it ranks in terms of maternal mortality, suicide is extremely rare in pregnancy. According to the UK figures, it is around one in 500,000. It is extremely unusual and there are much more common causes of maternal death. This is really more a question for psychiatrists. From my discussion with psychiatrists, particularly in our hospital, it can be extremely difficult to decide how suicidal a woman is and how to rate it. Our psychiatric colleagues tell us that, in pregnancy, if a patient's mental state is so altered that she has suicidal ideation or suicidal intent, she needs psychiatric treatment. If the psychiatrists tell us the only way the woman's life can be saved is through a termination of pregnancy, it will require a number of psychiatrists to agree with that view. If that is the case, following a multidisciplinary meeting about the case, that is what we will do. The legislation confirms, reassures and provides clarity, certainty and protection for the doctors involved in the treatment of pregnant women in these very difficult situations. It also provides clarity, reassurance, certainty and protection for the mothers and their families. With regard to the protection of the baby, I totally agree with what Dr. Mahony has said. In every situation where intervention must be made in order to save the mother's life, we do our utmost to prolong the pregnancy as long as we possibly can to give the baby every chance of survival. Intervention is only made at the point at which we feel that if we do not intervene the mother may die.

With regard to the Medical Council recommendation on the number of psychiatrists and obstetricians involved in the decision, it is a resource issue for our professions. I will allow the psychiatrists to answer the question about their specialty. If we get an increase in the number of women seeking to avail of termination of pregnancy in this country based on the legislation, there will be resource issues for our obstetric personnel, our psychiatric personnel and our hospitals.

On the question of the legislation being prescriptive or silent on the methods of termination, I do not think the legislation should be prescriptive in any way. The decision on how a pregnancy needs to be brought to a conclusion is based on a large number of factors. The method used will be one that is the safest for the mother in any particular situation.

On the question of whether the scheme of the Bill provides adequate protection for us as doctors, I think it does. It goes a long way towards bringing forward legislation that sits well with the Medical Council guidelines, which is good. In the case of a minor - someone under the age of 18 years - there are appropriate services that need to be put in place to deal with younger women. Professionals in mental health care need to be made available to allow the appropriate care to be given. The same multidisciplinary team involvement will be required in any major decision-making for patients who are minors and for older women.

Dr. Peter Boylan: A number of points have been raised. The issue of suicide has come up again, as has the incidence of suicide in pregnancy. Until recently, the CSO did not stipulate that it had to be included on a death certificate whether a woman was pregnant in the recent past. We will never know the incidence of suicide among women in the early stages of pregnancy.

From time to time, coroners have issued verdicts that avoided the use of the word suicide out of sensitivity to the families involved. It is understandable but perhaps not helpful in other contexts. I will say no more about suicide; it is a matter for the psychiatrists, but it is important that members understand that we just do not know. A question was directed to me about Professor Ferguson's paper and bad science. I defer to the College of Psychiatrists of Ireland, which will deal with this in evidence on Monday. I am not a psychiatrist and, as I emphasised before, we should be wary of people interpreting articles, information or papers in a field in which they are not practising on a daily basis and in a field in which they are not expert. I would not give an opinion on an orthopaedic problem to somebody who might need a hip replacement. I would not dare give that opinion. Similarly, I would not give an opinion in regard to psychiatric problems. I am not trained for that and I have no experience in it. We will always strive to save the life of the baby. We make those decisions on a daily basis. There are ethical issues involved and we deal with those on a daily basis as well. That is what we do in our practice so there is no big problem in respect of that.

Under the heading of reasonable opinion in my statement, I said that I welcome the confirmation that the constitutional protection to the right to life of the unborn child is retained at all times where practicable. Some campaigners are attempting to suggest that late terminations will be performed in Irish hospitals if this legislation is passed, implying that doctors would deliberately kill an unborn baby who is capable of existence outside the uterus. Some of the more extreme groups are suggesting that newborn babies might be killed if this legislation is passed. These views are clearly extremist, have no basis in fact and are, quite frankly, insulting. There should be no suggestion that obstetricians and neonatologists would ever fail to make every effort to maintain the life of a baby once the threshold of viability is reached.

I refer to the issue of how we assess the risk. The legislation reflects the judgment in the X case by saying it is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate, as this approach insufficiently vindicates the pregnant woman's right to life. We are talking here about the right to life of a woman and we need to remember this in discussing this entire issue. It is interesting, though, that no figures are available for what percentage risk of death is acceptable and I hope that, in the future when the legislation is passed, that we, as obstetricians, will be able to take into account a woman's point of view as to the degree of risk she is willing to accept. Some women are willing to accept an extreme risk and are willing to die in order to hope that they might have a child; other women decide that the risk is too great for them and, in these circumstances, when the outlook is utterly hopeless they prefer to have a termination of pregnancy and perhaps try again. I need not elaborate on that anymore. We have to be careful about trying to quantify risk that is unquantifiable.

The question of consultant numbers and ratios has come up and the committee would like some figures. The figure in our maternity hospitals is approximately one consultant per 1,000 deliveries. The ratio in the UK, with which we are frequently compared in all sorts of ways, is less than one in 500. We are one in more than 1,000. Those of working in the National Maternity Hospital recently visited a hospital in Malmo, Sweden, which is of similar size to our hospital. There were 30 consultants on the staff there; we have eight. I hope that answers the question. It means that obstetricians working in this country have no shortage of experience in dealing with complicated obstetrical cases and are well able to make decisions in the best interests of both patients for whom they are caring.

Have I left anything out?

Chairman: No. Deputy Doherty had a question for Dr. Coulter-Smith.

Deputy Regina Doherty: The only reason I asked the question again is because his opinion is so highly regarded, I would not like it to be misconstrued by people. He said if we introduced this legislation, it could lead to an increase in abortions. How and why?

Dr. Sam Coulter-Smith: I said in my statement that it may lead to an increased number of requests for termination of pregnancy in this country. The reason I say that is I do not have any understanding - I do not think anybody has any understanding - of the numbers that could try to avail of the service in this country if it is passed into legislation. Currently, approximately 5,000 women a year and probably more go from Ireland to the UK for termination of pregnancy. They never cross the threshold of our maternity services. We do not know who they are and we do not have any understanding of the issues they have. Some of them are crisis pregnancies and some are a result of rape and incest. It is unfortunate that those areas are not covered in this legislation but that is a conversation for another day. Because we do not know who these women are and what their issues are, we do not know how many of them may try to use this legislation to get a termination in this country. If they do, then the point I was making is that we do not have the infrastructure, resources or the staff available to deal with that issue if it arises.

Chairman: Deputy Fitzpatrick indicated that his question was not answered.

Deputy Peter Fitzpatrick: I asked Dr. Coulter-Smith to explain the difference between abortion and necessary medical treatment which may result in the death of the baby.

Dr. Sam Coulter-Smith: An abortion and a termination of pregnancy is when a pregnancy is brought to an end. Most people's understanding of that terminology would be when that process occurs early in pregnancy. In most situations, terminations or abortions are performed before 12 to 14 weeks. What was the second part of the question?

Deputy Peter Fitzpatrick: It related to the necessary medical treatment for the mother, which could cause an abortion.

Dr. Sam Coulter-Smith: Is the Deputy talking about a situation where a woman may have cancer of her womb?

Deputy Peter Fitzpatrick: No, I refer to where a woman is undergoing medical treatment and she gets medication, which would cause the death of the unborn child. What is the difference in this regard? Does that happen much?

Dr. Sam Coulter-Smith: The sort of thing the Deputy is probably talking about is in the realms of oncology where a woman has some form of cancer that requires treatment, which may be harmful to the baby and result in the death of the baby. Is the question what is the difference between the two?

Deputy Peter Fitzpatrick: Yes.

Dr. Sam Coulter-Smith: Both will lead to the termination or the end of the pregnancy.

Deputy Denis Naughten: Dr. Tony Holohan made the point earlier that there may have been early deliveries on the basis of suicidal ideation. Was there any experience of this in any of three hospitals? When the witnesses reply later, they might respond to that.

Senator Ivana Bacik: I thank the three witnesses for bringing their expertise for our benefit. I thank Dr. Mahony, in particular, for reminding us so powerfully of the facts of the X case and of the evidence of the suicidal intent of that unfortunate young woman. We have heard

useful evidence about the lack of access to intensive care units in the maternity hospitals. All three witnesses have suggested that the definition of "appropriate location" under head 1 should be broadened to include Government approved hospitals. Related to this, under head 4, it is required that one of the two psychiatrists would be attached to an appropriate location, that is, to a maternity unit. As Dr. Coulter-Smith pointed out, currently only three sub specialist psychiatrists are attached to the three large Dublin maternity hospitals. Does that mean in Dublin if a woman is seeking to access the procedure under head 4, there are only there psychiatrists from whom one psychiatrist can be drawn? That is a restrictive pool. We heard earlier from the medical bodies that this restriction might not be practicable. It might be too restrictive and it might be better to require that a psychiatrist be defined more broadly because many of the women will be young girls, in respect of whom a child or adolescent psychologist might be more appropriate.

Dr. Boylan, in his submission, pointed out the time limits for the review process under head 6. He pointed out very helpfully that the time limit would currently allow for 14 days before the clinical review could take place, which would lead to undue delay for a woman in accessing her constitutional right to life. What sort of time limit would be practicable?

With regard to the finding on the criminal offence and the chilling effect currently provided in the 1861 Act, is the new wording in head 19 sufficiently tightly drawn to ensure the chilling effect will be reduced or removed? In particular, should the woman herself be criminalised? The head refers specifically to the Criminal Law (Suicide) Act 1993 as a model. Under that Act, the person who attempts suicide is not himself or herself criminalised, only those who aid and abet the person.

Chairman: I call Deputy Mary Mitchell O'Connor.

Deputy Mary Mitchell O'Connor: The master of Holles Street hospital has answered my question very comprehensively.

Senator Jim Walsh: My first question is for Dr. Boylan. In respect of head 3, he states consideration should be given to the possibility that termination might need to be carried out in a private institution. Could that include Marie Stopes?

With regard to head 6 and the point made by Senator Bacik, when the psychiatric personnel were before us they actually made the point that the appropriate treatment for somebody who is suicidal would be to take them into care for a minimum of a couple of weeks, in which period they would be observed and treated, before determining what should happen next. Dr. Boylan seems to be ruling that out as a possibility.

Dr. Mahony laid heavy emphasis on the lack of clarity over when interventions can be made at present. I remember when she was here on the last occasion. Was there any occasion on which she was unable to intervene, leading to the death of a mother under the current legal position? Dr. Mahony mentioned Ms X and stated she should be listened to. I do not disagree with her. She will know that Ms X did not have an abortion. In 1997, Ms C was brought to Britain unaware of the fact that she was going to have an abortion. She was subsequently suicidal. She was in this House two days ago talking to Members. Should Ms C and women who have had abortions and who have suffered from serious trauma subsequently, sometimes for 20 and 30 years, not need to be listened to also?

I thank Dr. Coulter-Smith for the clarity of his presentation. He mentioned something that

struck me. It was stated that if one carries out an induction of a baby of 25 weeks, there is a risk of death or disability and cerebral palsy. That was not mentioned by Dr. Boylan or Dr. Mahony. Does Dr. Coulter-Smith agree it is a possibility? I have been told by an obstetrician that there could be a 50% chance of cerebral palsy for that early delivery. Do Dr. Boylan and Dr. Mahony agree that we should operate on the basis of evidence-based medicine and, above all, do no harm? Can they point to any evidence that will actually vindicate the position that abortion is a treatment for suicidality? I acknowledge that is outside their range.

The spectre is being raised that this, perhaps, is a very restricted regime. I suggest that the doctors examine California's Therapeutic Abortion Act 1967. Within three years of enactment, the number of abortions grew from hundreds to 61,000. An expert and constitutional scholar in the Visitors Gallery, Mr. Linton, will be able to fill in the witnesses on precisely what happened in that area. The committee chose not to hear him but I am sure he will talk to the witnesses privately and advise them on the challenges facing us because of the opening of the suicidality issue.

Senator John Crown: Hearing politicians lecturing specialist doctors about following evidence-based guidelines was one of the most eye-rubbing, incomprehensible moments I have experienced since I came to Leinster House.

Chairman: If the Senator does not mind, he should speak to the heads of the Bill.

Senator John Crown: I am sorry about that.

Let me point to a little bit of evidence to which, I am glad, my friend and colleague, Dr. Boylan, has already alluded. The figures are that Ireland has 2.4 obstetricians per hundred thousand members of the population while the figure for the second lowest-rated country in Europe, the Netherlands, is four, which is twice as high. The Netherlands has a birth rate of approximately two thirds that in Ireland. Our proportion of obstetricians to members of the population is one third the European average, and we have one of the highest birth rates in Europe. None of the hospitals in our network can provide comprehensive care to a woman who becomes seriously ill in pregnancy. Most of our maternity care is being given in small units or specialist stand-alone hospitals that do not have adequate backup. My profession, our medical schools and hospitals bear some responsibility for this; the fault is not entirely that of politicians, but let us at least leave this Chamber after these three days of debate having put firmly on the public agenda the need to reform the way in which we deliver obstetrical care in this country. We need to reform it urgently.

Let me get down to the business of the moment, the endless tendentious questioning about the suicidality issue. All of the doctors who have been here will have been here because we follow evidence. There is extremely close agreement that it will nearly never happen that a doctor will be confronted with somebody who requires an abortion on grounds of suicidality. Some believe it will actually never happen while most agree it will, at most, happen very rarely. With regard to people's concerns, I fear that Dr. Coulter-Smith may have been misquoted in the national media, and that his concerns may have been misinterpreted today. I ask him to clarify this. He alluded today to the possibility that obstetricians in general might be forced to carry out a medically unnecessary abortion because a psychiatrist indicates an abortion is necessary, and obstetricians know that the evidence base suggests it never is. For the benefit of those present, could the doctor clarify that the people who would make that decision-----

Senator Jim Walsh: I have here-----

Chairman: One speaker, please, Senator Walsh. Senator Crown's time is up.

Senator John Crown: I have been very careful about not interrupting. I am desperately fond of Senator Walsh as a person but his behaviour today has not been edifying. I am sorry to have to say that. He has been repeatedly rude today.

Chairman: Could we speak through the Chair on the heads of the Bill?

Senator John Crown: I ask Dr. Coulter-Smith and my other colleagues to clarify that they are satisfied that in the very rare and probably never-to-arise event of an abortion being recommended on grounds of suicidality, it would be done by people who are actually aware of the evidence base of medicine and who would assess the matter and reach a unanimous consensus.

Chairman: There are four members who want to speak. We are to conclude this section of the hearings at 4.35 p.m.

Dr. Rhona Mahony: On Senator Bacik's point, we have already covered the lack of intensive care. I will come to Dr. Crown's comments presently. I passionately believe that the maternity hospitals should be co-located and that they require a great deal of further resources to carry out their day-to-day work.

I appreciate the comments on psychiatrists. The additional resources needed in psychiatry comprise a question best posed to the psychiatrists.

I am interested in the Senator's comments on head 19. She is absolutely correct. If a doctor has made an error in judgment or has not acted according to the law, I do not believe a woman could then be at risk of finding herself in breach of the law. If it were the case, it would not be wise law, I would argue.

The question of time limits is more related to Dr. Boylan. I agree, however, that we must be very careful that the appeal time not be too long. The appeal time must be appropriate to the urgency of the medical condition that is unfolding.

With regard to head 3, on the termination of pregnancy in private institutions, the concern must, of course, be addressed. I refer to the idea that one could set up a clinic and perform terminations of pregnancies. I think we can assume that Government-approved hospitals would get around that so it would not be possible to set up a clinic. That is not what we are suggesting here. Practically, it is very unlikely that a Marie Stopes or termination-of-pregnancy clinic would be dealing with very sick women at risk of dying. That is simply very unlikely. Most of the women would be in hospital because they would be very ill.

With regard to head 6, it seems to be a matter for the psychiatrist. There is a hint and a suggestion that we should be locking women up. I would always not concur with that, but that is a matter for the psychiatrists.

With regard to the effect, I have no doubt that the termination of pregnancy can be really harmful for a woman's health, and the circumstances surrounding it can be really harmful. I also believe that, on very rare occasions, it could save a life. That is my only comment on that. Psychiatry is not my area of expertise. With regard to delivery at the threshold of viability, I practice in foetal and maternal medicine and believe that there is no doubt that where we deliver babies at a very early gestations, there is a risk of cerebral palsy. To give an example, the survival we expect now in Ireland at approximately 24 weeks is approximately 50%, and of those

survivors we might anticipate that up to 50% of those babies will have cerebral palsy. These are enormous considerations and we spend much time, if we have time, talking to parents, counselling them and making them aware of this. However, what we are talking about here is saving women's lives and we are making the assumption that if we do not carry out this termination or interruption of pregnancy, even if it is at 24 weeks and with all the risk of cerebral palsy, the woman will die and her baby dies too. It should be noted that medical obstetrics is extremely complex, as are these decisions. That reflects the complexity of what we do.

In response to Senator Crown, I am glad to have the opportunity again to talk about figures, because I missed that opportunity in the last round. I note the presence of Paul Cullen in the Press Gallery. He wrote a very nice article two weeks ago in which he looked at comparisons between here and the UK. He said Scotland has 121%, England 81% and Wales 63% more obstetricians than Ireland. I might be misquoting the figures, but it was clear there is a big disparity in the number of obstetricians here. Dr. Boylan says we have about eight obstetricians. It is actually fewer than that when talking in whole-time equivalents. The majority of consultants in our hospitals work between two areas, so when we look at the numbers ratios, we must look at whole-time equivalents. Dr. Boylan is correct that it is about eight whole-time equivalents. There are approximately 15 consultants on the staff but it is about eight whole-time equivalents. The same applies to neonatologists. We have just under four whole-time equivalent neonatologists looking after more than 9,000 babies.

There are huge resource issues that must be addressed, and addressed urgently in obstetrics. However, that is not a matter for this Bill. We must be very careful. The resource issues need to be addressed, but we drafting this legislation in the context of women who might die, so we must not let resource issues influence this important legislation which will last into the future.

What can we say about the rarity of suicide? It is extremely rare. I agree it is unlikely we will see it. We just do not see it because it is a rare condition which is best dealt with by psychiatrists. This Bill is not about legislating for suicide intent in pregnancy; it is not about suicide. It is about the risk of a woman dying, whether that is for mental or physical reasons. This Bill will largely cater for women who might die either because of direct complications of pregnancy or because of a medical disorder such as cardiac disease. We might never see a woman presenting through this process with suicide intent. She will likely go to England.

Dr. Sam Coulter-Smith: With regard to the lack of intensive care facilities, I agree that head 1 must be broadened to include the general hospitals as some of our sickest patients will be in those institutions. It is absolutely correct that there are three specialist perinatal psychiatrists, all of them based in Dublin. This is a very restricted pool of professionals in this area. Not only are we under-resourced from a maternity services point of view, the mental health support of those maternity services is also under-resourced. It is something that must be addressed.

I have nothing to add to what Dr. Mahony said about decriminalisation in head 19.

To return to a question I missed earlier, I was asked if I was aware of any intervention in a case of suicidality. I am not.

There was reference to the Californian experience. I do not have any knowledge of that or of what legislation was introduced which might have led to that change.

We have talked in detail about the consultant-patient ratio. Our midwife-patient ratio is also approximately half of what it should be. The internationally recognised appropriate ratio of

midwives to patients should be between 1:25 and 1:30. In our hospital at present it is approximately 1:50. That is in a situation where, at our peak levels of activity, there were 42 deliveries in a 24-hour period last December. That was delivered from nine labour ward rooms. One cannot imagine the level of activity and the risk associated with trying to put that level of activity through an extraordinarily busy labour ward. It is not a matter for this setting, but I should point out that the safety of the services we provide is down to the skill, dedication, hard work, missing meals and missing breaks of our extraordinarily talented and gifted midwives. We owe a huge debt of gratitude to that group, mainly women although there are some men.

