DÁIL ÉIREANN

AN COMHCHOISTE UM AN OCHTÚ LEASÚ AR AN MBUNREACHT

JOINT COMMITTEE ON THE EIGHTH AMENDMENT OF THE CONSTITUTION

Dé Céadaoin, 11 Deireadh Fómhair 2017

Wednesday, 11 October 2017

Tháinig an Comhchoiste le chéile ag 1 p.m.

The Joint Committee met at 1 p.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
James Browne,	Jerry Buttimer,
Lisa Chambers,	Paul Gavan,
Ruth Coppinger,	Rónán Mullen,
Clare Daly,	Lynn Ruane.
Bernard J. Durkan,	
Peter Fitzpatrick,	
Billy Kelleher,	
Mattie McGrath,	
Catherine Murphy,	
Hildegarde Naughton,	
Jonathan O'Brien,	
Kate O'Connell,	
Louise O'Reilly,	
Jan O'Sullivan,	
Anne Rabbitte.	

Seanadóir / Senator Catherine Noone sa Chathaoir / in the Chair.

The joint committee met in private session until 2.20 p.m.

International Developments in the Provision of Health Care Services in the Area of Termination of Pregnancies: Lyndon B. Johnson School of Public Affairs and World Health Organization

Chairman: We are now in public session. I welcome members and viewers watching these proceedings on Oireachtas TV. Before we commence our formal proceedings today, I wish to point out that the Honourable Ms Justice Mary Laffoy, Chairperson of the Citizen's Assembly, has written to me to provide clarification in relation to a recommendation of the assembly in respect of reason 13 regarding no restriction as to reason. Members will recall that this matter was discussed at last week's meeting when it was raised by Deputies Rabbitte and Coppinger. In order to clarify the matter I will now read the letter from Ms Justice Laffoy, dated 11 October 2017, into the record.

Dear Senator Noone,

I refer to an exchange that occurred during the committee hearing last Wednesday, 4 October, about the specific recommendation made by the Assembly in Reason 13 on Ballot 48 on the Eighth Amendment of the Constitution.

I am aware you read the exact percentages of that vote into the record subsequently for clarity. However I am aware that some recent media reports may have engendered some confusion on this issue also. As such, I think it would be of assistance if I reiterated the recommendation of the Assembly in regard to Reason 13. The precise wording of Reason 13 was 'no restriction as to reasons'. The recommendation of the Assembly (by a majority of 64%) was that termination of pregnancy with no restriction as to reasons should be lawful here, but this was further qualified by the Members views on gestational limitations or none. In relation to gestational limits, those Members had further expressed their view on the Ballot as to whether termination of pregnancy should be permitted up to 12 weeks gestation only, up to 22 weeks gestation only, or with no restriction as to gestational age. The option which achieved the highest number of votes here was *up to 12 weeks gestation only* with 48% voting for this option. Accordingly the recommendation of the Assembly for Reason 13 is that termination of pregnancy should be permitted with no restriction as to reasons, but up to 12 weeks gestation only. According to the resolution approving establishment of the Assembly: "all matters before the Assembly will be determined by a majority of votes of members present and voting, other than the Chairperson who will have a casting vote in the case of an equality of votes". Full details on the voting arrangements and procedure are provided on pages e825 to e828 of the Report, and the Members of the Committee may wish to familiarise themselves with this note, which was provided to the Members of the Assembly in advance of the meeting in April. I hope this provides full clarification on the matter.Yours sincerely,The Hon. Mary LaffoyChairperson

The Citizens' Assembly.

That was for clarification purposes.

Before I introduce our witnesses today, at the request of the broadcasting and recording services, members and visitors are asked to ensure that for the duration of the meeting their mobile phones are turned off completely or switched to aeroplane mode. The gentlemen in our technical department have advised that some phones have been left on, which has caused interference. On behalf of the committee I extend a warm welcome to our witnesses today, who will be addressing international developments in the provision of health care services in the area of termination of pregnancies. We are joined by Dr. Abigail Aiken, assistant professor at the Lyndon B. Johnson, LBJ, School of Public Affairs, Texas, USA and by Dr. Ronald Johnson and Dr. Bela Ganatra, both of whom are from the department of reproductive health and research at the World Health Organization, WHO. They are all very welcome to this afternoon's meeting and I thank them for their attendance.

Before we commence formal proceedings I must advise our witnesses of the situation regarding privilege. By virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to this committee. However, if they are directed by the committee to cease giving evidence on a particular matter and continue to so do, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against 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 ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable.

I now invite Dr. Aiken to make her presentation.

Dr. Abigail Aiken: I thank the committee for inviting me here today to testify. My name is Abigail Aiken and I am assistant professor at the LBJ School of Public Affairs at the University of Texas at Austin. I have been asked to address the committee on international developments in the provision of health care services in the area of termination of pregnancy. I will focus specifically on how these developments have affected the ways in which Irish women access abortion.

Most abortions in Europe take place in clinical settings and are divided into "surgical" abortions and "medical" or "medication" abortions. In Ireland, however, women do not have access to these clinical services and between 1970 and 2016, at least 184,000 Irish women have travelled to England and Wales to access abortion in a clinic. Since 2006 however, a non-profit, online tele-medicine service called Women on Web has provided early medication abortion in countries where safe, legal services are not available. Under this model, a woman fills out an online consultation form, including information about her gestational age, co-morbidities and contraindications. A medical doctor reviews the consultation form and, if appropriate, approves the request and prescribes the medications mifepristone and misoprostol which are used in medication abortion. Both medications are on the WHO's list of essential medicines and Women on Web prescribes them in the dose regimen for medication abortion recommended by WHO.

After the woman makes a donation of between €70 and €90, or however much she can afford, a partner organisation dispatches the medications and they reach her by mail. Once the

woman receives the medications, she takes them at home using the clear, simple instructions provided to her by email from Women on Web. Information, advice, and support are provided in close-to-real-time via an online help desk, again through email. All women receive information about the signs of potential complications and instructions for seeking in-person medical attention. Three weeks later, women are asked to fill out an online evaluation reporting the clinical outcome of the abortion and their experiences using the service.

Women in Ireland have been accessing early medication abortion through this online telemedicine model since 2007. Exhibit 1 shows that since 2010, the first year for which data are available, the number of Irish women requesting early medication abortion through Women on Web has more than tripled, from 548 in 2010 to 1,748 in 2016. These numbers include women in both Ireland and Northern Ireland because it is often very difficult to distinguish between the two. Since 2014, other telemedicine services have also been available, so the numbers for 2015 and 2016 are lower bounds.

By contrast, exhibit 2 shows the number of Irish and Northern Irish women travelling abroad to England and Wales. It shows that between 2002 and 2016, the number has fallen by almost 50%, from 7,913 in 2002 to 3,992 in 2016. The number accessing telemedicine has increased and the number travelling to England and Wales has declined.

Who are the Irish women who access abortion through online telemedicine? Exhibit 3A shows the age distribution and 3B shows the parity of women in Ireland who accessed this early medication abortion through Women on Web between 2010 and 2015. This is a sample size of 5,650 women. Members can see that women of all reproductive ages are represented, with the most common age groups being between 30 and 34 years, representing 26% of all requests, and between 25 and 29 years, representing 24% of all requests. Exhibit 3B shows that the majority, 63%, are mothers.

The pregnancy circumstances of the same 5,650 women are displayed in exhibit 4. What members can see is that the majority of women, 54%, were using contraception when they first became pregnant and thus experienced a contraceptive failure. Some 44% of them reported that they were not using contraception when they became pregnant. To put this figure in context, consider that the unmet need for contraception is twice as high in Ireland compared to Great Britain, at 11.2% compared to 5.1%. Finally, only 2% reported requesting early medication abortion due to rape. We know that in Ireland, rape is an under-reported crime. Less than 32% of survivors in 2015 reported that incident to the Garda.