In terms of Professor Crown's point about how often this situation occurs, I agree that suicidality in pregnancy is extraordinarily rare. Most obstetricians will go through their entire working life and not encounter this situation. However, it is important that if a woman's life is deemed to be at risk, she has access to the appropriate psychiatric care. If termination of pregnancy is deemed to be appropriate in that situation, that is fine. We will get involved and we will do that. However, it is important that gestation is not covered by that element of the legislation, and that leaves this open.

Dr. Peter Boylan: With regard to Senator Bacik's points, the issue of head 1 being broadened has been dealt with adequately. I support everything that was said. As to whether a perinatal psychiatrist should be involved, we do not have three. We have one and a half. As Dr. Mahony said, these are whole-time equivalents, so we have 1.5 perinatal psychiatrists for 75,000 pregnant women per year. It is approximately 100,000 if one includes miscarriage. That is questionable.

Regarding the time for the medical review procedures, seven days is too long to initiate the process, with another seven days for the review team to give an opinion. These women are at risk of death and a fortnight is probably too long to wait in those circumstances. The circumstances will vary from one woman to another. We need to be able to individualise. My personal opinion is that seven days is too long.

On head 19, I have difficulty with the proposal that a pregnant woman who undergoes a termination will potentially face 14 years in prison. If a woman is subject to medical opinion and if that opinion, even if erroneously, concludes that termination is necessary to save her life, it is entirely unreasonable to expect her to second-guess a doctor's opinion in this respect. It would appear somewhat bizarre and contradictory to propose that a woman be sentenced to 14 years imprisonment on foot of accepting medical advice in this State, whereas should she travel to the UK and have a termination there, she is protected under the constitutional amendments of 1992. That does not seem to make sense.

There were several other questions relating to the Marie Stopes clinic and private institutions. The end of the sentence was omitted by Senator Walsh, that is, in emergencies. Women in emergencies will not be attending the Marie Stopes clinic and I doubt very much that the Minister would approve that the Marie Stopes clinic terminate pregnancies.

Head 6 is a matter for comment by the psychiatrist. In my practice I have not come across an instance where a woman has died because we have not terminated her pregnancy. I have come across it in other circumstances in the recent past.

Should women who have had an abortion be heard? Absolutely. Women who have had all experiences should be heard. However, the climate in which women have terminations in this country, albeit they have them abroad, is quite hostile. We should, perhaps, carry out some re-

search on the influence of hostility, antagonism, guilt and so forth that these women experience and the inability, in particular for women who have foetal abnormalities and who go abroad for a termination, to grieve for the loss of that child. They grieve for them; these are very much wanted children.

Very often women who have terminations for apparent social reasons or mental distress very much want the child but cannot cope with the prospect. We need to listen to these women. It is not within the remit of this Bill. Of course we need to listen to women; that is what we are about.

Very premature babies have a risk of brain damage. Their brains are very fragile, they are exposed to lack of oxygen, they can have bleeds on the brain and, in effect, strokes, and end up with cerebral palsy, blindness, brain damage, etc. However, if the mother dies, the baby dies too. We have to make balanced decisions based on the best evidence of the woman in front of us, taking all things into account. We do not want to have two deaths on our hands. I think one should respect the professional opinion of professionals who are making these decisions.

There was a question about evidence-based medicine in the context of suicide. I will leave that to the psychiatrists. I am not an expert in that area.

The Californian experience was referred to. It might be useful - and I am sure the committee has done so already - to look at the experience in Northern Ireland where, as I understand it, termination is allowed for foetal abnormality incompatible with life and not just a threat to the life of a woman. There are about 40 terminations a year in Northern Ireland out of 25,000 births. If one extrapolates from that, there will probably be about 60 for 75,000 births in Ireland. That is a guesstimate, but it is certainly not thousands upon thousands. It is a small number. I thank Senator Crown.

Chairman: There are four minutes remaining in this section and three members have indicated, two of whom have not yet spoken. I will call Deputies Maloney, Healy and Troy, and ask them to be brief.

Deputy Eamonn Maloney: I welcome the witnesses, as others have done, and thank them for their contributions. I have long held the view that the relationship between all of us and our doctors is very special, and I think most people would hold that view. The relationship between a pregnant woman and her doctor is unique, based on care, trust and so on. I have always been uncomfortable with the idea of legislators - that is, people like myself - interfering in that relationship between a woman and her doctor in pregnancy and childbirth.

To use that awful phrase, "We are where we are." We are dealing with a Bill which is extremely restrictive and deals with only one item - namely, pregnant women whose lives are at risk by suicide. We are not dealing with women who are raped and conceive; I wish we were. We are not dealing with fatal foetal abnormalities. If we were brave enough as legislators we would be, but we are not.

We have to try to be honest about pregnancy and the law. It is the height of hypocrisy that the law of our land allows for information to be given to women who wish to avail of abortion. It goes even further, allowing free travel if one wants to have an abortion. However, when it comes to a very restrictive piece of legislation to show some care towards what have been described as rare cases, we wrestle with ourselves about doing so. We have to get to a stage where we as legislators will introduce legislation that will not even be availed of.

Chairman: I ask Deputy Healy to be brief.

Deputy Seamus Healy: It is important that we remember that the backdrop to the Bill we are discussing is the constitutional protection of the life of the mother and the unborn in Article 40.3.3°. It is also the background to the X case, which refers to the real and substantial risk to the life, as distinct from the health, of the mother, which can only be averted by a termination. We are talking about a situation in which there will be very strict and onerous access procedures in the Bill.

I have some brief questions for the medical witnesses. Are they happy that there is now legal clarity for medical practice as a result of the Bill? Are they satisfied that there is protection for medical and nursing personnel involved in these areas? Are they satisfied that the question of adequate access to terminations where they are medically necessary, which was referred to specifically in the European case, is provided for in the heads of the Bill?

Deputy Robert Troy: I understood the purpose of these hearings was that those of us with no expertise in this area could be informed in order that we would be able to make an informed decision when we eventually come to legislate. That is why we are all here as legislators. The Supreme Court in the X case held that the correct test was that the termination of pregnancy was permissible if it was established as a matter of probability that there was a real and substantial risk to the life of the mother and that this risk could only be averted by the termination of her pregnancy.

The expert group said, regarding the application of the test, that although medical decisions may be difficult in particular cases, the complexities will not arise from the words of the test but from diagnostic and treatment issues, and that implementing the decision does not, therefore, require another definition of the test. Why do the witnesses think there is a need to separate physical illness and self-destruction? Should it not be left to medical professionals to determine what the real and substantial risk is? On the creation of a separate head on self-destruction, do the witnesses feel this will create a rebuttable presumption in this regard?

Chairman: I ask Dr. Mahony to respond.

Dr. Rhona Mahony: I note Deputy Maloney's comments. It is quite extraordinary that in Ireland the 1861 Act stands and we have not legislated for the X case, yet we have gone to great lengths, as I said earlier, to avoid addressing the reality of maternal death during pregnancy. Therefore, women are allowed to travel from this jurisdiction despite the fact that termination of pregnancy remains a criminal offence in Ireland. That is, of course, extraordinary.

Deputy Healy asked number of questions, some of which might best be addressed to the lawyers. When we talk about legal clarity and whether I am happy that the provisions in the Bill give us what we are looking for, there is provision to remove the 1861 legislation, which I favour. There is provision in the Bill to have doctors protected by the law in making their opinions, and where they perceive there is a substantial risk to life I believe, under this Bill, they will be protected in that regard, which is very important.

On whether there is adequate access, there are number of issues. In terms of emergencies, all of the 19 units in this country have comprehensive cover. For example, in the case of haemorrhage or fulminating blood pressure, all units in Ireland are capable of carrying out those procedures. If they are not, they should not be open for business, because if one is running an obstetric institution one must be able to take on obstetric emergencies.

In terms of access for more complicated medical disorders, as I said, we have a great network. We cannot have every single medical discipline in every single hospital. We do network for expert opinion and can pick up the phone and talk to each other. We all know each other quite well. We are used to working together. We have a culture of working together and of seeking other opinions.

On the specific area of access - namely, the question of seven days to make a submission and seven days for appeal - I agree with Dr. Boylan. We have to be very careful. There is a medical problem at stake and how imminent the risk of death is will determine the procedure. Compared with many other specialties, obstetricians are well used to dealing with emergencies. In fact, a great deal of our business is emergency and unplanned in nature. If ever there was a specialty suited to delivering in this role, it is us.

An interesting question was posed in regard to midwives. If there is a liability, it lies with doctors who are the ones who assess the women and make the judgment. Such is the case in many instances in medicine. Where I make a decision to do an operation, I am responsible and accountable. That is how I practise.

The Supreme Court judgment is truly an interesting one. I will begin by saying, as I have many times, that I do not distinguish between physical and mental risk to life. We are talking about whether a woman will die. If she commits suicide, she is dead, in the same way that a woman might die from pre-eclampsia, haemorrhage or whatever else. I do not make that distinction. I am not a lawyer, but what is central to the whole judgment is the interpretation of Article 40.3.3°. Clearly, prior to any prospect of a baby surviving, because of prematurity, it cannot be about a balance of rights. That does not make sense. It can only be about the substantial risk to the life of the mother because if she dies, her baby dies too. That is central to and the core of this whole issue. We must seek to prevent two unnecessary deaths and save women's lives. We cannot simply balance rights at 15 weeks gestation because then one will find against termination of pregnancy and I am afraid some women will die.

Dr. Sam Coulter-Smith: Senator Marie Moloney referred to rape and lethal foetal malformations as grounds for termination. I agree that it is unfortunate these two issues are not covered in the legislation because they are serious and real problems for a certain number of patients.

In terms of legal clarity and protection for the medical profession, including the nursing profession and other health care professionals involved in such cases, the legislation goes a long way to providing the clarity, protection and reassurance they require in dealing with these extremely difficult cases.

In regard to the X case and the fact that suicidality is included in the provisions, the legislation should be all about protecting doctors in situations where they have to act in order to terminate a pregnancy to save a mother's life. It should not matter what the issue is, whether it be suicidality, cancer, heart disease, complications of pregnancy and so on. What we, as a profession, are seeking is the reassurance, clarification and protection we require under the law to enable us to act in the best interests of a mother, while, at the same time, always doing our very best to save the baby in these very difficult circumstances.

Dr. Peter Boylan: I do not propose to say a great deal in response to the comments on hypocrisy and so on in this country because that is not relevant to our discussion on the heads of the Bill. I am happy that the Bill, if enacted with the alterations we are suggesting, will intro-

duce legal clarity and provide protection for doctors, midwives and so on.

The question was raised about access in respect of the decision as to whether a woman is entitled to a termination. There is also the question of access in the case where the decision is that she should have a termination to save her life. We have discussed the issues relating to which hospital and so on and doctors' definition of a specialist register, etc.

Deputy Robert Troy asked why we should separate medical from psychiatric illnesses. I have always felt, like my colleagues Dr. Mahony and Dr. Coulter-Smith, that if a particular procedure is required to save the life of a mother, the reason the procedure is required should not depend on whether the risk to her life is a consequence of a medical condition such as a congenital or complex heart disease or the consequence of an imminent danger that she will kill herself.

An issue we have not covered in great depth is that of conscientious objection, which I propose to deal with briefly. It is important to note that this issue also applies to the mother. We, as doctors, may make a decision that a mother is very likely to die, unless there is a termination of pregnancy, but the woman herself may refuse that termination because she is willing to take the risk or she has a conscientious objection to undergoing a termination of pregnancy. As doctors, we will respect that wish. Likewise, the wishes of doctors and midwives who have a conscientious objection to being involved in a termination of pregnancy will be accommodated. Those of us who have trained abroad, in the United Kingdom and elsewhere, have personal experience of this and not faced any difficulty when it has come to performing terminations of pregnancy, primarily for social reasons in the United Kingdom. There is no problem with this and no need for people to be afraid. Nobody will be forced under this legislation to do anything against his or her conscience. Everybody should be reassured about this. We are adult, professional people.

Chairman: As we are talking about new life, I take the opportunity to congratulate Deputy Damien English and his wife Laura on the birth of their twin baby girls this morning.

We have completed the slot for members' questions and will now move on to questions from non-members, for which half an hour is allocated. Unfortunately, there will not be sufficient time to accommodate all ten non-members who have indicated. I will begin by calling Deputies Peter Mathews and Terence Flanagan and Senator Paul Bradford in that order.

Deputy Peter Mathews: I thank all three doctors for attending. Dr. Rhona Mahony left us with a huge silence and a question in regard to the X case. The five women who had had abortions, some of them many years ago, who came to speak to us are left with deep scars in the same way that a physical injury leaves physical scars. Their scars have faded, but they have a lot of the answers which this legislation is trying to address, yet their request to attend the discussion on the Bill was declined. That is a screaming silence which more than matches the question from Dr. Mahony that left us with a stunning silence.

I say, "Thank you from my heart," on my own behalf and that of my family to all the doctors, obstetricians, gynaecologists, general practitioners, surgeons, nurses and midwives who assisted in the births of my children. I had the honour of attending all four births, each of which was a wonderful miracle. I hope the witnesses ask themselves from time to time the question of when they believe life begins. The sanctity and miracle of life, whether in plants or animals or human beings, are utterly important. Is Dr. Peter Boylan aware, to go with the bad science point, that it is now legal in Britain to mix hybrids of humans and animals? Scientists are al-

lowed to work on these in laboratories until the hybrids reach 14 days gestation, at which point they must be destroyed. That is bad science.

Chairman: Does the Deputy have a question on the heads of the Bill?

Deputy Peter Mathews: This is a chance to discuss the core of the issue-----

(Interruptions).

Chairman: No, we are discussing the heads of the Bill.

Deputy Peter Mathews: The bad science in Britain has allowed approximately 7 million abortions. That is very bad science, irrespective of Professor Ferguson's research papers. We are talking about the deaths of 7 million people, more than in the Holocaust. In America 55 million lives have been lost.

I thank the witnesses for all the work they do to look after people. My wife was very important to me when she was pregnant. Equally important are my daughters, my sisters, three of whom are nurses, and my brothers, two of whom are doctors and may be known to the witnesses. This country has to keep foremost the value of life in everyday life.

Chairman: The Deputy's time is up.

Deputy Peter Mathews: I have a question. We have heard about mothers and women, death during pregnancy and the need to preserve all life. Of course, it should be so, at all times. I will do anything that is necessary; I will stop my job here to help somebody in order to preserve a life. I mean that. Let us talk in the way we talk to our families across the dinner table. Dr. Holohan has 30 letters behind his name, which is 1.15 alphabets in professional qualifications. We must respect the human, the spirit and the breath of life.

Chairman: I thank the Deputy. Please keep the language temperate and refrain from straying.

Deputy Peter Mathews: It is philosophy.

Deputy Terence Flanagan: Dr. Mahony argued strongly before this committee in January that greater clarity is required in the law governing the termination of pregnancy, and that all the heads of Bill do is simply quote verbatim the X case test without offering any assistance in interpreting this, including what constitutes a real and substantial risk. How does this provide the clarity she said was needed?

I ask all the witnesses how the proposed legislation currently stands if two psychiatrists rule that a woman needs an abortion. Would an obstetrician feel comfortable overruling their professional opinions? How is the role of the obstetrician envisaged in that type of scenario? If a woman presents in the 20th week of a pregnancy with twins, states she is suicidal and requests an abortion for one twin - what is described as a "selective reduction" in the UK - would doctors be willing to carry out such a termination? If two psychiatrists told a doctor to abort a child at 20 weeks' gestation, would it be done, or could the doctor request that the termination be delayed in order to give the child a better chance of survival?

Senator Paul Bradford: I welcome the witnesses. Dr. Mahony has stated a number of times this afternoon, as she did in January, that the legislation is all about woman's health. That

has been echoed so often by the Taoiseach, the Minister for Health and many others that the message could go out that without this legislation, women's health would be at a profound disadvantage. In this room this morning we listened to other witnesses, and Professor McAuliffe reminded us - we should not need such reminding - that maternal health services in Ireland are among the very best in the world. She stated that "families should be reassured that they are receiving the very best of care during pregnancy", with Irish experience in this regard comparing "very well" with the UK and the rest of Europe.

There is the issue of a "chilling" factor, and we have allowed a myth to be created that is becoming a chilling factor. It postulates that Ireland is somehow a dangerous place for pregnant mothers and women. Will the witnesses comment on that and let us know if they agree with what we heard this morning about the superb current state of services in Ireland for pregnant women, with maternal health care in this country virtually second to none? Dr. Mahony expressed grave concern here in January about the current legislative position but when asked if she had ever been unable to intervene to save the life of a mother in her hospital because of the current legal position, I believe she stated she had not been unable to do so and had always been able to act. Will she comment on that?

I fully agree with Dr. Mahony's comment today that suicide is death, but I would invite her to agree with my statement that abortion is also death. All of us should try to ensure that with whatever legislative changes we enact, the medical changes that will be required, along with the investment spoken of by Senator Crown and others, must be addressed to ensure that the spectres of both suicide and abortion are removed as far as practicable from the landscape.

The witness indicated surprise at how the 1861 Act remains in force, but it is still operational in Britain, where we are exporting our problem. The 1861 Act in Britain is not stopping the huge abortion problem there. Perhaps we should take that fact on board as well.

Deputy Robert Dowds: On a point of order, I understood, as a member of the committee, that we would be discussing the heads of the Bill today. I appreciate the Chairman has a very difficult job.

Chairman: Will the Deputy allow me and help me to do it?

Deputy Robert Dowds: Will the Chairman insist on people addressing the heads of the Bill?

Chairman: I have done so on numerous occasions and I appeal to everybody to take a collective intake of breath, exhale and calm down. I am doing the best I can.

Dr. Rhona Mahony: With regard to Deputy Mathews's comments, I agree that, undoubtedly, women can suffer very grave psychiatric trauma because of having to have a termination of pregnancy. That is not at issue. The issue here is the risk to life because of suicide and suicidal ideation. I remind the Deputy that if a woman commits suicide, she dies and her baby dies too. I have no doubt that women find termination of pregnancy very painful. The issue of when life begins is really not for discussion today. We are talking about the substantial risk to maternal life in pregnancy.

The Deputy commented on the number of terminations performed elsewhere in the world. That is disingenuous and does not add anything to today's debate. We are not talking about termination of pregnancy for any reason; we are discussing termination of pregnancy within a very narrow and confined context of risk to life, where terminations of pregnancy are performed

to save a woman's life. These instances are rare. In my hospital, which is one of the busiest maternity hospitals in Europe, we perform approximately up to five of these procedures every year. Please do not confuse us with figures of 7 million or other large numbers. That is disingenuous.

Deputy Peter Mathews: I am not confused. I am very clear.

Chairman: I thank the Deputy, but he has already spoken well.

Deputy Peter Mathews: I am not confused, in case the doctor believes I am.

Chairman: We should have one speaker at a time.

Deputy Peter Mathews: I am not being disingenuous.

Chairman: When the Deputy was chairing the Dáil he did not interrupt speakers.

Dr. Rhona Mahony: Senator Bradford agreed with my comment that suicide is death and indicated that termination of pregnancy is death. The point of this is to prevent two deaths. In other words, when faced with the possibility that if we do not terminate a pregnancy two people will die, I believe a woman has the right to have her life saved. We should not stand by and let two lives be lost unnecessarily. These are complicated situations.

I do not understand the legal position in Britain as I belong in this country and practice within Ireland's jurisdiction.

Dr. Sam Coulter-Smith: I do not have anything further to add to Dr. Mahony's comments directed at Deputy Mathews. Deputy Terence Flanagan asked what is a real and substantial risk to the life of the mother, which is very difficult to identify. We should leave that up to our very competent doctors in obstetrics and gynaecology, oncology and cardiology and any other specialty dealing with very sick patients. We have a very high standard of medicine in this country and it is appropriate to put legislation in place to protect our doctors and let them do what they do best in treating women and all patients to the very best of their ability. We do not need to be prescriptive on those lines.

We were asked if an obstetrician would overrule a psychiatrist. We do not have the expertise and experience in the psychiatric area to overrule a psychiatrist, so I cannot see that happening. However, we do have conscientious objection to protect us in that regard.

We were given several scenarios and asked if we would perform a termination of pregnancy in such circumstances. It is very important to stress that the only position in which a pregnancy would be brought to a conclusion in this country as covered in the legislation would be if the woman's life is at risk and she will die if nothing is done. That is the important point that we are all here to stress. We are all here to look after women and babies. In a scenario in which the baby will die and we can save the mother's life, we need the freedom and protection to be able to act.

Reference was made to the safety of Irish health services, and this was also alluded to this morning. Yes, our results are excellent and remarkable. I stressed earlier that this was down to the skill and dedication of our midwives and the excellent doctors who work from facilities that are absolutely not fit for purpose any longer. To tell the committee about the Rotunda Hospital, we have nine delivery rooms when we should have 16. Our public postnatal wards were built in 1757. The infection control risks we face on a day-to-day basis are ridiculous. It is absolutely crazy in this day and age that we are providing modern-day obstetric services out of a building

which is no longer fit for purpose, but the results are fantastic. That is down to the staff.

When we are talking about saving mothers' lives, we should not use the terms "abortion" and "saving mothers' lives" in the same sentence, full stop. It is a dreadful reflection on anyone who would actually do that. This is about saving mothers' lives, preserving dignity and not stigmatising anybody. These are wanted pregnancies, loved pregnancies, and intervention has to be made to save the mother's life. To call it an abortion is wrong.

Dr. Peter Boylan: The legislation is incredibly restrictive by international standards. Any suggestion this is a liberal legislative programme needs to be utterly rejected. Comparisons with the United Kingdom or any other country in Europe - in fact, any other country apart from Malta - are disingenuous and false. This is incredibly restrictive which everybody needs to recognise. I have a fundamental problem with people abrogating the term "pro-life" to themselves and trying to paint me into a corner where I am held up as not being pro-life. Nothing could be further from the truth. As I have spent my entire professional career trying to care for and save lives, I have a fundamental personal objection to this.

Deputy Terence Flanagan asked about clarity regarding the law. This will clarify things for us as physicians practising on a daily basis. At the moment we are left to interpret the Constitution in our daily jobs. It does not happen very often, but it does happen when there is a risk to the life of the mother. We cannot be expected to interpret the Constitution; we are not constitutional lawyers. We are dependent on the members of the committee, the legislators, to do their job, for which they are paid, and legislate. It has taken a long time and I applaud the Government for initiating the process and, at last, legislating and standing up and doing what is required to protect the lives of mothers and give us the certainty that we can practise as we need to do.

An obstetrician feeling uncomfortable can invoke the conscientious objection clause. That is not an issue. Questions were asked about whether we would terminate a single twin if the mother asked for it. No, let us not go there, as that is getting into silly territory.

Senator Paul Bradford made reference to the health of the mother. This is about the life of the mother; not about her health. We are concerned that if a woman is not allowed to have a termination of pregnancy, she will die, not that she will be unhealthy. This is about death. Stop introducing the term "health" because it is irrelevant.

Ireland is not a chilling place. It is very good, but it is not because of the facilities available or anything else; it is in spite of what Dr. Coulter-Smith has very eloquently and repeatedly drawn attention to in terms of deficiencies in services.

I was asked if I had ever been unable to intervene because of the current legal situation, to carry out a termination of pregnancy and the woman had died. I have not, but I have personal, inside information and knowledge from the west of a woman who died last year because the doctors were unable to terminate the pregnancy because of the law.

Chairman: There is an ongoing investigation in that regard, if Dr. Boylan could be careful in his remarks about it.

Dr. Peter Boylan: That is my expert opinion.

Chairman: Thank you.

Dr. Peter Boylan: I also have personal experience as a junior doctor of a woman who died during pregnancy because she had a conscientious objection to termination of pregnancy. She was so desperate to give birth to a child that she did and then she died. That happens too and we, obviously, respected her wish.

There was a question to the effect that suicide was death and so was abortion and an implication that the problem could be averted by investment. That is incorrect. If the mother dies, the baby dies. We are talking about the preservation of life. This is a preservation of life Bill. We are talking about the preservation of the life of the mother and if the mother dies, so too does the baby.

Chairman: I apologise that we will not get to everybody. The three members in the next sequence are Deputies Liam Twomey and Michael Creed and Senator David Norris.

Deputy Liam Twomey: Each of the witnesses might answer "Yes" or "No" to the following question. If the Houses of the Oireachtas passed legislation similar to the Bill before us, would it force any of the witnesses to do anything against best medical practice as we know it now? It is important to clarify this with a "Yes" or "No" answer for the committee.

My next question is about the heads on physical and mental illness and has as much to do with the legislation as with a medical ethos. A physical illness is very much about an objective diagnosis which one can clearly make very straightforwardly, whereas mental illness involves a more subjective diagnosis. Under the legislation as proposed, there is a reference to two psychiatrists and one obstetrician. Do the witnesses feel the obstetrician should have an informed opinion to add to those of the psychiatrists rather than an overall veto? This more or less goes back to what is a medical ethos and the relationship with the patient. Dr. Boylan has said the decision is the patient's because some patients want more and some want less, which is the basis of the relationship practitioners have with them. Perhaps we should approach it from that point of view in the legislation.

Since I qualified as a doctor 20 years ago, 100,000 women of child-bearing age have had terminations in other jurisdictions. I have treated and looked after some of these patients when they have returned and I would never paint their experiences in a uniform way. They have all experienced matters differently, both then and since, and we must be very humane about how we discuss their experiences.

Senator David Norris: I commend the Chairman for his clear and decisive chairing and indicate to my colleagues that buffoonery almost invariably tends to discredit a viewpoint, however well intentioned.

Chairman: On the heads of the Bill, please, Senator.

Senator David Norris: It is very much welcome that the Title of the Bill includes the words "protection of life" as it provides space for the many of us in the Oireachtas who are strongly pro-life and also strongly pro-choice. It is a timid step and very little, very late. I regret that it does not deal with fatal foetal abnormality, incest, rape and the health of a woman. If it was the health of a man, there would quite a difference.

I was very concerned by a letter by the Archbishop of Dublin, Dr. Martin, which I took very seriously and raised as I was so concerned. I raise it again in the context of some of the comments made which I may have misinterpreted but which seem to constitute a general suggestion that as a result of the Bill a pregnancy might be terminated and the child or the foetus born left

to die or deliberately killed. That horrified me and I raised the issue on the Order of Business. I have learned a lot today and would like to know if I would be correct to say the termination of a pregnancy does not automatically mean the termination of the life of the foetus or the child. I would like to be able to mention this next week in the Seanad. It is vitally important for the way the Bill is treated.

I address a question to Dr. Coulter-Smith who raised two interesting hypothetical questions - one on the delivery of a baby at 25 weeks and the second on delivery at 20 weeks and the consequences for the health of the child through cerebral palsy or whatever else. He raised this issue in the context of suicidality, but would it not also be the same ethical question if it occurred in the case of a sudden medical emergency, the worsening of a cancer or the onset of a dangerous heart condition?

Deputy Michael Creed: I thank the witnesses for their contributions and preface my remarks by saying it is regrettable that we tend to elevate or diminish contributions depending on our own perspective. We are all trying to grapple with something that is enormously complex. I agree that the "pro-life" and "pro-choice" terms do an injustice to the complexity of the issue. We should be more tolerant of all contributions. To describe some contributions as buffoonery is to miss the point and the complexity of the issue.

In the contribution of Dr. Mahony today and in January, she made reference to the lack of clarity and the fear of going to jail for acting in a manner to protect women's lives and the lives of the patients. I have read the heads of the Bill. Where is the clarity in respect of vindicating that right to treatment that was not clear up to now? Perhaps it will emerge when the legislation proper is published but I do not see the clear referral pathway where a woman can access the service she requires. I would like the witnesses to take me through the heads of the Bill that provide that legal clarity. What does Dr. Mahony see that she can do today that she felt she may go to jail for in January?

Dr. Boylan made the point that this is conservative and does not deal with a host of issues we should deal with if we were more courageous. Many of us are fearful of the law of unintended consequences. The figure for suicidal tendencies during pregnancy is one in 500,000. If there are 100,000 pregnancies in the country per year, including miscarriages, it suggests that under head 4, which provides for suicidal women during pregnancy, we should be looking at one case every five years availing of legislation under head 4. If it emerges during a review of the legislation that it is far more than that, will the three witnesses consider the legislation is flawed?

Head 19 has been referred to in the context of the chill factor and the consequences for doctors and women. I might have sympathy for the woman being subject to serious sanction but it is important to keep a chill factor in the legislation. Reference has been made to the 1861 Act. Without that provision, are we facilitating a more liberal regime than envisaged by law under the previous headings?

Chairman: We have four speakers and our time expires at 5.20 p.m. I will call the remaining members before calling the witnesses. I ask Senators Mullen and Hayden and Deputies Timmins and Tóibín to be brief.

Senator Rónán Mullen: I thank the Chairman for the job he is doing, which is difficult. Underpinning my questions is the fact that I would not like there to be a chilling effect on legislators or specialists doing their best to understand what the evidence says. That is a job we must all do. It is quite clear from Dr. Coulter-Smith's paper that it is a job he and his colleagues,

as obstetricians, must do having regard to what they have learned from their psychiatric colleagues. I do not think my friend, Senator Crown, necessarily intended it but it is important to remember that we must respect one another's genuine search.

I have two housekeeping questions that we should ask of all our guests and they are meant in the best spirit. Do our guests mind telling us whether they were consulted in any way by the Department of Health or the HSE post the expert group in the preparation of the heads? I have not had the chance to read the papers in detail but Dr. Coulter-Smith said he was here to give the views of himself and his colleagues in the Rotunda Hospital. Are our other guests here in a purely personal capacity, are they speaking for their colleagues or a majority of their colleagues, or did they consult among colleagues?

My second question concerns Dr. Mahony's point about the X case. She posited the test of the possibility and the challenge is that the Supreme Court in the X case found, without the benefit of a psychiatrist in the High Court, that it was where there was a probability. The difficulty seems to be whether there is any evidence on which psychiatrists could rely that could allow them to say that, as a matter of probability, this will happen. I ask Dr. Coulter-Smith if that lies under his statement about enacting and underpinning the idea that the termination of pregnancy is a solution when there is no evidence to support the intervention. It creates a major ethical dilemma for the profession.

Building on that, the legislation does not just put the obstetrician in the role of carrying out the procedure but of certifier. The obstetrician's certification is necessary along with that of the two psychiatrists. In the same way that under head 2, the doctors are faced with a child of 20 weeks in the womb and every effort will be made to bring two patients out safely and hold off on treatment, as Dr. Mahony and others said. In exercising the certification role, would the witnesses consider asking the psychiatrists whether it is possible to delay the procedure to get the child to the point where it could be delivered not just prematurely but also safely and well?

Chairman: Tá an t-am caite.

Senator Rónán Mullen: Is that within the witnesses' capacity under these heads?

Finally, what is the situation in regard to painkilling in these situations under heads 2, 3 and 4 when dealing with later term deliveries?

Senator Aideen Hayden: Like a number of speakers, I am conscious this Bill is about the preservation of maternal life and we are addressing ourselves to the heads of the Bill. However, Dr. Coulter-Smith's testimony has come up again and again with regard to suicidality. Looking at his written contribution, he says his overriding concern includes self-destruction and termination of pregnancy. He is concerned about the lack of evidence. In spite of Senator Crown's question, I am at a loss as to his answer. If no evidence exists, surely none of his psychiatric colleagues would prescribe a termination of a pregnancy in these circumstances, no more than he would prescribe the termination of a pregnancy on the grounds of heart failure, for the sake of argument. I am at a loss to see how this is relevant.

Dr. Coulter-Smith mentioned that the inclusion of suicidality would lead to an increased demand for termination services. He mentions the difficulty we have with resources in the Irish State but we do not know how many of the 5,000 women who travel abroad do so because they are suffering from mental health issues. Nor do we know whether part of our excellent record in Ireland is due to the fact that women over 45 years of age travel abroad because they believe

their lives may be at risk and choose to vote with their feet. We suffer from a lack of evidence. The 5,000 women who travel out of this country may be dismayed to have it suggested that a lack of resources should be a reason they should not have a legitimate answer to their medical and mental problems in this country.

Deputy Billy Timmins: To clarify, these are the heads of the protection of life during pregnancy Bill, not the protection of maternal life Bill. I have the height of admiration for the medical profession in this country and across the globe. There are many places I would rather be than here but there is a duty upon me, as a legislator, to inform myself. In trying to get that information, if I come across as confrontational with witnesses, it is not the intention. We admire the work they do.

I agree with Dr. Boylan on head 19. We probably should look again at that issue and the penalty. Notwithstanding that, I hear the term "the chill factor" used continually with regard to the criminal law. Broadly speaking, the concept of the criminal law is to have a chill factor, not a soothing factor. Also, with regard to the issue the witness raised about science and the origin of it, the State gets things wrong. There are many examples in this country of where the State got legislation and policy wrong. The State is not always right, as is evident from the many cases taken against it. In respect of the X case, the evidence from the psychiatrist was that in the forecasting of suicide there was a false positive in 97% of cases. That is important.

We must take all these factors into consideration when formulating legislation. This is probably the most important legislative measure I have had to vote on in my time in the House and I want to get it right. I compliment the witnesses. I particularly compliment Dr. Coulter-Smith because he has articulated in his document many of the concerns that were expressed to me by ordinary people, medical professionals, gynaecologists and doctors from all corners of the globe. It is really important that the concerns he has articulated are made known. I do not know if a gynaecologist has expressed them in public previously. We have received letters privately and seen letters in the newspapers but they might not have been expressed in a forum such as this. Given what Dr. Coulter-Smith has said regarding head 4, and he has obviously discussed it with his staff, does he anticipate a difficulty in the Rotunda Hospital with head 4 being implemented if the legislation is passed as it is, based on his knowledge of the staff currently serving there?

Deputy Peadar Tóibín: Everybody here believes that in every case everything must be done to save the life of the mother, regardless of what side of the debate one takes. There are no ifs, buts or doubts about that. Many people are of the view, and they agree with the psychiatric evidence and the advice, that this should be done with a two patients solution, that both patients must be saved in that scenario. I believe the 5,000 women heading to England every year is a double disaster. It is a disaster that those crisis pregnancies occur and it is also a disaster that 5,000 lives are being lost every year. We heard a very moving presentation from Women Hurt yesterday. All of them said that, if necessary, in their situations they would have done everything possible to convince people that they were suicidal in order to procure an abortion. One of the women said that she was coached to say that she was suicidal to procure an abortion. One woman asked me to ask a question here, which is, if that type of abuse were to happen in the future, would the doctors be certain that this Bill would prevent it?

Dr. Peter Boylan: There is much to cover. Will the legislation force us to do anything against best medical practice? No. With regard to two psychiatrists and one obstetrician having an input into the decision and the patient decides, the patient decides within the law and we also decide within the law. When this legislation is enacted we will all have to work within the law.

There is no question about that. There is a huge variety of different experiences. Unquestionably, many women are damaged by termination of pregnancy, and many women are damaged by not having a termination of pregnancy. That is life. Life is messy and we as obstetricians and doctors see all the shades of human experiences. There is a wide spectrum and one cannot just focus on a single particular group.

This Bill is about the protection of life. People have different opinions about the inclusion of foetal abnormality, rape, incest and so forth. However, the terms of this Bill are very straight and we should not get into discussing other issues in this environment. Archbishop Martin's letter referred to the possibility of a baby being left to die or a baby being killed. Those two would be criminal offences. There is no question about that. Everybody must be reassured on that. He raised the question perhaps hoping for clarification of this issue in a public forum. I am very happy to clarify that for the archbishop.

We have dealt with the question of pre-term birth. On the chilling factor and the 14 year jail sentence, I do not have a problem with doctors being held responsible for making illegal decisions regarding termination of pregnancy. That must stay on the Statute Book. No doctor has a problem with that as far as I am aware. I do have a problem with a woman being criminalised if she follows medical advice. I think that is fundamentally wrong and unfair, particularly if she has the constitutional protection of this country if she goes to the UK and has the same procedure. It just does not make sense.

There was a question about the law of unintended consequences and the fear that there would be a very liberal regime of termination of pregnancy as a result of this legislation. The figure of one in 500,000 has been introduced into the debate. That is a woman who commits suicide in the UK, which has a very liberal regime and where there is very easy access to termination of pregnancy, effectively on request. We will never be able to answer the question of how many women would commit suicide in this country if termination of pregnancy was not available because it is available. It is just available in the UK. Therefore, we will never be able to answer that question.

However, it appears that genuine suicide risk in pregnancy is extremely rare. We must trust our professional colleagues in psychiatry who assess this risk on a daily basis. The committee will hear evidence on Monday from experts in psychiatry and I urge the members to listen to the balanced opinions that will be put forward that day, and not to be swayed by ideological opinions. We were asked if we would ask a psychiatrist to delay a termination if the duration of the pregnancy was 20 weeks. We are obliged under this legislation to take due care to do all we can to preserve the life of the baby. It is not a question of a psychiatrist rolling up and saying we should terminate a pregnancy without any discussion between us. We do not act like that. It is not a professional way to behave and we do not behave like that. These will be joint decisions taken in consultation with our psychiatric colleagues, whose opinions we respect and trust.

With regard to the State getting things wrong, I am not sure that is relevant to this. I have made reference to head 19. I do not believe a woman should be criminalised. Yes, everything must be done to save life. That is what this Bill is about; it is about saving lives, which is why it is called the protection of life during pregnancy Bill.

The question has arisen about women being coached to fool experienced professional psychiatrists to believe that they are genuinely suicidal. We have to trust psychiatrists. They are not going to be fooled. They are well able to recognise women who are attempting to pull the wool over their eyes. I do not think there is any question of a psychiatrist in this country being

fooled by somebody setting themselves up. Undoubtedly, there will be mischievous people who will try to trick them into the belief that they are suicidal when they are probably not even pregnant in the first place. However, our psychiatrists are a smart bunch of people. They will recognise those women when they walk in and they will be able to deal with it. Do not worry about that.

Dr. Sam Coulter-Smith: My comments on the first question would echo those of Dr. Boylan. Senator Norris asked about babies being left to die or deliberately killed. There is absolutely no question of that happening in this country. He also asked if termination of pregnancy was the equivalent of the death of a child. It is not, because it depends on the gestation at which it occurs. We dealt with that earlier. He asked about the different clinical scenarios. Where there is a threat to the life of the mother based on a physical illness, in all likelihood the evidence will be much clearer. Where there is a risk of suicide, the evidence is a little less clear and it makes that situation much more challenging and difficult to deal with. That is where the expertise of our psychiatric colleagues is required. Senator Norris is absolutely correct that whether the intervention occurs because a woman has a physical illness or because she is suicidal, the outcome of that situation will be the same at a particular gestation. However, I argue that the evidence behind the decision-making is different.

Reference was made to the incidence of suicide in pregnancy. Dr. Boylan has alluded to UK figures. The situation in relation to the UK laws is different. Dr. Boylan has mentioned that where a coroner in Ireland may not record a case of suicide and may record an open verdict, it presents a greater challenge in trying to have an understanding of the actual figures. We can agree, however, that it is extraordinarily rare and unpredictable. Members may ask the psychiatrists when they talk to them next week, but they will tell members it is an unpredictable and rare event.