Why do Irish women request abortions? Irish women's reasons for requesting them through online telemedicine are shown in exhibit 5. We can see that by far the most common reason, cited by 62% of women, is being unable to bring up a child at this time in their lives. We did some in-depth interviews with a sample of these women and they revealed that this category included, but was not limited to, being in a physically or emotionally abusive relationship, being unable to provide for existing children with the addition of another child, and being physically or emotionally unequipped for a pregnancy. These statistics mirror the reasons for abortion among Irish women who travel to clinics in England and Wales. Some 96% of abortions to women who travel to England and Wales are performed under ground C of the 1967 Abortion Act, which allows for abortion when the continuation of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the woman. The remaining 4% of those abortions to women who travel are performed under ground E, for severe foetal anomaly.

In light of the recommendations of the Citizens' Assembly with respect to the allowable grounds for abortion up to 12 weeks of gestation, it is worth noting that the Irish women who are accessing online telemedicine are under ten weeks of gestation at the time of their request. Similarly, 85% of abortions to Irish women who travel to England and Wales occur at under ten weeks of gestation, and almost all, 92%, at under 13 weeks.

How do Irish women make the decision about whether to travel offshore to England and Wales or access abortion through online telemedicine? Section A, which I will not put up on members' screens but which they have in their packets, shows data from in-depth interviews with Irish women who have used online telemedicine and illustrates some of the reasons women choose this option. Reasons include the significant expense and logistical difficulties of travel, the increased privacy, comfort, and dignity of managing medication abortion at home, and a preference for conducting the abortion at the earliest possible gestational age. Travel is often associated with delays in seeking care; people want to do this early. I cannot give the members all the examples but I will read one given by Mairead, who is 32 years old: She stated:

> I really didn't want to travel at all. The whole thing was just so stressful and the idea of having to go to a foreign country on my own and go through it on my own was just horrendous. So, if I'm able to get hold of abortion pills and do it at home that's a better and a much cheaper option. The idea of having to go do it in some random clinic in England is just awful. At home, my friend was able to support me through it all and it made an absolutely massive difference. The idea of having to travel alone and go through that on my own in a foreign country is just unthinkable.

When Irish women choose this online telemedicine model, what are their experiences? Exhibit 6 shows the feelings reported by 1,000 women who went through the early medication abortion with Women on Web between 2010 and 2012. Members should note that these do not add up to 100 because most people chose more than one feeling. By far the most commonly reported feeling was relief - that was about 70% of women - followed by satisfaction at about 36%. Many reported a mix of emotions, for example, feeling both sad and relieved or feeling both loss and empowerment. Among the sample, 98% felt they had made the right choice and would recommend the at-home telemedicine model to another woman in Ireland in a similar situation.

Sections B and C in the qualitative packets show data from in-depth interviews with Irish women documenting their experiences both with online telemedicine and with travel. Women who travelled often struggled to cover the financial cost, which can be over €1,000. They had difficulty finding child care and getting time off work and therefore losing more money that they could not afford, and they experienced stigma and shame, as well as the trauma of managing side effects from an abortion on their way home. One could be bleeding sitting in a plane. To give an example, Emma, who is 24 years old, stated:

> So basically when you get to the airport and you get on that flight, it's kind of known, that this very early flight is the flight people take. You're waiting to board the plane and you can see the other women and you all know you're there for the same reason and to be honest, there's this horrible immediate sense of shame that comes with it and it's very overwhelming. But the very worst part was when I got back to the airport afterwards and had to wait five hours to get a plane home, sitting there feeling I'd just committed a crime. I was so traumatised by that travel experience I still can't wrap my head around it.

Women who used online telemedicine instead of travelling commonly describe a contrast

between the acceptability of the abortion itself and the anxiety of being found out and potentially prosecuted. I will give members an example from Stacey, who is a 27 year old mother of two. She stated:

> The procedure was very straightforward and it did feel very safe with all the information they gave. I had some anxiety that if something had gone wrong, as can happen with any safe medication, it's hard to know who can I trust - would I incriminate myself? All these things are going through your head because I wasn't able to do this legally. So, I had all of that extra anxiety.