On the question as to whether I was consulted on the heads of the Bill, the answer is "No". With regard to efforts to achieve maturity, it is enshrined in the Bill that all doctors are duty bound to ensure they make every effort to get the baby to maturity where it will survive, if that is at all possible, and the only reason one would intervene to terminate a pregnancy is if all other avenues have been explored and there is no other option.

With regard to the large number of women who go to the United Kingdom, I agree absolutely that we do not understand the issues they have. I was not suggesting that if termination of pregnancy was required for any of these women, it would not be performed because of a lack of resources, but that if what was described occurred and there were to be a greater demand for the type of service in question in this country, our current resources could deal with it.

On head 4 and intervening in a case of suicidality, no obstetrician would have an issue with intervening and performing a termination of pregnancy if it were to save the life of the mother and if every other avenue had been explored and there were no others.

Dr. Rhona Mahony: On the question of whether it would alter my practice if we passed the legislation, the answer is "No," although there are some amendments we have discussed today that need to be taken into consideration. We have had a discussion on the concept of physical illness versus mental illness. One is objective - we have definite signs - and one is very subjective. I am an obstetrician and cannot assess suicidal ideation, but I am very confident that my colleagues who are experts in psychiatry can assess it. They do this very commonly in the course of their practice. As an aside, one very tragic objective outcome of suicidal ideation is death.

On Senator David Norris's comments, the Bill, of course, is not about physical health but about the risk to life. That needs to be very clear. We are not talking about physical or mental health but about the risk of death from any cause, be it physical or mental. In the majority of cases it will pertain to death from physical causes.

With regard to Archbishop Martin's letter, I really hope that by now it is clear to everyone that we are not in the business of killing babies and there is no question that a baby that is capable of surviving will not be offered every support to optimise its survival. There is no question that a baby born at 28 or 30 weeks gestation would somehow be killed. That is murder, a criminal offence, and out of the question. One must understand that we will do everything and exhaust every single medical avenue open to us to prolong pregnancy such that a baby may achieve viability and to give babies born at early gestations every support to optimise their survival. We do this all the time. It is a very fundamental part of our job.

I have been asked directly to clarify what I am worried about. The 1861 legislation still stands and nobody has yet told me it does not. The Supreme Court judgment is in place, but it has not been legislated for. I presume we are all here because we see a necessity to legislate for the Supreme Court case. We need legal clarity surrounding the termination of pregnancy to save women's lives and the sort of legislation and regulation that will afford us legal protection and flexibility to do our job. It is really important that everyone take on board that the 1861 legislation pertains not only to doctors but also to women. That is very important. The question of women being at risk of penal servitude must be taken on board. Therefore, I welcome this legislation and commend the Government for introducing this long-overdue Bill.

We return time and again to the question of suicide which is extremely rare in pregnancy. I am not a psychiatrist, but I have some expertise in publishing papers and setting up studies. There is no evidence regarding suicide. There is a lot of evidence on mental health and many papers dealing with different aspects, but there is no paper in this country that deals specifically with the outcome of suicidal ideation. Gold standard therapy would involve a randomised controlled trial. That would give us the best evidence. All other evidence is quite flimsy, actually, and one will have different papers stating different things. I do not believe there should be a randomised controlled trial. Are we really going to take women with suicidal ideation and randomise them into two arms, one that is allowed a termination of pregnancy in the belief we are saving their lives and another prevented from terminating their pregnancies in the belief this might result in their dying. That study should never be undertaken. There is no evidence; this is extremely rare and there cannot be compelling evidence when the numbers are very tiny.

With regard to head 19, I agree that we need to be very careful. Women should not be liable for criminal prosecution on the grounds of this, particularly considering that when we may perform a termination of pregnancy, the women concerned would be taking a doctor's advice that they should have a termination of pregnancy to save their lives. There should be no question under any circumstance of a woman being liable legally. That answers that question.

We had a discussion on the circumstances concerning two patients and it was stated 5,000 women travelled to England. That is not the issue; today we are talking about the heads of a Bill that deals with the protection of life during pregnancy.

On the question of suicide, the idea that women will turn up in front of expert psychiatrists and lie in vast numbers and the suggestion our psychiatrists who are extremely well trained and competent have no idea how to assess ideation just have no basis in fact. Furthermore, we need to be very careful. Women with suicidal ideation need to be taken seriously and believed. I

would be a very bad doctor if I began every single medical consultation with the presumption that my patient was lying.

We have had a conversation about resources. I would be the first person to say obstetrics and maternity services in this country are dreadfully under-resourced. There is an urgent need to address the resource issues within the maternity sector. The approach we should have is not to fail to legislate in this Bill; the approach should be to address the issue of resources in the maternity sector. I hope the Government will take on board these views and give maternity services the attention they so urgently need and deserve.

Chairman: I thank our three witnesses, Dr. Mahony, Dr. Coulter-Smith and Dr. Boylan.

Sitting suspended at 5.40 p.m. and resumed at 5.50 p.m.

Obstetric Care Facilities - Smaller Hospitals

Chairman: We will resume in public session for the fourth and final part of today's discussion and analysis of the heads of the Protection of Life during Pregnancy Bill 2013. I remind Members and witnesses to ensure their mobile telephones are tuned off as they interfere with broadcasting, which is unfair to members of staff. I welcome Dr. Gerard Burke of the Mid-Western Regional Maternity Hospital, Limerick; Dr. Mary McCaffrey of Kerry General Hospital in Tralee; Dr. Máire Milner of Our Lady of Lourdes Hospital, Drogheda; and Dr. John Monaghan of Portiuncula Hospital in Ballinasloe. I thank them for attending these hearings and apologise for the delay in commencing this session. I hope the delay has not discommoded them too much.

Before we commence, witnesses are advised 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 entitled thereafter only to a qualified privilege in respect of their evidence. Witnesses are further directed that only evidence connected with the matters under discussion is to be given. They are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person 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 to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable.

I call on Dr. Gerard Burke to make his opening statement.

Dr. Gerard Burke: I thank the Chairman for his invitation to attend this discussion. I welcome the publication of the Protection of Life during Pregnancy Bill 2013 and commend the Government on bringing it forward. I also commend the members of the committee and other Members for the intellectual effort they have put into this debate through the course of the day. It has been a long day, so I will be brief.

On the issue of resources, in the next decade we can expect in the order of 100 maternal deaths in Ireland. It is possible that one, two or three of these potential maternal deaths might be affected by the legislation before us. In terms of the number of possible deaths, therefore,

this great intellectual effort will affect a relatively small number of women. It is important that the Oireachtas would at some point address the state of the maternity services. The unit in Limerick which I represent, for example, has the lowest number of obstetricians in the whole of Europe at two per 100,000. This shortage of resources will likely lead to some difficulties in the future.

Turning to the specifics of the heads of the Bill, the first issue that has come up for discussion in my department is the question of what is a real and substantial risk to the life of the woman. I note that this is not defined clearly in the heads and I understand the reasons for that. The issue has been raised in the submission by the Institute of Obstetricians and Gynaecologists, which I support. My personal preference is that there would be an explicit statement setting out that this is a matter which cannot be defined in terms of real numbers or percentages, and that it should really be left to the medical experts to determine. It would be wrong if what is actually a matter for legislators were ultimately to be decided by a court.

We have identified two minor technical issues that should be addressed, the first of which relates to the question of an ectopic pregnancy. It is possible to have an ectopic pregnancy within the womb, in the cervix, in the neck of the womb or in the scar of a previous caesarean section. We are seeing more and more of the latter as the rate of caesareans has risen. One can have a pregnancy that is ectopic but within the womb, and that is an extremely dangerous condition which could fall under this legislation.

The second issue, which was also pointed out by the delegates from the institute, relates to locations. Some 40% of babies in Ireland are born in stand-alone hospitals, namely, the three in Dublin and my own unit in Limerick. Some of the more difficult work we have to do is carried out in the general regional hospital. A caesarean section on a critically ill woman, for instance, would have to be done in a general hospital. That needs to be included in the legislation.

Chairman: Thank you, Dr. Burke. I now invite Dr. McCaffrey to make a statement.

Dr. Mary McCaffrey: I thank the Chairman and the committee for the opportunity to contribute to the discussion. Like Dr. Burke, I commend the Government and the legal draftsmen on putting together these legislative proposals under such difficult circumstances. My submission is intended to reflect on how the proposed legislation might impact on the practice of obstetrics in small to medium-sized units, that is, in units with three consultant obstetricians on the staff. There are 12 such units out of the total of 19 in the country, and they deliver approximately one third of all babies. Therefore, they make up a significant number of deliveries. I will not dwell too much on the issue of resources other than to say that, in general, we would tend to be very under-resourced.

There has been a great deal of repetition in the discussion today, so I will address only those heads of the Bill which we consider specific to the practice in our units. I have collaborated with a number of colleagues in clarifying our position in this regard. In regard to head 2, which deals with the risk to life from physical illness, not being a risk of self-destruction, my understanding is that this relates to cases of severe heart disease, cancer or other major medical illnesses. Under the proposed head, one obstetrician and a doctor from the speciality caring for the significant complex medical condition are required to make a decision regarding ongoing management of the pregnancy. We feel that the bulk of these cases, in general, are likely to be managed in tertiary referral hospitals and are not likely to impact on the smaller maternity units. The only exception is that in Kerry, Letterkenny and Wexford, which have similar units, during the holiday season the most amazing range of patients about whom one knows nothing arrive as

visitors to the area. We are very aware that those women require the backup of intensive care in a general hospital and we endeavour, where possible in our units, to transfer them out safely but we are aware that exceptional circumstances occur and medicine is not always black and white. That needs to be reflected to protect us under the legislation.

Regarding head 3, risk of loss of life from physical illness in an emergency situation, sadly, in the course of our work we deal all the time with patients who have severe impending infection, severe pre-eclampsia or haemorrhage. The legislation now protects us in a way that we were not protected before so we welcome it for those cases. The proposed legislation suggests that one doctor would sign out for making decisions with regard to the care of the patient. It is best practice in most situations that two obstetricians would be involved in such decisions and in general that is what happens. Once again, however, we go back to the fact that in a small maternity unit with only three obstetricians there will always be periods in which only one person is on duty at night and weekends. That person has to be protected and his or her clinical judgment has to be taken on face value. In the January submission I suggested that perhaps where someone felt he or she wanted a second opinion and that was not available in-house, consideration should be given to having a panel of experts in the Dublin maternity hospitals who would be available to people who wanted to collaborate with a colleague.

The wording of head 4, risk of loss of life from self-destruction, should be changed. Suicide is a terrible word but that is what it is. The issue that came up with all the people to whom I spoke is that we do not feel, as obstetricians who are not trained in psychiatry, that we have any role in diagnosis of suicidal intent. We accept and understand that the psychiatrist's input is crucial in this instance. We accept and acknowledge that we can make an input to assist the psychiatrist in managing the pregnancy as it proceeds, if that is what is required, but we do not feel that the current batch of obstetricians is adequately trained to diagnose suicidal intent. We are, however, available to support our psychiatry colleagues in that diagnosis. In all of the conditions involved we realise that there will be situations in which potentially viable foetuses will be born and we must endeavour where at all possible to deliver them in units where they have the appropriate neonatal backup and support for the babies that potentially need neonatal care.

It is also important to point out that not all maternity units and psychiatry units are on the same site. A significant number of hospitals in the country have a maternity unit but no psychiatry unit. If an acutely ill woman is admitted to a psychiatry unit, there will be resource issues in terms of providing a team of psychiatrists to look after her if she is in a maternity unit and *vice versa*. The fact that many psychiatry units are off-site has not been thought about. Equally, many maternity units, as Dr. Burke has pointed out, do not have the backup of intensive care or general hospital facilities.

My point about head 9 does not appear in my written submission because it was only identified by someone during the course of the day. Under head 9:

> (4) A person who –
>
> (a) having been directed under subhead (2) to attend before the committee without just cause or excuse disobeys the direction,
>
> (b) fails or refuses to send any document or things legally required by the committee under subhead (1) to be sent to it by the person without just cause or excuse,
>
> shall be guilty of an offence and shall be liable on summary conviction to a class C

fine (not exceeding €2,500).

I assume that nobody will put herself or himself forward to be on a committee unless she or he truly wishes to be there and is a volunteer. Medical and staffing circumstances may overtake committee members in a hospital so that they cannot attend a committee meeting. There was a suggestion that maybe there was a bit of carrot and stick about this provision, with more stick than carrot and that it would be hard to recruit volunteers if they felt they were going to be fined and criminalised. There should maybe be a little reflection on that point.

For a significant number of colleagues with whom I have discussed head 12, conscientious objection, this is a really significant area. There are many obstetricians in the country who have conscientious objections to being involved in providing termination of pregnancy. This must be respected. Under Medical Council guidelines, they are entitled to have conscientious objections. The important point is that the public will know that where the life of the mother is at risk and where medical care is needed appropriately, the care of the mother and her baby will always be paramount for every doctor and that if a doctor has a conscientious objection, he or she will have the facility to provide access to another colleague in a timely manner. That is very important.

Over the past couple of months there has been some suggestion in the media and elsewhere that doctors should have to declare their moral and ethical objections to being involved in termination of pregnancy prior to taking up employment. This has caused fear for a number of colleagues, not those of us currently employed because we have our jobs but people in the future might feel that they would be disadvantaged or discriminated against at interview by an employer who feels that a certain doctor is not going to do terminations but one who will do them is needed on the staff. This has to be taken very seriously because under subsection (3) of head 12, "No institution, organisation or third party shall refuse to provide a lawful termination of pregnancy to a woman on grounds of conscientious objection". If there is a hospital management structure that for whatever reason feels all of its doctors must provide terminations, no doctor should fear that if he or she applies for a job there and has a particular ethical point of view, he or she will be discriminated against in getting a job. That is very important. A few people would like to know who is the "third party" referred to in that subsection because that was not clear to us.

There are some other issues that I feel are worth mentioning that I did not see highlighted in the heads of the Bill but maybe I missed them. One is the issue of resources to allow medical staff to carry out these duties safely under the legislation. I am not here to represent the psychiatry profession but they would say that they struggle under the current resources to deal with the mental health tribunals and that imposing an added burden on them would be significant. We also have to acknowledge that the majority of obstetricians practising in this country today do not carry out terminations of pregnancy and probably have not done in the past. They will need to have training for that so that they can safely provide care for their patients and do not work outside the scope of their practice. Many people feel that termination of pregnancy is a procedure that is totally and utterly safe but we know from the confidential inquiries in the UK that there can be morbidity and mortality for women after the procedure. Therefore, it is crucial that if we introduce a medical procedure in this country that people are appropriately trained and feel that they can work well within their scope of practice. Another issue that I may have missed arises if the person is under the age of consent. Are there extra legal procedures and requirements that we would need to incorporate into legislation?

Finally, if legislation is enacted there will need to be a period when hospitals and the regula-

tory bodies can put care plans in place to ensure safe practice so that the legislation is not passed one week and people are expected the following week to provide a level of medical care that has not been communicated to and discussed with those on the ground.

Chairman: Thank you, Dr. McCaffrey. Our next speaker is Dr. Máire Milner, from Our Lady of Lourdes Hospital. You are very welcome, Dr. Milner.

Dr. Máire Milner: Thank you very much, Chairman. I will be extremely brief. I welcome the heads of the Protection of Life during Pregnancy Bill as put forward by the Government. It is needed because there are areas of uncertainty that we encounter during our practice. They are not common but neither are they very rare. Our population and our medicine are changing all the time. Women are now falling pregnant at ages and with diseases and on treatments that previously would not have been encountered. This gives rise to logistical challenges and difficulties for us as clinicians. This can give rise to incidents in which the life of the mother may be threatened. I welcome the bringing of clarity into an area of uncertainty. Dealing with a woman who is critically ill brings its own uncertainties. For us to have a background of uncertainty about our legal position has been very unhelpful and difficult. Accordingly, I welcome this legislation.

With regard to the suicide part of it, this is a more difficult area. Intuitively, while this is a very unlikely scenario, I think we have to recognise that the submission of the Institute of Obstetricians and Gynaecologists pointed out that mental as well as physical illness can have similar indications. I endorse the submission by the Institute of Obstetricians and Gynaecologists and I would be happy to answer any questions the committee may have on that.

Chairman: I welcome Dr. John Monaghan from Portiuncula Hospital, Ballinasloe, County Galway. I apologise that he was not able to make a submission in January but I welcome him to make an opening statement now.

Dr. John Monaghan: I appreciate the invitation to speak at this gathering. I previously sent in a submission in early January which dealt with two specific matters which I will deal with today. As I was instructed to deal with the heads of the Bill, I have four points to make this evening. The word I am intending to use is "clarity", which seems to be the word of the evening.

Head 2 refers to risk of loss of life from physical illness. My point on this is personal and relates to cancer. Senator Crown may be one of the most eminent oncologists in the country, maybe in the world. I have a personal point to which he may attend. One of the reasons we are here is the judgment of the European Court of Human Rights in the A, B and C cases. One successful plaintiff, C, was a woman who had been treated for cancer. She was, according to the expert report, "unable to obtain clear advice as to the effect of the pregnancy on her health or the effect of medical treatment on the foetus." If this legislation goes through, as broadly outlined in the heads of the Bill, will a woman such as C be in a better position?

Part of my reason for bringing this up is that the medical risks involved with cancer in pregnancy, which is one of the major threats to a woman's life that may lead to a need for termination, have changed dramatically over the past few years. A Belgian doctor, Dr. Frédéric Amant, has spoken in Ireland several times on these developments and there are several publications in *The Lancet* on the matter from last year, which I attached to my submission. While they may be technical in nature, I added them for two reasons. The first is that they describe the changes in the treatments available and the second is that they deal with the problems of treating cancer in pregnancy. The three that are listed are under-treatment because of fear of treating the baby,

late diagnosis and the carrying out of terminations of pregnancy when not required.

My end reason for bringing up this subject is that I suggest to the committee that the legislation should mention somewhere that patients with cancer in pregnancy should be referred to a single cancer treatment centre which has acquired expertise in the management of pregnant patients. One of the articles I attached to my submission dealt with the question of leukaemia or blood and bone marrow cancers. The reason I put it in is that it is an extraordinary complex area. As an average obstetrician and gynaecologist, it is beyond my understanding. My basic idea is that patients who are pregnant and have cancer should have access to a specialist oncology centre with surgery and radiotherapy. There should be one such centre in the country which has expertise to offer this particular group of patients.

My second point refers to head 4, which deals with the risk of loss of life from self-destruction. The other reason we are here today is the Supreme Court case of X, which occurred 22 years ago. As an obstetrician, I do not have any first-hand experience of psychiatry. It reflects an enormous change in obstetric practice that an obstetrician is being asked to intervene in a physically healthy pregnancy. While it appears from the legislation that an obstetrician would be involved in the decision-making, he is referred to otherwise possibly as a technician, suggesting that maybe he should be involved so he does not feel like a technician. However, my gut is extremely unhappy with the idea of a mindless terminator for psychiatric reasons. This decision was made 21 years ago. From the hearings that were held in January, I do not believe any case of suicide associated with refusal of termination has ever surfaced. The evidence from my reading of it seems to be extremely poor. Many of the speakers earlier were happy to take the expert advice of a psychiatrist to act if required. I am not certain how a psychiatrist can reach a decision on this matter where to date I do not believe any evidence has been produced.

The psychiatric or suicide risk clause has been brought in in other jurisdictions and has been widely - I would say universally - abused. Last year, *The Daily Telegraph* did an exposé of the abuse of psychiatric reasons in the UK, with the use of pre-stamped forms. People went to one doctor to get a form stamped, then to another to get it stamped and then got a termination. I can see no reason, despite the safeguards built into this legislation, that culture could not arise in this country in the future. I am extremely concerned as an obstetrician that I would be drawn into a situation in which a termination of pregnancy will be done for psychiatric reasons without very clear evidence that this is to the patient's benefit. If the baby is going to lose its life in this circumstance, then I would want to be very clear that there is a clinical benefit to the mother. To date, I can see none of that. That is my big issue with the heads of the Bill.

The other matter which I would like to deal with is the question of conscience, which Dr. Mary McCaffrey mentioned as well. I use the term "conscience" rather than "conscientious objection" because the latter implies that this is a problem. Twice in the past few months, as a doctor, I have been told that a doctor should leave his or her conscience outside the room. I would ask the committee to reflect on what it means if a doctor suspends his or her conscience faculties. Conscience is not a religious concept. If one sees somebody beating a child on the street and one continues to do one's shopping, then there is something wrong with one's conscience. It is an obvious thing. For example, if I decided to suspend my conscience with a patient on a waiting list and he offered me €300 to go up the list, then that is a very tempting, painless and invisible transaction which I am sure occurs in the political world. The only thing that will stop a practitioner-----

Deputy Regina Doherty: That is an objectionable statement.

Chairman: I ask Dr. Monaghan to withdraw that remark.

Dr. John Monaghan: I am certainly happy to withdraw it. I was not quite clear what the remark was. I was referring to myself only.

Chairman: Okay.

Deputy Bernard J. Durkan: It was a reference to bribery among politicians.

Dr. John Monaghan: I can assure members that was not my meaning, nor was it intended to be interpreted in that way.

In relation to the conscience matter, conscience has been under attack in the past five years or so in the medical literature. I have attached two articles on conscience to my submission - one hostile to and one supporting conscience. The Bill to be produced should recognise the importance of conscience rather than the importance of conscientious objection, on which I would be happy to answer questions.

In relation to head 19, it appears to be a significant endorsement of the constitutional position of the unborn in this country where it states it shall be an offence for a person to do any act with the intent to destroy unborn human life. I support this. As obstetricians would know, the problem in other jurisdictions is that children, or babies, are directly killed by injection or suction and evacuation of the uterus. I know that previous speakers have referred to this and said they do not see it happening in Ireland. Certainly, surgical termination, as it is called, is more dangerous than medical termination of pregnancy and the Act should specifically prevent doctors from killing a baby, where it is necessary for it to be delivered, directly before it is born, either by surgical means or lethal injection. I ask that this be specifically included in the Bill.

Deputy Caoimhghín Ó Caoláin: I thank each of the speakers and apologise to Dr. Burke that I was not back in time to hear his oral presentation, but I thank him for his written submission.

I am not directing my questions at anyone in particular, but I am anxious to learn from the witnesses if there are particular differences in their collective experiences because of their largely rural, non-Dublin city locations, as against those of the other witnesses we heard earlier. I refer to some of the questions we asked in relation to the situations that might apply. We presume obstetricians-gynaecologists not being registered on the specialist listing with the Medical Council would be something the witnesses would reflect also because they would have colleagues on the general rather than specialist listing. That is important.

In terms of a smaller number of professional colleagues, does this create particular situations, given the larger body of colleagues those from the major Dublin-based hospitals would have to call on? For instance, I refer to the issue of conscientious objection, to which Dr. Monaghan referred. Are there given situations where the witnesses may not have the complement of necessary professionals to make the evaluations? For instance, in relation to the risk of loss of life from physical illness, we are looking at two medical practitioners - one obstetrician-gynaecologist and other a medical partitioner in a specialist division. Is there sufficient professional cover on each of the hospital sites across the jurisdiction currently designated - the 19 within the proposed legislation - to comfortably ensure there will not be unnecessary delays and that the assessment can be made in a hospital where the woman is presenting and that there will not be a requirement for an examination at two locations on the part of the woman involved? Surely, the professionals would go to her at whatever hospital site she was located.

It was exposed to us when we spoke to the masters of the various Dublin-based maternity sites that they had no intensive care facilities within the three hospital sites. I put up my hand and said I did not realise that. Are there infrastructural difficulties which should be shared with us and on which we might be able to reflect because I have made the point that the passage of legislation is not only about what it says but also about the capacity to implement and that means resourcing?

I wish to ask about one particular issue which has not presented before, that is, the incidence of ectopic pregnancy. Again, I put up my hand and say I always thought an ectopic pregnancy occurred outside the womb, but it is all about learning, which is why we are here. Are the witnesses making a case to include this in the legislation? Will they elaborate a little on it? Do they accept that we have made no other such exceptions in terms of physical illnesses presenting? Might it not be covered? Would the witnesses' professional assessment be sufficient to determine whether a termination was required in the so-called 7% of cases that present a risk to the life of the mother?

Deputy Billy Kelleher: We are talking about smaller maternity units, but I presume a lot of the complicated pregnancies would be referred to the larger hospitals. Was there ever a time when a woman had to be referred to England for a termination because the professionals were unsure, because of a lack of clarity in the law, about continuing treatment or intervening to save her life where there was not an immediate substantial risk but a potential risk if she did not receive treatment?

I refer to the broader issue of resources. I know it is not part of the heads of the Bill, but it is critical if we are passing legislation which will immediately, or potentially, overburden maternity services. Dr. Sam Coulter-Smith feels the legislation, as is, could potentially overburden maternity services. Do the witnesses have concerns about this happening in the smaller maternity units throughout the country as a result of the legislation as it is constructed?

Deputy Seamus Healy: I apologise for the duplication of questions, but in this session we are dealing specifically with how the proposed Bill will affect the smaller and more rural units such as the one in south Tipperary from where I come. I seek clarification on the appropriate locations. I take it from what the witnesses have said the locations need to be broadened because there may not be psychiatric care facilities, for instance, on-site. For example, the unit in Limerick is stand-alone and does not have a coronary care or intensive care unit immediately available. What exactly are the witnesses saying in terms of extending the locations? Are there enough personnel available in the smaller units to actually implement the provisions set out in the Bill? If there are not, what other personnel might be needed? It has been suggested that in most of the units, one is talking about one in three or one person being available every third weekend. What difficulties are caused by that? The possibility of a local panel, a national panel, or both, has been suggested in relation to that.

I have a related question on how smaller units might be affected by conscientious objection. Could such objections result in personnel not being available in smaller units to undertake the provisions of the Bill?

I would like to revisit a question I asked in the previous session. Do the witnesses feel that the Bill, as currently proposed, gives adequate clarity and protection to medical personnel in their units?

Chairman: Does Dr. McCaffrey want to start?

Dr. Mary McCaffrey: I represent the second smallest unit. Clonmel is a little behind us. The questions asked by Deputies Ó Caoláin and Healy about smaller units are quite similar. I think we need to step back and look at the three indications which are outlined under this Bill. When we talk about the risk of loss of life from a physical illness in a medical emergency, we are looking at women who have severe infections, bleeding or severe pre-eclampsia. As I said already, sadly we deal with this every year in all of the small maternity units throughout the country. We deal with it appropriately and in a manner that is clinically appropriate.

Obviously, we all want more resources. In an ideal world, there would be no three-person maternity units in the country. That stance would certainly be taken by many senior obstetricians. We have three-person maternity units at this time. We deliver care to women in emergency situations. We deal with it adequately and appropriately. We link into our sister hospitals. Tralee General Hospital's sister hospital is Cork University Maternity Hospital. Some of our patients from north Kerry go to Mid-Western Regional Maternity Hospital in Limerick. We have access to the expertise from those places.

When a woman who walks in the door needs to be dealt with there and then, we have the resources to deal with her. Ironically, the maternity unit in our hospital has an intensive care neo-natal unit and access to a cardiology service in the town. We regularly do teleconferencing for non-maternity cardiology cases. The cardiology team sends down teams to look after patients who are not pregnant. Our resource is better, in many ways, even though we have a smaller maternity unit.

We were also asked about the risk of loss of life from physical illnesses such as cancer. Severe cardiac disease was the other example that was used. As a general principle, patients in those types of situations tend not to need immediate care within the next hour. We have access to the specialist care units in Dublin, Limerick and Cork. I think most small maternity units have appropriate links and are able to care for their patients. There are multidisciplinary cancer teams. There is an oncology team looking after each unit at this stage.

I am not here to speak for the psychiatrists. The committee will have access to them on Monday. The psychiatrists in my unit appear to think that they would not have the resources to deal with this and that additional resources would be needed. Ironically, it is not an obstetric resource in that situation.

Conscientious objection would never come into play when someone's life is in danger there and then. That has always been our practice at the time the woman is dealt with. Nothing will change in that regard. Obviously, we would expect every doctor to look after an acute medical situation. In a less acute situation, we would expect doctors to meet their requirements under the Medical Council guidelines. If they are not going to look after a patient, we would expect them to ensure someone else looks after that patient in a timely manner. I would be disappointed to hear there is any unit where a person would suffer due to a conscientious objection of all the staff. I do not think such a unit exists. We will always look after the life of a mother and the life of a baby.

I do not think I have missed anything that was asked about small units. We will keep saying we need more resources. I do not think any woman will suffer in a small maternity unit as a result of a lack of resources if this legislation is enacted.

Dr. John Monaghan: Deputy Kelleher asked about referring people to England for a termination. I have never referred anybody to England for a termination. I have sometimes referred

people there for medical or diagnostic expertise, but I have not done so for a termination. I know that women are referred there for treatment or delivery in cases of congenital malformations, but such cases are not the subject of this legislation.

The Deputy also asked about the overburdening of the maternity services. Our unit at Portiuncula Hospital delivers approximately 2,200 mothers a year. We might encounter one or two cases of serious maternal illness where the pregnancy has to be ended. I think the figure given for the Dublin hospitals was 30 a year. Such cases do not overburden the maternity service. If a patient has a very serious fulminating pre-eclampsia, for example, she might need to be transferred to a tertiary unit in Galway or Dublin. There may be problems with the transfer if there is overcrowding in the tertiary centre. I do not envisage that this legislation will overburden maternity services significantly unless there is an explosion in the number of terminations of pregnancy under psychiatric or self-destruction grounds.

Deputy Healy asked whether psychiatric services are located alongside maternity services. In the rural system, there might be a maternity or general hospital in one town and a psychiatric hospital in another town. In practice, almost all of the rural maternity units are in close proximity to a psychiatric department. I am afraid I did not understand fully the question about the central location of personnel.

The Deputy also asked about conscientious objection. As Dr. McCaffrey said, if one is prepared to allow a mother to die, one is guilty of very serious professional negligence. There has been no maternal death in my hospital, or death of a woman who was transferred out of the hospital, for 29 years. I am sure that is the norm throughout the country. It is not true that the conscientious refusal by obstetricians to offer necessary treatment which might involve termination of pregnancy is leading to maternal deaths. I am sure it has been pointed out already that this country's maternal mortality rate has always been significantly lower than the rate in the UK, regardless of the figures one uses. Similarly, the maternal mortality rate in Northern Ireland, where the UK Abortion Act does not apply, is lower than the rate in the rest of the UK. I do not think conscientious objection could be considered to endanger women's lives in any way. We do not know where conscientious objection would arise in psychiatric cases. I do not know how an obstetrician would deal with an emergency precipitated by suicide. I cannot imagine that scenario.

Dr. Máire Milner: I want to make a comment about the development of networks around the country. It has been proposed that hospitals would work with a larger centre. In our own instance, the Rotunda Hospital would work with Cavan General Hospital and Our Lady of Lourdes Hospital, Drogheda. In fact, this works very well. Quite a lot of service development is currently ongoing. A huge amount of support and back-up is available from regional centres. This is taking place and being rolled out around the country. This helps greatly as a means of support.

Dr. Gerard Burke: I shall first mention the psychiatry cases as there is a lot of hysteria about the matter. In my career I have never encountered a patient who was suicidal and was brought to me to discuss a treatment that might include a termination.

Chairman: I ask the witness to talk into the microphone so that people can hear him.

Dr. Gerard Burke: This has never happened in my career and I do not expect that it will. The numbers are so small, most of us will never see this in an entire career.

The idea that you would have a patient arriving into your office with two abortion tickets from random psychiatrists is nonsense. That is not the way that medicine works. We would have a working relationship with the psychiatrist. If you did not know the psychiatrist and did not trust them you certainly would not be doing anything near terminating a pregnancy. The institute has made a suggestion in this regard, there would be a second obstetrician involved and I would support that. I can tell you, there are very few of us in the country - 125 consultant obstetricians - and we are not beholden to psychiatrists telling us what to do. We have to do this procedure ourselves so we are going to be absolutely certain that it is thoroughly justified, medically and ethically. That is the way medicine operates.

In regard to Deputy Ó Caoláin's question on whether Limerick is different, Limerick has 5,000 babies and eight obstetricians so it is more like Dublin and Cork. We do not have the problem of small numbers. We have the entire range of sub-specialty facilities available. I would say that when there is any question of a maternal death, the entire resources of the hospitals are wheeled out to deal with that woman. It goes to the top of the priority list, as you can imagine. They are taken extremely seriously. Cardiologists etc. would drop everything to deal with a thing like that.

In regard to resources, we have very few obstetricians. When the country was awash with imported money a few years ago not a red cent was voted to improve the resources by this House. The Deputies were aware of the issues because the numbers were well known but not a red cent was put into maternity services.

With regard to the question of an ectopic pregnancy, this happens in about maybe one in 2,500 cases so we will see a number of cases. In my unit we will see two every year. They are extremely difficult to deal with. They are one of those issues that could come under this legislation. We do not refer people to England for terminations but a lot of our patients, in difficult circumstances, elect to go to England for a second opinion. Of course, we have a responsibility to make sure, if they are critically ill or unwell, that they do not go to an inappropriate place. They would be pointed in the right direction of where they could get top class care in a university type hospital with a full foetal maternal medicine service. We do not have data on this, in terms of numbers, but certainly it is not extremely rare.

A conscientious objection would not arise in my unit. There are eight of us and I do not think there will be any difficulty about providing opinions and care.

Is there adequate clarity? The one issue that I would bring up is that I think you, the legislators, should determine what is meant by a real and substantial risk to the life of the mother. I think that is your job but because we cannot put numbers on it, because we do not have data, because things change over time, because the timeframe is very unclear, because the dates in the literature are very unclear, and we often only have our expertise, experience and knowledge to work with, I think it would be beholden of the Deputies here to sign that job over to the obstetricians and the other medical experts. I think that should be specific in this piece of legislation. You can trust us in this regard. The people who are in at night and at the weekend dealing with haemorrhages and heads that are impacted, we are not waiting in the long grass to start doing terminations. That is not the way we operate. I think that the Oireachtas can trust the medical profession that it is going to do its absolute best to save every single life. That is what we do, day and night.

Deputy Ciara Conway: I thank Dr. Burke for his comments and he summed up the debate very well.

I come from Waterford which is a small service - it might dispute that - but I mean in comparison with the ones that we heard about earlier today. I would like to clarify the following matter. If a woman has a pre-existing medical condition is it most likely that she will be referred to Dublin or the specialists? The super specialties cannot be in every hospital. They are in Cork University Hospital or one of the specialist hospitals in Dublin. Is it not good practice for a woman with a cardiac problem, regardless of whether she is pregnant, to be sent to the most senior cardiologist to get whatever specific care necessary? A pregnant woman should also enjoy such specialist care. Is that the current practice in small hospitals? My feeling is that it is but perhaps it is worth saying.

I want Dr. Monaghan to clarify a matter. He said that maternal deaths were higher in the UK and he asserted that this is directly linked to the fact that abortion is available in the UK. Is that what he said? I am not sure about the correlation. If I picked him up wrong, I apologise. However, I would appreciate some clarification on that point.

Senator Jillian van Turnhout: Deputy Conway has asked my question on specialists.

This morning we heard from the Irish Medical Council and the Institute of Obstetricians and Gynaecologists. The institute, in particular, suggested that heads 2 and 4 should be merged because it does not differentiate in terms of logistical arrangements between physical or mental reasons for considering a termination. They did agree that maybe the number of specialists involved in the different decisions would vary but that they should not be differentiated within the Bill.

Dr. Monaghan rightly explored with us the complexity of some cases such as oncology and said that each case would be very different. My understanding is, and I was a little concerned with some of the comments made, that psychiatry is a medical specialty and psychiatrists are qualified doctors. However, I know that we will explore the matter more on Monday.

Let us examine the resource issues and availability, especially locally, out-of-hours and during holiday periods. I shall try to put myself in the position of a woman who is in a place that none of us wants to be in, whether it is a physical or mental diagnosis that she has received, what help can she receive from the locality? Will she be referred to Dublin? With regard to the time limits stated in the legislation, are the specialties available in a local area? Will she be referred to a larger unit?

I fully respect conscientious objection and it is important. Do we need to consider, when we are examining geographically appropriate locations, whether we will have an adequate number of professionals employed who have not declared a conscientious objection?

Deputy Regina Doherty: I had looked forward to hearing the contributions this afternoon because there was some genuine concerns raised with regard to how the process would be carried out differently in some of the smaller hospitals around the country versus some of the larger hospitals in our cities and in Dublin. The delegation addressed the matter but raised more concerns for me after two of the witnesses this afternoon addressed certain things. Dr. McCaffrey spoke about introducing a new medical procedure and by so doing said we would have to ensure that there was specific training provided. Dr. Monaghan talked about the difference between a surgical termination and a medical termination. Now I am confused. The very clear message we got this afternoon from the three masters of the maternity hospitals who attended earlier was that this is about the protection of life of both the mother and, in all cases except the worst, of the life of the baby. In my head, surgical termination does not come into that equation.

In my head, that is not the introduction of a new procedure into Ireland. It is doing something Dr. Monaghan says we are already doing on a weekly and monthly basis and something Dublin hospitals say they already do in terms of medical interventions anyway. Can Dr. Monaghan clarify for me if there is a variance in practice or in the perception of what the uniformity of practice might be, or is it the case that I am picking up what he is saying incorrectly and as something different from the determination of the three masters who spoke this afternoon as to how they see things panning out if the legislation is passed?

Dr. John Monaghan: On Deputy Conway's question about smaller hospitals and specialists, most hospitals probably have between three and five physicians, that is, medical people, who would generally cover one specialty each. The commonest arrangement might be to have an endocrinologist, a cardiologist, a gastroenterologist and, perhaps, a respiratory physician. Roscommon Hospital, which is near Ballinasloe, has a respiratory physician but there is not one in Portiuncula. There is a cardiologist in Portiuncula Hospital. That would be the arrangement. In the case of a serious medical problem, such as a woman with a major heart disease, a local assessment would decide the severity. There are many patients with mild cardiac disease being managed in local hospitals, and then the move to transfer them would be made. I do not think there has ever been a problem with referral or obtaining expertise. I referred earlier to the cancer problem, which I thought was different from cardiology. One finds cardiology expertise in Galway and Cork, and specific skills would not be required for the management of pregnant women. If surgery were required, it would not be that much different. I do not know if that is helpful on the specialist question.

I was asked about maternal deaths. There has always been a difference, as is well known, between Ireland and the United Kingdom. The question was whether this was because of abortion. I am not suggesting it is because of abortion, but I suggest that if abortion was a significant factor in the improvement of maternal health, the figures should be better in the United Kingdom than they are in Ireland, especially given that a very large number of terminations are done in UK. I suggest that the results should be better in the UK than they are here if medically mandated abortion improves women's health.

A related issue which I have studied slightly myself is the problem with recruitment into obstetrics and gynaecology in the United Kingdom for the last 35 years. The matter is well written up in the reports of the Royal College of Obstetricians and Gynaecologists. Another study which was published in the *British Journal of Obstetrics and Gynaecology* showed that recruitment into obstetrics and gynaecology was highest in Northern Ireland and lowest in places like Leeds and Oxford. Certainly, Dr. Jim Clinch, who was one of the doctors who was keen to come today but could not, is of the opinion that if an abortion culture becomes widespread, it seriously affects recruitment into obstetrics and gynaecology. That would have been my experience. I worked in the NHS for three and half years in total. Certainly, in my time in the north of England, I used to speak to medical students and ask them if they would consider a career in obstetrics and gynaecology. During the two years I was in the north of England, no student said he or she was interested in a career in obstetrics and gynaecology. When asked the reasons, fear of being sued and a hard-working rota were cited, but the single biggest factor was that students did not like the abortion culture, not for particularly ethical reasons but because it was distasteful to them.

I was asked about psychiatrists as qualified doctors. I cannot second guess psychiatric expertise, but I do not think psychiatric expertise around the country is different to the expertise in the city. Much is made of the availability of perinatal psychiatrists and I am not sure that is

as important as has been stated.

Dr. Máire Milner: Deputy Conway asked about surgical termination as referred to by Dr. Mary McCaffrey. This is very similar to a procedure we employ for miscarriage. Absolutely, there are issues. While I am not sure a consultant would have to retrain, things will depend on the circumstances. This is not in any way going to be a very common scenario and it does not introduce hugely difficult technical or logistical difficulties. Surgical termination is a procedure that is employed every day in some hospitals. It depends. There are now many ways of dealing with miscarriage where the uterus has not started to empty itself. We are talking here about where a woman's life is in danger, which means one is often talking with someone who is very ill. Sepsis, which we have all been hearing about from the case in the media, is often occasioned by the rupture of the membranes and the pregnancy is, therefore, already starting to evacuate itself. It is similar with severe pre-eclampsia or haemorrhage. Very often, the haemorrhage is coming from the uterus which is emptying itself anyway. I do not think there is a huge concern about technical difficulties. I do not know if I picked up the Deputy's question correctly.

Deputy Ciara Conway: If I am correct, Dr. Milner is saying that the difference between a surgical and a medical intervention is that a surgical intervention means conducting a D and C whereas a medical intervention means-----

Dr. Máire Milner: Giving tablets.

Deputy Ciara Conway: -----delivering the baby and trying to save it.

Dr. Máire Milner: No. Very often, we use medication in early pregnancy where women have a missed miscarriage. This is an everyday procedure happening several times a day in our maternity hospitals. Very often, when one approaches this medically, one still ends up in theatre as parts of the pregnancy are still left inside. One can use medical or surgical means early in pregnancy. After 12 weeks, it is probably much more likely one will use medical means due to the size of the baby's limbs and the size of the head and so on.

Dr. Mary McCaffrey: I will deal first with the issue of pre-existing medical conditions. More and more women in the reproductive age group have pre-existing medical conditions who heretofore either may not have been alive or in a position to be pregnant. There are many women who had cardiac surgery as children who will already be under the care of a cardiologist. It is absolutely hard to believe that they would be managed anywhere other than at a tertiary referral unit. For example and as I mentioned in January, the Coombe Women's Hospital has a very specific clinic where it looks after medical problems in pregnancy. They liaise with various specialties. The question the Deputy is asking is whether we refer people on to centres with special expertise. Certainly I do and I am sure most colleagues do. Women are also very well informed now and women who have come from a clinic like that where they have been with a cardiologist since they were two or three years of age will be very well versed in the risks to them in terms of their pregnancy and will already know they need to be under specialist care.

On access to psychiatry at weekends, a woman who is pregnant is no different from any person who walks into an emergency unit at the weekend who is seriously ill, be it with a psychiatric illness or otherwise. Every unit that has a psychiatric service has 24-7 psychiatric care. Whether a person is male or female, pregnant or not, he or she is assessed. The service kicks in immediately as does the liaison team. I am not sure what the right answer is to whether people should declare conscientious objections in advance. It would be disappointing if people were discriminated against and disadvantaged. The situation will be extremely rare.

With regard to training for new procedures, when I was collaborating around the country this was an issue brought up by a person who felt the institute and the Medical Council should ensure people were versed in the types of procedure and at what gestation one would do a surgical rather than medical procedure. It is really more about guidelines and ensuring everyone is appropriately trained to manage the situation. Managing a miscarriage is slightly different to managing what will be a live child after 12 weeks gestation. It is important to have guidelines that people are aware of. We see people back from the UK with complications from termination. This is in a country where people are trained. In the same hospitals in the UK, some will have operations and some will have medical procedures. It is important to have training, consistency and guidance for clinicians because there will be occasions where doctors will be employed who have never been exposed to these kinds of procedures before.

Dr. Gerard Burke: With regard to Deputy Conway's comments on Waterford, her clients in Waterford are probably in a better position than many clients in Dublin because the patients in Waterford with cardiac disease will be delivered in a hospital with an intensive care unit and a coronary care unit. I discussed this matter with Professor Fionnuala McAuliffe earlier in the week with regard to a patient I delivered on Wednesday at the regional hospital with cardiac disease. There was no point sending the patient to Holles Street because they would have to bring her to St. Vincent's Hospital. This is a resource issue. This is the Joint Committee on Health and Children and it behoves members to do something about the state of maternity services. It could be solved quite easily and we could build four new maternity hospitals relatively cheaply if we issued a new tranche of the national solidarity bond and called it maternity bonds. It would solve the problem for relatively little investment.

Chairman: We will tell the Minister for Finance.

Dr. Gerard Burke: The other issue is a new medical procedure but I do not think it is a new medical procedure. If people feel they were inexperienced, transfer is an option. I agree with the institute that psychiatric illness is an illness, the same as any other, and it is reasonable to merge heads 2 and 4.

Chairman: We have five committee members left to speak.

Deputy Peter Fitzpatrick: Deputy Regina Doherty asked a question I was going to ask. Fair play to her. I asked all the questions I had to ask in session 3 but I will repeat one question about which many of my constituents are concerned. Are the witnesses satisfied the proposed legislation will provide for mandatory care of newly-born children resulting from later stage termination in order to vindicate their equal right to life in the Constitution?

On the list of smaller hospitals, I see Our Lady of Lourdes Hospital in Drogheda, which the people of Louth call a big hospital.

Chairman: The list refers to other hospitals, not small hospitals.

Deputy Peter Fitzpatrick: It is doing a fine job.

Deputy Denis Naughten: I refer to Dr. Gerard Burke's evidence. He flagged an issue flagged in January, which is how to define a real and substantial risk. He referred to it on a number of occasions. Last January, Dr. Rhona Mahony, master of the National Maternity Hospital, raised the specific concern of whether a real and substantial risk is 10%, 50%, 80% or 1%. Interestingly, the evidence of Dr. Gerard Burke contradicts the evidence of Dr. Rhona Mahony earlier. She believes the legislation provides clarity. I do not believe there is but Dr. Gerard

Burke could comment on her evidence.

In Dr. Tony Holohan's evidence, he said that there may have been women who had early deliveries due to suicidal ideation. Although two of the witnesses were asked twice, they did not answer that question. I ask the four witnesses whether they have experience of early delivery based on suicidal ideation. Has it happened within their facilities?

We are anxious to have smaller units present to indicate whether there are different implications for smaller units in respect of this legislation. Subhead 1 defines the appropriate location. With regard to Dr. John Monaghan and Portiuncula Hospital, the facility must provide obstetric and mental health services. That is quite close at the moment, with Portiuncula and an acute unit in St. Brigid's Hospital in Ballinasloe. There are two acute psychiatric units in the Roscommon-Galway services, one in Ballinasloe and one in Roscommon. One of these will close in the not-too-distant future. If the one in Ballinasloe closed, would that have implications on the delivery of the service? I ask the speakers from smaller hospitals if they have specific concerns regarding the implementation of the legislation and the definition of appropriate location when they consider the traditional agenda within the HSE to remove the smaller units. A HIQA investigation is ongoing and we do not know what recommendations are going to come of it. Have the witnesses any fear the legislation could be a Trojan horse?

There are normally three consultants in smaller units. Do the witnesses fear that if the three consultants had a conscientious objection to carrying out procedures and one was to retire, there would be an agenda to ensure a new consultant does not have a conscientious objection and would be recruited on that basis?

Are the witnesses satisfied with the neonatal emergency transport service available to them? Will that be adequate in future? Are the witnesses satisfied with the existing level of psychiatric support for pregnant women?

Deputy Mattie McGrath: I welcome and thank the guests. It is a relaxed session and I find it beneficial. The submission from Dr. Gerard Burke says it is unwise to attempt to produce a prescriptive legislative framework to cover all eventualities. Are clinical guidelines preferable and does legislation run the risk of being overly prescriptive? The witnesses make no reference to head 4 in the submission. Is termination of pregnancy justifiable on the grounds of the mother's threat of suicide? Will many of the witnesses' colleagues have concerns about it?

Resources have been mentioned all day. With the conscientious clause and the risk of having to employ dozens more people in the profession, we will not see our children's hospital built until 2050. The date was put back to 2017-----

Chairman: Deputy Mattie McGrath should stick to the heads of the Bill.

Deputy Mattie McGrath: I am sticking to the heads of the Bill. I am making a comment outside of the Bill as a member of the committee.

Chairman: I am being impartial and fair to everyone.

Deputy Mattie McGrath: The Chairman can be more fair to some than others. I am asking that the Chairman allow me to make a brief comment, within my time, as a member of the committee. Resources are a major issue and have come up all day. Where will we get the resources if and when we pass the legislation?

Senator Jim Walsh: I compliment the four obstetricians and thank them for their forthrightness. It is refreshing. We have been homing in on suicidality, which is an area of concern for many. It is quite a subjective area. Could the witnesses comment on the recording of the data, under the heads of the Bill, which only goes to the Minister? We have asked this of other witnesses. It should be done in a manner that is crystal clear, so we know precisely why and in what circumstances it was the only treatment on offer, and this could be reviewed publicly. Will the witnesses give us information in that regard and whether that type of information, with the names retracted, should be available under freedom of information?

Dr. Mary McCaffrey mentioned the conscientious objection issue and, in particular, people opting out. That is a concern if people of a particular disposition exclude themselves from the panels. As we have seen in the media over many months, the medical profession have people on both sides of this argument so the outcomes could be skewed as a consequence. I wish to link that with the comments about the lack of resources which have been made by all the groups appearing before the committee. Resources often lead to shortcuts being taken. Therefore, while it might start in a very thorough fashion, as happened in other jurisdictions, that will change within a short space of time.

Dr. Máire Milner welcomed the Bill and said it gives clarity. Dr. Rhona Mahony also welcomed it for the same reason. However, when Deputy Creed put a question to her about identifying in the Bill where she got that clarity, she was unable to pinpoint the areas. Can Dr. Milner point to the sections in the heads of the Bill which give her the comfort of that clarity?

Chairman: Thank you, Senator.

Senator Jim Walsh: I still have a minute.

Chairman: You do not.

Senator Jim Walsh: Finally, I have a question for Dr. Monaghan and, indeed, all the witnesses. Has there been any case in their experience where they have been so inhibited by current legislation that they were unable to deal with a mother whose life was at serious and substantial risk? Previous speakers were asked that question and only one case was cited, which was the recent case in Galway. I understood the coroner said in that case that, in fact, it was different issues rather than the legislation. Are any of the witnesses familiar with that case to shed more light on it?

Senator John Crown: I welcome our colleagues. It has been a long, gruelling day. We have a couple more ahead of us and it is great that we have heard such a spectrum of opinions. I must give a slight preamble before the question.

Chairman: I wish you would not do that.

Senator John Crown: I must. Sometimes my colleagues here miss one point, which is that in western countries maternal mortality is an extraordinarily rare event. In Ireland in recent decades we have had entire years with no maternal mortality. The occurrence of one maternal mortality is a disaster. If we have to legislate to prevent one maternal mortality, we should do it. This is not like cancer or heart disease mortality, where there are thousands of deaths per year. This is different and we must treat it differently.

In the previous hearings, I got to the crux of the matter by putting the Dublin folks through a detailed interrogation. We worked out that, although figures are not kept, there are approxi-

mately 30 abortions per annum in Ireland within the legal parameters of our Constitution, that is, to preserve the life of the mother. They reckoned there were six to eight in each of the Dublin maternity hospitals and, with a little extrapolation, that is what we reckoned to be the probable total. I have asked some of my colleagues about this and my understanding is that the great majority of these will be for cardiovascular complications, blood pressure emergencies, renal failure emergencies, occasionally haemorrhage and sometimes cancer.

Incidentally, in a long career of practising cancer medicine I have never had to send anybody for an abortion to save their life. It is not typically the way it happens. Many of my patients have made a decision to have an abortion and I have supported them in their decision, but I have never said to them that they need it to save their life.

Of the 30 cases per annum, the great majority will fall into the categories I outlined. My best guess, and I ask my colleagues to comment on this, is that in the majority of those cases it is not a sudden, out-of-the-blue event where a previously normal healthy pregnancy suddenly deteriorates. There is usually a warning - the woman has had pre-eclampsia, which is a blood pressure and kidney problem occurring in pregnancy, or it is discovered that the placenta is dangerously misplaced or that there is cancer-----

Chairman: Thank you.

Senator John Crown: One second, Chairman. I have not interrupted anybody today and I have tried to stay within my time, so just hear me out.

My understanding is that in the great majority of cases there will be warning, so the scenario of this type of occurrence occurring in one of the smaller hospitals is very unlikely because the hospitals will generally refer the patients to one of the larger, specialist units at an earlier stage in their pregnancy where they will be cared for by the high risk people. In those rare cases where it will occur in the smaller hospitals, it will be category one or the emergency. It is the one where the patient is either bleeding or dying of abnormal blood pressure, the doctor cannot consult, there are no psychiatrists and the patient is not suicidal. The doctor sees a woman whose life will drain from her body in the next few hours if they do not end the pregnancy, something which is very rare. That is my understanding of the only cases the witnesses will see. Is that the case? Should anybody have a right to conscientious objection in that setting? If they do, they should not be in that job.

Chairman: The final speaker in this section is Senator Aideen Hayden, who is replacing Senator John Gilroy for this session.

Senator Aideen Hayden: I thank Dr. Burke, Dr. McCaffrey, Dr. Milner and Dr. Monaghan for a really interesting session. As one of the witnesses mentioned, medical treatment is evolving and what we want is robust legislation that allows medics to do their jobs in the future. That is the bottom line. That includes mental health and mental health treatment. I have some specific questions about the heads of the Bill for all of the witnesses.

With regard to head 1, appropriate location, do they have a view on the designated hospitals or do they think that list should be extended to cover all approved hospitals?

At present, the definition of the unborn makes no allowance for where a foetus has no prospect of survival or, indeed, is already dead. Do the witnesses think we should consider changing the definition of "unborn". Dr. Burke has already given his opinion on heads 2 and 4 and their amalgamation. Do the rest of the witnesses have a view, given that the Medical Council

and the Institute of Obstetricians and Gynaecologists have indicated that it would be useful to merge them on the basis that they go to the crux of the issue, which is a threat to the health of the mother in pregnancy?

With regard to the requirement in head 4 for two psychiatrists, a view has been expressed that this might be unduly onerous, particularly depending on where one is located in the country. Ironically, it might be more difficult to comply with that requirement in Dublin than it might be in other locations. As Dr. Burke said, one might be less well served in Dublin than one might be in other parts of the country. Is the requirement for two psychiatrists unduly onerous? More importantly, is it unduly restrictive in requiring one of the psychiatrists to come from one of the hospitals that have been nominated for the purposes of carrying out a termination?

As regards the provisions under heads 6, 7 and 8 and the timescales provided, do the witnesses believe those timescales are workable or could they be further reduced?

My final question is about the penalty of 14 years imprisonment provided for under the legislation. Do the witnesses have a view on the severity of that penalty?

Chairman: Deputy Kelleher indicated he had a question.

Deputy Billy Kelleher: Have the witnesses ever encountered a case, either through peer discussions or in their own facilities, where they felt they had to refer a woman to England because they were unsure within the current parameters of the law, in order to provide treatment when she returned? In other words, she would not be able to get the treatment until such time as a decision had been made on that. Perhaps they will clarify that.

Dr. John Monaghan: On the last question, I said "No" earlier.

I am getting a little confused, Chairman, due to the number of questions. The first one I have noted is on the care of newborn children. Was it about the care of newborn children who were born following a termination of pregnancy?

Deputy Peter Fitzpatrick: Is Dr. Monaghan satisfied that the proposed legislation will provide for mandatory care of newborn children resulting from a later stage induction in order to vindicate their equal right to life under the Constitution?

Dr. John Monaghan: On that question, one would have to separate the physical illness from the psychiatric component. With physical illness, one may be forced to deliver the baby because one has to do it. Simply, the baby could be born at 20 to 24 weeks; it has to be done. The psychiatric component is unknown. The question has arisen as to whether one could care for the woman until the baby had reached a certain stage of viability. It has been suggested if a child is delivered at 23 or 24 weeks and survives, because of the age at which it is delivered, it is significantly more likely to be handicapped by cerebral palsy or blindness or suffer from another serious life-long disability. I could not say anything more than that on that question.

On the real and substantial risk and the obstetrical element of impending serious maternal illness, an experienced clinician knows a real and substantial risk. Decisions on the medical complications involving cardiology, cancer, etc. are often multidisciplinary and an experienced clinician would know the answer intuitively. The only question to which the answer is unknown is that of suicide. I cannot comment on it.

Deputy Denis Naughten referred to the subhead on obstetric and maternal health and the

closure of a psychiatric unit. I would not be able to tell whether the closure of a unit in Roscommon, for example, would affect the unit in Ballinasloe or *vice versa* in terms of the availability of services. There is a centralising tendency within the HSE and, in the past 15 or 20 years, hospitals have gradually been run down. Dundalk, Monaghan and Roscommon are examples. I do not know what the effect from a psychiatric point of view would be. As I said, I am not a psychiatrist. If a problem proves to be an important medical one, the nearer the psychiatric help is to an obstetrical unit, the better. The question on appropriate locations and the removal of smaller units was the same.

Senator John Crown asked about maternal mortality, which he said was exceptionally rare. It is clear that the rate of maternal mortality is rising and has been for approximately the past ten years in the United Kingdom, Denmark, Canada and the United States. There is little evidence that it has risen in Ireland, but I do not think we can tell as yet. There are multiple reasons for the trend. The major one in the United Kingdom has been sepsis, or infection, in addition to increasing maternal age and higher rates of multiple pregnancy. There are many reasons. One component may be training and the care of pregnant women.

On the question about it being sudden or not sudden, it is correct to say many situations of termination of pregnancy in a rural unit would arise on a Sunday afternoon when somebody arrives in suddenly having seizures, in which case the baby has to be delivered immediately. Regarding whether one can extrapolate from this to take in the suicide question, I am not going to answer and I am not capable of answering. As I stated, it is a matter of grave concern to me.

Consider the question of having a right to conscience in a smaller department or rural unit. As I said, there is no evidence that conscientious objection has led to any maternal death. Senator Jim Walsh asked about the case in Galway. Certainly, there was no mention of the word "conscience" in the inquest report, which I read.

Deputy Denis Naughten: Has there been any case of early delivery on the basis of suicidal ideation in Dr. Monaghan's unit?

Dr. John Monaghan: It was never the case in my experience. I do not know of it ever having been an experience.

Dr. Máire Milner: Let me take the final point, on suicide. There were several questions on suicidal ideation and the termination of pregnancy at very early, intermediate or late gestations. We were asked directly whether we had had such a case. Psychological and psychiatric problems are very common in obstetrics nowadays as life is tough for a lot of people. We deal all the time with mental health issues. A question was asked about psychiatric support and whether it was adequate. We do not just go to the psychiatrist for psychological or psychiatric support; it is inherent in what midwives and obstetricians do. All members of the team are involved in supporting women.

With regard to delivering in the circumstances in question, it would be common to induce labour a week or two before, or usually within the ambit of, full term. Occasionally, it is slightly earlier on the grounds of mental health. Suicidal ideation is probably more common than we think because most people contemplating suicide do not tell anyone this during pregnancy. As far as we know, however, it is very rare.

Personally, I have had one or two cases in which a woman was in a psychiatric hospital for a condition directly related to the pregnancy. One woman almost died on her first attempt at

suicide, but it was never related to the question of terminating pregnancy. It never came up. She absolutely wanted to have her baby; it was the hormonal effect that was in question. The Bill is about the threat to the life of the mother by suicide or physical illness. It would be very rare, but, as with everything, one will see everything in one's practice if one lives long enough.

With regard to the comment made by Senator John Crown on what we are going to see, I do not believe we see anything different in our practices from what is seen in Dublin. We see fewer of the most difficult medical cases. We may not have as many women with congenital heart disease or who are having cancer treatment in pregnancy. We have a lower concentration, but we see the entire gambit. Often, as Dr. Monaghan says, what one must deal with is what turns up on a Sunday afternoon. We are not exactly in a different category; we are dealing with the same spectrum.

I have never referred to the United Kingdom from the point of view of worrying about a woman's medical condition, or in terms of having concerns for her future during the pregnancy. Personally, I have never had to do that, nor has it come into my ambit of practice.

On the question of where I can find clarity in the Bill, I am not a lawyer. I have simply read the heads of the Bill. In several situations in my career I had a worry at the back of my mind about a woman who was very sick with sepsis, in circumstances very similar to those in the Galway case, and I had hoped nature would deal with it. In fact, that is what happened, very happily. Nineteen times out of 20, nature does deal with things, but, unhappily, it does not always do so. For me, my patients and the staff on my team, the Bill gives my practice more clarity. I note this from having talked to my colleagues.

On the conscience clause, I again refer to the comments of all of my colleagues. First and foremost, we save the woman's life. We do not set out to terminate a pregnancy, but one does what has to be done to save the woman's life. There may be time to play with and one's conscience can come into that in some way. It is as likely to be one's skills as one's conscience that will come into play. As Dr. McCaffrey said earlier, if one does not feel one is able to deal with something, if one has time to play with one can refer to another colleague. The woman has a right to life, and that is the primary right. I have dealt with most of the questions.

Dr. Gerard Burke: My colleagues have dealt with a lot of the issues. I will again refer to the substantial risk and what its size may be. A figure of 10% was mentioned as the smallest one. If, over the next six months, 166 Deputies and 60 Senators were told that 10% of them, or 20 Deputies and Senators, would be dead by the end of that period, nobody would be in this House today. If we reduced the risk to 1%, two Deputies or Senators would be gone. I do not know which two it would be. That is the ridiculousness of trying to put a number and percentage on risk.

We do not know the numbers. When a complex patient comes along one cannot go to the medical literature and figure out the woman's exact percentage risk of dying if she is still pregnant next month or the month after. We simply do not know. The only way to deal with this is to say that the matter is for the opinion of the medical experts. I request that Deputies write that statement into the Bill, namely, that it is a matter for medical experts and the guidelines of committees that will oversee the legislation at hospital level.

In regard to the number of maternal deaths, infection is a particular factor that creeps up on one out of the blue. One does not see it coming. A patient who has ruptured membranes could be very well one day and have very mild signs of infection but could be extremely ill 24 or 48

hours later. My understanding is that there was a significant rise in the number of maternal deaths in Ireland last year. We have a low base, but it is possibly only a statistical chance. We would not be able to say there was a trend unless we had seen the figures for three years or so.

I agree with Senator Walsh that we should have much better data collection nationally on every aspect of medical care, not just this. It should be done so that everybody is clear what the effects of the interventions are; about that there is no doubt.

I answered Deputy Kelleher. I have never referred anybody to England for a termination.

The question of appropriate locations was again raised. There is a strong view from all of us that it should include general hospitals. I also agree that psychiatric illness should be treated in the Bill in the same manner as cardiac or respiratory disease. It is a real illness and carries substantial mortality. It needs a multidisciplinary approach, the same as one would get if one had a heart problem.

Deputy Seamus Healy: I asked about early deliveries on the basis of suicidal ideation in Limerick.

Dr. Gerard Burke: Mental illness is commonplace, as are other factors such as drug abuse. If we have a patient who is very difficult to manage due to psychiatric illness or drug addiction, and perhaps has some suicidal ideation, we will try very hard to get her to term - that is, 37 weeks - in order that the baby does not suffer from the effects of immaturity. Some patients develop medical problems which may necessitate early delivery. We would try to care for the patient very carefully until she got to 37 weeks, and thereafter.

Dr. Mary McCaffrey: The reason things worked best with me going last is that Senator Walsh directed a question to me and I did not get a chance to write it down. Can he repeat it?

Chairman: I am sure he would. He is not shy about talking.

Senator Jim Walsh: Dr Burke mentioned that conscientious people can opt out. If they opt out of the panels, given that politicians and medical personnel can be broken down onto one side or the other-----

Dr. Mary McCaffrey: I have it now.

Senator Jim Walsh: -----that might skew the outcomes because of the particular opinions of individuals involved. There is also the question of a lack of resources giving rise to a short-circuiting of the system. In other countries, all procedures were fully followed at the start, but within the space of 12 months people were taking shortcuts and notes were being left at reception already signed. A lack of resources generally gives rise to such developments. Do the witnesses know, in regard to the Galway case, whether a lack of resources-----

Chairman: We are not-----

Senator Jim Walsh: Dr. Boylan put on the record that in one instance that he knew of-----

Chairman: Sorry, Senator-----

Senator Jim Walsh: Or the lack of legislation-----

Chairman: I ask the Senator to take his seat. He is straining again.

Senator Jim Walsh: Is that true or untrue?

Chairman: To be fair, when Dr Boylan made that remark this afternoon I asked him not to reference it.

Dr. Mary McCaffrey: I thank Senator Walsh. Ironically, I thought about conscientious objection before I came to the committee today, and how the panels would be put together. As I understand it, the personnel who will go onto the panels will be nominated by the various institutes. Obviously, that will be the role of the institute, and it would be nice if there was a balanced approach as to who was on the panels. That would be important.

With regard to the possibility of a baby surviving because he or she was born on the cusp of viability, in the three Dublin maternity hospitals as well as Limerick and Drogheda there are neonatal units on-site. We would be mindful in smaller units that if a woman's pregnancy was going to end in that scenario she would be transferred to a place where full neonatal facilities were available for a baby that could possibly survive outside the womb.

I want to be quite clear about something which has not been said. It is illegal for a doctor in this country to refer anyone to anywhere for termination of pregnancy. It is almost unfair to ask us whether we have referred patients because-----

Senator Jim Walsh: I did not ask if you referred-----

Dr. Mary McCaffrey: We have never referred women because it is illegal to do so.

I find it difficult to see how the timeframe could be narrowed any further. A period of seven days is really tight. In an ideal world, one would try to get it as close as possible. A period of five days might be aspirational. There are weekends and panels have to be put together. It would be really difficult.

Merging the heads of the Bill in regard to medicine and psychiatry makes absolute sense.

On Senator Crown's comments, we may be very unlucky in smaller units, but cases always seem to happen on a Sunday afternoon and come out of nowhere. People do present seriously ill with pre-eclampsia - fulminating pre-eclampsia - out of nowhere. Women do present with sepsis. I know of cases in which people have come in seriously ill. Antenatal care is all about trying to predict in advance the issues that might arise. Looking at the confidential inquiries from the United Kingdom, they are very much into educating primary caregivers to be more mindful of picking up on these issues at an early stage. Unfortunately, however, many of the situations we deal with happen very acutely. I do not believe that in any of those situations any obstetrician would conscientiously or otherwise do anything which would tend not to save that mother's life there and then. We do get people with seizures and bleeding, so that is not an issue. Deputy Denis Naughten asked about the neonatal transfer team. We might talk about that at another time, but it is not appropriate to discuss it under the heads of the Bill.

In regard to the screening of job applicants, interview processes should put the best candidates forward for the job. Providing for rare circumstances is one aspect of the care we provide. What one would want is to have people in these jobs who will ensure the safety and health of the mother. I worked in the United Kingdom for a number of years and one is not allowed at interview to ask questions such as those suggested. I recall only one interview at which I was asked a question like that. I did not get the job and I never knew whether it was because I said I would not do a termination of pregnancy. We would have to be careful of discriminating

against people.

With regard to appropriate locations, what is outlined in the heads of the Bill needs to be extended to include general hospitals. Ironically, a woman presenting at Tralee would have access to a wider range of services than in some other places.

Fortunately, I have never seen a patient with suicidal ideation. I have certainly never seen a patient delivered early because of it. In fact, I am not aware of any instance in any unit where I have ever worked.

Chairman: Thank you, Dr. McCaffrey. That concludes the slot for members' questions. We now move on to questions from non-members, for which half an hour has been allocated. Six non-members have indicated and I ask each of them to be brief to allow time for discussion. I begin by calling on Deputies Bernard Durkan and Billy Timmins and Senator Rónán Mullen, in that order.

Deputy Bernard J. Durkan: Thank you, Chairman. It is generally accepted that most people in this country, as determined by the referendum in 1983, are pro-life in terms of their support for the equal right to life of mothers and unborn babies. Reference was made on numerous occasions both in January and during the course of today's hearings to the rarity of certain emergency or difficult cases that can arise. In 1992 the Supreme Court made a decision in a rare case as presented to it, as a former judge of that court is on record as having allegedly said. Incidentally, I do not wish to make reference to any case that is currently before the courts or is current in any way.

Chairman: Does the Deputy have a question on the heads of the Bill?

Deputy Bernard J. Durkan: I am quick to point out that it is totally inappropriate to have any discussion on that particular subject.

Will the delegates clarify whether it is their view that in the event of a woman presenting with a seriously difficult pregnancy, there is an acceptance, in hospitals throughout the country, that the legislation will provide clarity, that it is necessary and that it will at least facilitate medical staff in giving a universal response to a particular emergency case? In regard to conscientious objection, to what extent is that principle equally distributed between the right to life of the mother and the right to life of the as-yet-unborn baby, bearing in mind that the Supreme Court has made a particular decision in a rare situation?

Reference has been made to the small number of cases that will be covered by this legislation. Senator John Crown observed that it does not really matter how small the number of cases is. In fact, in the event of a small number of cases arising, they may well end up in the Supreme Court, and it will be a matter for that court to adjudicate. If it is generally accepted that the rule of that court is supreme - that it is the law and it must prevail - then the legislation now before the Houses is required because it is in accordance with the court's decision, which is regarded as the supreme decision. Will the delegates comment on that?

Dr. John Monaghan made a reference to surgical means and lethal injection. What is the extent to which lethal injection and surgical means have been recognised as suitable for intervention or termination of a pregnancy in this country? The question was already raised in regard to the gestation period at which one or other can be used. I would like confirmation of that because I am not aware of the situation in this regard.

Will the witnesses indicate whether, in the event that a close relative of anybody in this Chamber were to present in an emergency situation at a maternity hospital, it is recognised that whatever treatment is required for that woman and that baby will be given to them regardless of ethical or conscientious objections?

Deputy Billy Timmins: There are two lessons we should all take from today's discussion. The first relates to the funding that is needed to upgrade maternal facilities in this State and the second is the need for supports for the thousands of women who have had abortions and are suffering in silence. Those two issues must be addressed.

Earlier today Dr. Peter Boylan mentioned the submission to the committee by the College of Psychiatrists of Ireland. My understanding is that copies of that submission have been given to members. I would appreciate if non-members might also be furnished with a copy before the end of this session.

I thank the witnesses for their contributions this evening. I apologise for missing some of the discussion, but I have their written submissions. Medical and scientific fact is location-neutral and whether the opinion is given from the shadow of the mast at Donnybrook, on the banks of the River Suck or beside the Treaty Stone, I value that opinion in equal measure. I hope the contributions here this evening get the same airing and status as those that were given earlier.

The witnesses might be able to help me with a particular issue in respect of which I am a little confused. Dr. Sam Coulter-Smith, who indicated that he was speaking on his own behalf, expressed grave reservations about head 4. Dr. Peter Boylan and Dr. Rhona Mahony, on the other hand, did not seem to have the same reservations. I understand those two witnesses were also speaking on their own behalf; as I recall, they did not answer the question as to whether they were speaking on behalf of their colleagues. I am trying to ascertain the crossover in terms of whether personal opinion can have an impact on expert opinion, or are they one and the same? One might reasonably assume in the case of medical or scientific information that the facts are there, yet there seems to be such a divergence of views on the implications of head 4. Can the expert view be overshadowed or influenced, subliminally or otherwise, by the personal view?

Senator Rónán Mullen: I echo what Deputy Billy Timmins said regarding the availability of the submission from the College of Psychiatrists of Ireland.

Chairman: Copies will be available at 9.10 a.m. on Monday morning in the ante-room. We do not have the facility to have them available tonight.

Senator Rónán Mullen: Okay, but I understood that the Chairman meant Members of the Oireachtas when he referred to "members" earlier.

Chairman: I replied to the Senator's question on another matter with reference to Members of the Oireachtas. Unfortunately, the secretariat does not have sufficient staff to make copies available to non-members.

Senator Rónán Mullen: That is very regrettable.

Deputy Billy Timmins: If a copy were made available to me I could photocopy it.

Chairman: Members might take this matter up with the Seanad Committee on Procedure and Privileges.

Senator Rónán Mullen: If we could get one copy, we could make our own arrangements.

Deputy Billy Timmins: On a point of order, I could leave to make copies now and bring them back before the end of the session.

Chairman: They will be available on Monday morning.

Senator Rónán Mullen: Non-members are being subjected to a regrettable inconvenience in this regard. We are all putting in the full ten hours here.

I thank our expert witnesses, who have been given the difficult shift. How dramatic do they believe the change to obstetric practice in Ireland will be as a result of this legislation, particularly in respect of head 4? Dr. Mary McCaffrey talked about the need for training. She will correct me if I am wrong but I assume she is referring to a need arising out of head 4. I do not imagine that extra training would arise in regard to interventions under heads 2 and 3.

Do the witnesses have concerns regarding - to use the word employed by the Chief Medical Officer this morning - the subjective nature of the psychiatric assessment of suicidality? We heard from the obstetricians in the Dublin hospitals earlier that the figure of one in 500,000 refers to the number of suicides that actually take place in pregnancy. In other words, it is extremely rare.

Dr. Boylan and Dr. Mahony, I think, appear to suggest that this might be connected with the fact that Britain has a liberal regime. The sub-text seemed to be that if abortion were not available more would happen. Do they think that there is a cohort who will access it, if it is legal on this ground, or provided for because it is already constitutionally legal? Do they think that there is any reality in the view that a psychiatrist will be able to say this as a matter of probability and to certify that the person is likely to commit suicide? Does a psychiatrist have any tool, absent of course an underlying mental illness, that enables him or her to say that this is so as a matter of probability? I think the concern that many people have is that psychiatry and mental health have become the means in other jurisdictions in the western world by which the line is fudged between what is medical and what is, for want of a better word, a matter of choice and that medicine has been co-opted and indeed corrupted. Do they have any concerns that this could happen here? The obstetrician does have a certifying role in these cases, not just to carry out the procedure. On what basis will the obstetrician make up his or her mind? Will he or she not simply defer to the two psychiatrists? If that is the case is it meaningless for the legislation to say that an obstetrician must also be involved at certification stage?

We have talked a great deal about the conscientious objections of those who might not want to carry out or certify terminations. If there is a subjective element to a psychiatric determination in this case do any of the experts believe it might arise that a person who, as a matter of his or her personal philosophy, is pro-choice, might take the precautionary approach when a person presents, given that it would appear that he or she lacks an objective basis on which to certify? Is it possible that a person with that philosophical mind-set might be more likely to certify that the abortion is necessary as a matter of precaution?

Dr. John Monaghan: My ageing brain is finding it difficult to keep up with the pace of the questions. I will start with Deputy Durkan who asked about the rarity of cases and evidence, referring I think to the X case in the Supreme Court. I was not sure whether the Deputy was referring to other rare cases but his observation on the X case was very interesting. The relationship between the law and the practice of medicine is a very critical interaction in this instance.

Next Monday's hearings will be critical for the committee's decision on the question of the psychiatric evidence. My understanding is that if the medical evidence does not support it and we have a legal obligation to the Supreme Court there is a conflict which it is beyond a doctor to recognise. A doctor is ethically obliged to act on evidence. I regret that the expert group did not invite in expert psychiatric evidence because it seems as if this must be done by this committee in a public forum rather than by careful study of the evidence available. It is a very difficult issue and I appreciate the position in which legislators are placed in trying to deal with these two different aspects of the problem, the medical evidence and the Supreme Court decision.

Deputy Durkan also asked about surgical means. I did not check on the lethal injection but I did consult with a colleague yesterday on the question of surgical termination as in suction termination whereby the baby is sucked out and destroyed. This is the sort of technique that has been in use for many years in the UK since abortion was legalised. I asked my colleague whether this is commonly done and she said it is, principally because it is cheaper, even though the medical means are more appropriate. I cannot give any figure for the lethal injection but I know that patients of mine have availed of that and it is not rare but I cannot give any figures on frequency of use.

Deputy Bernard J. Durkan: At what stage of a pregnancy could it have been done?

Dr. John Monaghan: The suction termination would be up to between 12 and 14 weeks. The other would be from then on, up to term in some cases.

Senator Jillian van Turnhout: Is this in the UK?

Dr. John Monaghan: Yes this is in the UK. I am not talking about Ireland at all. I have no awareness of its ever having been done in Ireland.

Deputy Bernard J. Durkan: That was my question.

Dr. John Monaghan: I beg the Deputy's pardon. I misunderstood the question. We seem to be destined to misunderstand each other.

Chairman: In fairness to Deputy Durkan, he is easy to understand.

Deputy Bernard J. Durkan: The other question was about conscientious objection, the equality of the unborn and the mother.

Dr. John Monaghan: While the State recognises the equality of the mother and the foetus I have never come across, or heard of, a situation in which a doctor would have allowed a mother to die because he or she had a conscientious objection to abortion. That would be an unconscionable action for a doctor. In terms of the management because the child cannot survive without the mother the doctor must act to save the mother's life and in instances the baby loses its life as a consequence.

Deputy Timmins asked about the cross-over between personal and expert opinion. It is very clear from observing people, the Deputy may have observed it in me, that people have particular opinions, however, in the practice of medicine or giving an opinion, whether expert or not, the criterion one uses is whether the person is telling the truth. If somebody is prepared to massage data to suit his or her point of view then we are in a serious ethical situation. An opinion of a personal nature, if it is honest, should be capable of being an expert opinion too, although not all opinions are expert.

Senator Mullen asked about the effect of psychiatric indications on abortion incidence. It is certainly very well known that in the state of California abortion rates expanded dramatically on the basis of suicidal ideation. I cannot give any further answer to that question but the committee has a critical decision to face on the psychiatric evidence that it will hear next week.

Dr. Máire Milner: Deputy Durkan asked if we are happy that legislation would lead to a universal response in the case of a woman admitted to a facility who is critically ill and whose life is at risk because of the continuation of her pregnancy. That is the thrust, the hope, the feeling of the institute that represents the body of our opinion, that is, our professional body. It has made a submission endorsing the legislation with some discussion and recommendations. Would it be a universal response? No. We are human beings and the word "universal" is probably misplaced.

Deputy Bernard J. Durkan: Generally.

Dr. Máire Milner: Yes. I think so.

Lethal injection is not used to terminate the pregnancy it is used to kill the foetus or kill the baby. To my knowledge it is usually used later in the pregnancy and is given into the heart.

Deputy Bernard J. Durkan: Is it used in this country?

Dr. Máire Milner: No.

Deputy Bernard J. Durkan: Hence it is not relevant.

Dr. Máire Milner: Correct. Somebody asked about a close relative and whether it is recognised that appropriate treatment would be given regardless of conscientious objections. I cannot speak for every colleague in every situation. Legislation never guarantees an appropriate response or treatment at all times. That is why I assume the committee is sitting and this is the thrust of the proposed legislation.

Deputy Timmins spoke about personal and expert opinion cross-over. Clearly, there will be causes of cross-over. On suicide, we are talking about women threatening to take their own lives. Yes, it will be difficult to prove or disprove this. Yes, it is subjective and not exclusive to psychiatry but psychiatrists will have more experience in teasing out suicidal ideation than will we.

Doctors, particularly obstetricians and gynaecologists, dealing with pregnant women have significant experience of all of the psychology that goes with being pregnant and the problems and issues that people can have psychologically. Deputy Timmins asked if a psychiatrist would take a precautionary approach. By the time one gets to be a consultant, one is at least 40 years of age with a lot of experience. None of us is infallible but one has to make the best possible judgment. I cannot give an absolute on that. We are human beings but one makes the best possible judgment in the circumstances. The legislation is looking at two separate psychiatrists and the obstetrician looking after the woman.

Dr. Gerard Burke: Deputies Durkan's and Timmins's points have been addressed. I am grateful Deputy Timmins intends to upgrade maternal care facilities in the State and will make it his life's work over the next several years in haranguing the Minister on this.

Deputy Billy Timmins: I might not have much influence after these hearings.

Chairman: We will make sure the Deputy lives up to his commitment.

Dr. Gerard Burke: I believe it is feasible to raise the money to do it.

Chairman: The committee will address the issue of maternity facilities and care in June and July. Deputy Timmins is welcome to come back to the committee on that occasion to make his comments on this issue.

Dr. Gerard Burke: On the issue of whether we have concerns about the subjective nature of the psychiatric assessment, Senator Mullen knows there is no blood test or X-ray for suicide and it is inherently dependent on an interaction of questions and answers between the psychiatrist and the patient. We do not have any expertise in that.

Chairman: I am afraid but I must ask Dr. Burke to step back a little from the microphone as there is some interference. The Seanad is not used to people of Dr. Burke's height and stature so the microphone is being obstructed.

Senator John Crown: On a point of order, what about me?

Chairman: Gabh mo leithscéal.

Dr. Gerard Burke: We deal with psychiatrists all the time when discussing medication for patients suffering from depression or more serious illnesses. We have a working relationship with them.

I agree with the institute that the threat of suicide is a very serious matter but it would be a very unusual situation. As I have said before, most of us will never encounter such a request. I agree with the institute that we should have two obstetricians to discuss this matter in detail with a psychiatrist. It is a very big deal and we would give it a great deal of thought.

Dr. Mary McCaffrey: The proposed legislation does provide clarity for us and it is extremely well-crafted. With regard to the question as to whether someone will get the care they need, the life of the mother is always going to be paramount. Emergencies are always dealt with as such. As Dr. Burke, said earlier, when an emergency presents in any hospital, everyone from anaesthetists, cardiologists and whoever, rolls up their sleeves.

With regard to personal views, my personal practice would be if I ever felt my view was slightly personal and not based on evidence-based practice, one would sit down and discuss it with other colleagues. If necessary, one would ring someone in a specialty or sub-specialty related to the matter. The way medicine is practised these days, people do not tend to practise in isolation but as part of teams. Most hospitals also have governance groups as well.

With regard to Senator Mullen's question on whether this legislation will make a dramatic difference to our practice, I do not believe it will. I believe we will continue to practise obstetrics as we do. I do not believe we will see a dramatic increase in requests for assessments for suicide. I hope not anyway. Senator Mullen needs to ask the psychiatrists about the subjectivity of it but that is the reason there would be more than one psychiatrist on an assessment team. As an obstetrician I do not feel I have enough knowledge of psychiatry to have an input into the diagnosis but to be there to support the team of psychiatry staff in terms of planning where the pregnancy would go from there.

With regard to training, it is not so much training as the need for guidelines. For people who have not been involved in providing termination of pregnancy services - even to decide whether

it will be surgical or medical - we will need guidelines. Hopefully, it will be something that will be a very rare event.

Chairman: I call Deputies Peter Mathews, Arthur Spring, Terence Flanagan and Senator Paul Bradford.

Deputy Peter Mathews: I thank the four professional consultants for their presentations. I feel I learned much more in this session than in the earlier one on the actual delivery of the safe care for mothers and their babies. I got a much better sense of conversation and real meaning about the whole issue.

We are here to discuss the heads of the Bill. That derives from the difficulty that there is in applying the Constitution's Article of the equivalence of life when it arises in difficult and rather rare circumstances, namely, the threat to the life of a mother. As Dr. John Monaghan pointed out, there was the particular case of the X case on which the Supreme Court made a majority decision - not a unanimous one - in terms of its understanding based on what had been presented to it which was only a limited picture. The court got a psychologist's report, not one from a psychiatrist or a body of psychiatrists. The court was painted into a corner and had to determine for one case.

We have to be honest about this and decide how we want to express the intention in law as to what is the meaning of the Constitution in its application and what is guided by guidelines from professionals. One point that has come out in this and the last session is that guidelines are delivering excellent care for mother and child. There have been little setbacks here and there which have been accidental and unfortunate, as well as being very tragic for the families involved. For everyone's wife, mother, sister or daughter who is expecting a baby, everything - the whole fire brigade of medicine - will be brought to bear in saving that mother's life. Being honest about it, the expression of the Constitution in its simple English is followed by the fact that the life of the mother is of paramount importance at all times, the profession has a duty of care to that mother at all times and that it will use the best guidelines within its professional specialties at all times to deliver that. We come back to what even Dr. Boylan spoke about, that is, trust. Dr. Monaghan spoke about that. We have got to trust people. We trusted our mothers not to drop us when they put us in our prams. We trust those around us. Today there has been the hijacking of a few set backs to lead us down various long paths of complication and multi-word argument and discussion and we are getting away from the truth.

Chairman: Go raibh maith agat. Deputy Mathews is way over time.

Deputy Peter Mathews: Remember psychiatry was hijacked in Britain, America and France.

Chairman: We are on the heads of the Bill now.

Deputy Peter Mathews: France introduced strict legislation in 1975 and today underage girls can go to their GPs and obtain a lawful abortion without the knowledge of their parents. That started from strict legislation.

Deputy Arthur Spring: The experts, who have provided information throughout the day, have been nothing short of top class. It has been very informative for Members of the Seanad and the Dáil and I think lay people at home, who are watching this, will feel very informed. I acknowledge the fact we are trying to become as educated as possible before we make decisions and I thank the witnesses for their contribution. It is rather unfortunate that the regional areas

do not get the same level of attention from the media and maybe from other circles which they warrant. I hope that will be reflected throughout the weekend, if that can be done.

The first observation I have is that the regional hospital could potentially be undermined as a result of the level of ability in the maternity hospitals in Dublin. I think we need to put that to bed. I would like the witnesses to be able to say that in the event of an emergency pregnancy presenting at a regional hospital, the skills and the staff would be adequate and that they could cope with what is under the heads of the Bill.

One of the issues which is pertinent is conscientious objection. One has quite a small psychiatric unit and quite a small maternity unit in a regional hospital. If a psychiatric unit is not adequate to deal with a patient presenting with suicidal ideation, does that mean the patient should be referred to a hospital where there is a substantial psychiatric unit? How would that impact on the ability of that person to be able to obtain the services should she merit a termination due to the fact that suicidal ideation is a reality?

Do the witnesses see the heads of the Bill as appropriate to deal with cases presenting? Can we say this legislation does not provide for a form of liberal termination, or abortion? Can we say it is appropriate to the Supreme Court ruling and that we are living up to what is in the programme for Government?

Deputy Terence Flanagan: I congratulate the Chairman on chairing today's proceedings efficiently and I welcome the witnesses. Will every effort be made to save the baby's life in every case where a pregnancy is terminated post-viability? In the case of suicide, do the witnesses think there should be a possibility of a review on behalf of the unborn of a decision to certify an abortion under head 4? If, under the provisions of head 4, a termination was to be performed at 23 weeks, would the witnesses refer the case to one of the large Dublin hospital where the baby would have a better chance of survival or do they anticipate or expect that their hospitals would deal with the case? If two consultant psychiatrists agree that a patient is suicidal and that this constitutes a real and substantial risk to her life, which can only be averted by the termination of her pregnancy, could they envisage any situation in which they would disagree with them?

Senator Paul Bradford: We are now almost 12 hours into today's session and we will have two more sessions next week. We had a number of hearings in January, we have had Dáil and Seanad debates and a huge degree of political engagement on this matter. I suppose if anyone was returning to planet Earth from Mars and was given that backdrop, they would think we were talking about a major piece of new legislation or change in the law. However, notwithstanding the debates we have had and the debates to come and a parliamentary process, which certainly in my 20 years plus here, has never been utilised before, we are advised by the Government - the Taoiseach, the Minister for Health and others - that no new law is being put in place, that there will be no change and that this is simply codifying, which the new buzz word. Notwithstanding the hours, weeks and months of debate, this is not about a new law or a change. That is what we are being advised by very senior Government sources. As far as the witnesses are concerned, is this about a change in law and a change in practice? If not, what is it about?

Dr. John Monaghan: Deputy Mathews drew our attention to something which is extraordinarily important in medicine and in every branch of life and is reported to be disappearing, that is, trust. An English baroness, Onora O'Neill, wrote a book about trust, which has had a huge impact. I have been a member of the Medical Council for the past five years and I bought a copy of it for the members of the council. Many of them found it very useful to reflect on this

and a lot of it relates to health care. I do not know how to relate it directly to the abortion question but there is certainly evidence from other countries of serious breaches of trust. During the week the trial of an American, Dr. Gosnell, showed there are ferocious breaches of trust and dishonesty associated with what one might call the abortion industry and it would be appalling if that came into this country.

Deputy Spring raised the question of conscientious objection between two psychiatric units - in other words, if a person was suicidal, she would be moved to another psychiatric hospital. Is that correct?

Deputy Arthur Spring: If there was not adequate provision in a regional hospital, would the person be moved to a larger hospital?

Dr. John Monaghan: I am sure that would depend on the condition of the patient and so on. As far as I know, there is not a huge amount of transfer between psychiatric units. If one develops a mental illness, one would often stay in the same hospital. I do not think there is sort of specialist centres like there would be for neurosurgery or something like that. I thought the Deputy was referring to the question of conscientious objection in one institution and whether the patient could go to another one, but that was not what he was asking. I would not be able to answer that question. I think it would be best asked of a psychiatrist.

Deputy Arthur Spring: Dr. Mary McCaffrey referred to Kerry General Hospital.

Dr. John Monaghan: She might take the question. Deputy Flanagan asked if every effort would be made to look after a child born after a termination. That seems to be the plan, according to what is written. I do not know any doctor who would not make every effort. The question arises, in particular in the psychiatric area, where the patient does not want the child to be born alive. That is why I suggested earlier that it should never be the situation that the child is directly killed in the uterus at any stage of gestation. It would not be unknown for babies to be born supposedly at 17 weeks but to be found to be several weeks further on, particularly in the circumstances of psychiatric illness, uncertain dates and so on. I would strongly advocate that there should be no possibility that a child would be eliminated before it was born. At 23 weeks, certainly if a child was going to be born because of serious maternal illness or because of a foetal reason, it would be transferred to a large Dublin hospital, or to Cork or Galway.

Senator Bradford asked about the suggestion that no change is being made. I think there is a very significant change in the proposed legislation. For the first time, deliberate abortion, as opposed to forced abortion, will be available in this country. I refer to termination of pregnancy in a formal legal sense, rather than in dealing with medical emergencies. It remains to be seen what effect this will have. I think it is very difficult to predict. As I said before, I am very concerned about the ability to control the psychiatric aspect of it.

Dr. Máire Milner: Deputy Flanagan asked about the delivery of babies at the margins of viability - 23 weeks - in the Dublin hospitals and the regional neo-natal intensive care units. I draw his attention to the submission made by our professional body - the Institute of Obstetricians and Gynaecologists - which states:

> We highlight the fact that enormous additional challenges to clinical management arise when termination is being considered in gestations approaching foetal viability but still extreme prematurity. In current practice, all efforts are exhausted within medical margins of safety to prolong the pregnancy in the foetal interest.

We are talking about where the mother's life is at risk. This is where the balance has to be achieved. Senator Spring-----

Deputy Arthur Spring: I am a Deputy for now.

Deputy Bernard J. Durkan: Very much so.

Dr. Máire Milner: Excuse me.

Chairman: Thank you. We will have one speaker, please. Respect the witness, please.

Dr. Máire Milner: As I have already said this afternoon, I feel the legislation is appropriate to our practice and our patients. I await the contributions to be made by our colleague psychiatrists next week. I do not believe this will lead to liberal abortion. This specifically relates to instances where the life of the mother is at risk. As I have said, our psychiatric colleagues may elucidate the area of suicidal ideation to a better degree.

Senator Bradford asked whether this is a change in law or in practice. Clearly, a change in law is being proposed. Will it lead to a change in our practice? I have spoken already this afternoon about clarity and trying to protect doctors in uncertain situations where there is uncertainty about whether a woman will survive in the rare instance of potentially terminating the pregnancy so that her life may be spared. I was asked whether that will change my practice. It will afford me a degree of protection and comfort and it will give rise to an improved situation for our patients.

Dr. Gerard Burke: I would like to respond to what Deputy Mathews said. The majority of obstetricians feel there is a problem about clarity with this. We need clarity about it. In our work, we set out to avoid a termination and to continue with the pregnancy. That is always our aim. A termination of pregnancy is a horrible outcome for all concerned, including the obstetrician. We are trying to make these very difficult decisions and to prolong the pregnancy as far as possible. The actual consultative process with the patient and the other medical doctors who are assisting her will be more open and less difficult - we will be more likely to arrive at the right decisions - if we have clarity and openness about the decision-making process. We feel vulnerable when dealing with marginal cases.

(Interruptions).

Chairman: Dr. Burke without interruption. Deputy Mathews has spoken already.

Dr. Gerard Burke: The big issue is how much difference this legislation will make. It will make very little difference - hardly any - to the actual practice of medicine and obstetrics. The number of cases that will fall under this legislation will be tiny. The number of patients in our practice who are at risk of dying is relatively small. The number of those cases that are marginal from a decision-making perspective is really very small. When one starts bringing things like psychiatry into this issue, the number is absolutely minuscule. Most of us will never encounter this situation. I have been a doctor for over 30 years and I have never even heard of a case like this, other than the X case.

I was also asked about deliveries that take place at 23 weeks. The full range of very expensive services is wheeled out to try to save babies that are delivered at 22 weeks. I do not think any babies of that gestational age have survived in Ireland. We would try to save them.

Senator Bradford also asked whether there will be a change in practice. I do not think there will be - nothing significant, certainly.

Dr. Mary McCaffrey: I apologise to Deputy Spring, who is my local Deputy, if I have totally confused him. I think I have.

Deputy Arthur Spring: I would like one of the-----

Dr. Mary McCaffrey: Can I just take the issue-----

Chairman: We will have no bias or favouritism shown towards Deputy Spring.

Deputy Arthur Spring: The Chairman will be happy to see the Cork colours.

Dr. Mary McCaffrey: Can I just clarify what I actually meant? Any person - male or female, pregnant or not - who arrives at an accident and emergency unit in any hospital or at a psychiatric unit tonight or tomorrow night will be dealt with acutely, assessed and admitted. All the services will be rolled out for them. Some psychiatric services in smaller hospitals are concerned that if there is a larger number of review committees and review processes, or if assessments for two psychiatrists have to be done together, that rather than the acute situation might put a strain on the resources of the department in question. As the legislation is enacted and brought into practice, it will be important for the health services to watch what level of resources is needed to allow obstetrics and psychiatry to continue to provide safe practice. My earlier comments did not relate to the safety of the acute situation. They were about the ongoing assessments that might arise. We have all seen how the mental health tribunals are costing a fortune and have taken on a life of their own. That is really what my remarks were about. I apologise if I came at it in a circuitous manner.

Deputy Flanagan raised the issue of viability, which is obviously very important in a smaller unit. We have to acknowledge that the dates of many pregnant patients are actually wrong, despite good ultrasound scanning. If they present very late on in a pregnancy, there is always the possibility that their due date might fall a week or two either way. My personal practice in such situations is to transfer the patients in question to a place where all the neo-natal services are available. I suspect anyone in a smaller unit would do the same. It strikes me now that I did not answer Deputy Naughten's question about neo-natal services and I apologise for that. If the woman is too ill to be transferred, we can deliver the baby locally before getting a neo-natal transfer team to come down, provide the services in the smaller hospital and, if the baby survives, take it to a larger unit. That happens in smaller units on a regular basis.

Senator Bradford asked whether there will be a change in law or in practice. Obviously, if a new law is on the books, then it is a change in law. On the question of whether there will be a change in our practice, my personal feeling is that there will be much more reassurance and clarity in terms of dealing with difficult situations. I know there is great concern about the possibility of opening the floodgates. I think the law is so tight, for example in requiring two psychiatrists and all the support services for the diagnosis, that I do not think the things we do will change hugely. It will provide huge security. It is very hard to be on one's own on a Sunday afternoon in a small hospital, trying to decide whether one will be reported to the Medical Council if one does something and worrying whether there will be gardaí in the hospital the following morning. There is great security in knowing that I can deliver this seriously ill woman and there is not going to be a witch hunt outside my door the following morning. It is a worry for a lot of people in the current climate with patients.

Deputy Terence Flanagan: I had four questions. My question on the review clause was not answered and it related to suicide. Does the delegation think that there should be a possibility of having a review, on behalf of the unborn, on a decision to certify an abortion under head 4?

Chairman: In order to be consistent, I will allow Deputy Mathews to contribute. However, I ask him not to make a speech.

Deputy Peter Mathews: I know. I want to comment for clarity sake. Dr. Monaghan, I said that the guidelines, to me, from all of the conversations, appear to answer all of the questions of the proposed legislation under the heads. The other lady doctor said-----

Chairman: Dr. Mary McCaffrey.

Deputy Peter Mathews: -----that if one goes to an accident and emergency department, one will get whatever it takes, but one will get the same in this too. Dr. Monaghan said that he needs clarity in order to feel safer in the work that he does but he has already said that he feels safe and will do everything that he has to do. That is a contradiction.

Chairman: That was not a point for clarification. Does the delegation wish to respond to Deputy Flanagan's question?

Deputy Bernard J. Durkan: Earlier the Chairman indicated that he would allow me a quick intervention.

Chairman: No. Who wants to answer Deputy Flanagan's question?

Deputy Terence Flanagan: My question is for everyone.

Dr. John Monaghan: It has been the situation in the United States where legal representation has been provided for a foetus that is under threat. One of the questions that is also unanswered is what is the role of a father in a situation where termination of pregnancy is to be undertaken.

Chairman: We will not deal with that now.

Dr. John Monaghan: I have not thought about the issue myself. It may well be that, in a critical legal battle, I would not see any problem with the child being legally represented since it has a constitutional right in this country.

Dr. Máire Milner: It may be something that the psychiatrists are interested in and may address next week.

Dr. Mary McCaffrey: I have never thought about it. I apologise. It would be something new to add on to the legislation that is currently there, so it would be without our remit.

Dr. Gerard Burke: The foetus is my patient as well. The same with my colleagues, we will do our best for that foetus to see that it gets to viability.

Deputy Terence Flanagan: Thank you.

Chairman: Senator Colm Burke absented himself from this session this afternoon and I thank him for doing so. He did not have to do so, but he did it.

We have had over 11 hours of discussion and I propose that we adjourn. Before doing so, I apologise to the ushers, stenographers, sound and secretarial staff for keeping them longer than the prescribed time. We thank them for their patience and work. I formally thank the witnesses, Dr. Gerard Burke, Dr. Mary McCaffrey, Dr. Máire Milner and Dr. John Monaghan for their testimony and presence today.

The joint committee adjourned at 8.34 p.m. until 9.30 a.m. on Monday, 20 May 2013.