At-home use of abortion medications obtained using online telemedicine has been demonstrated to be both highly effective and safe. Exhibit 7 is a table showing the clinical outcomes of abortion for 1,000 Irish women who accessed Women on Web between 2010 and 2012. Members can see in the first column that, overall, 99% of women were able to end their pregnancy, and 95% were able to do that without a surgical intervention to help them complete the abortion. These outcomes compare favourably to those for medication abortion, the same type of abortion performed in a clinical setting, up to the same gestational age.

In exhibit 8 members can see the treatment for post-abortion complications among the same group of 1,000 women who used online telemedicine. Overall, 3% received treatment for any adverse event, 2.6% were given antibiotics, less than 1% required a blood transfusion for very heavy bleeding, and no deaths were reported. These complication rates, while still very low, are slightly higher than in the clinical setting. However, since outcomes are self-reported, there is no way to judge whether the appropriate treatment was given to someone or whether unnecessary treatments were given just in case.

Although early medication abortion provided through online telemedicine can be shown to be safe and effective in terms of a clinical outcome, the current Irish abortion law limits the information and support that Irish health care professionals can provide to women. Section D illustrates a variety of experiences that Irish women seeking abortion or seeking follow-up care after abortion have had with health care professionals in Ireland. These range from encountering hostile attitudes, to being provided with inadequate information, to being too afraid to speak to a health care professional for fear of a negative reaction or being reported to the authorities. An example of that is from Adele, who is 29 and a mother of four. She stated:

> God no, I couldn't talk to any doctors about it, definitely not, because I was just so scared. You hear these horror stories of women getting arrested and imprisoned. So, I was completely alone. I did go in when I found at first I was pregnant when I didn't know what I was going to do and I went in and said, "okay, I'm pregnant", but I obviously never told them any of my intentions. And their reaction was just like, "great, you're pregnant, we'll put you in for your 12-week scan". But I couldn't say anything because you don't know how they're going to react.

She could not talk about her thinking or her feelings to anybody because she did not know the reaction she would get.

Some Irish women may be unable to avail of either travel or online telemedicine. Moreover, even those who do manage to access one of them are often in precarious positions in that it is touch and go as to whether they can do it.

Section E in the qualitative packet makes plain the consequences of this lack of access

to safe abortion care. Through in-depth interviews, Irish women described the methods they would have had to resort to or which others sometimes would have made them resort to through coercion had online telemedicine or travel not been accessible.

Very unfortunately, these include coat hangers, starvation, high doses of vitamin C, strenuous exercise, large quantities of alcohol, scalding water, drinking bleach, throwing themselves downstairs or running into traffic. Rebecca, who is one example of cases given in a package of information members will have received, is 39 years old and has two children. She explains:

> I was walking up to 20 km every day. I was doing sit ups, I was doing squats. I was doing anything I could possibly do to make this happen. I don't think I ate for several days because I had read that if you have an extremely low calorie count and ... [you take] vitamin C that can cause a miscarriage. I was actually reading pregnancy sites that warn you not to do things and everything they were warning you not to do was exactly what I was doing; roasting hot baths to the point that I almost scalded myself, and when I think about it I'm an educated woman, do you know, I'm a grown woman. It's just so sad.

The lack of abortion services within the formal health care system in Ireland means that to access safe and effective care, Irish women must rely either on travel to a clinic offshore or on online telemedicine. Travel carries a significant cost in terms of financial, social, physical, and emotional resources and is out of reach for many. Online telemedicine circumvents many of these costs and is safe and effective, but carries considerable legal risk, which also limits the supporting role Irish health care professionals can play for women when they are faced with these pregnancies. Irish women who need abortions are not restricted to any one demographic group or reason for needing care. Some need later abortions because of foetal anomaly or serious health risks that develop during pregnancy, but the vast majority fall under the broad category where the risks posed to their physical and mental health of continuing the pregnancy outweigh the equivalent risks of ending the pregnancy, and almost all are under 13 weeks pregnant by the time of their abortion. Medically, the gold standard of care would be to legislate for safe, legal, accessible abortion care services throughout Ireland that will meet the needs of the women who need to rely on them. I thank the members for their time.

Chairman: I thank Dr. Aiken for her opening statement. I call Dr. Ronald Johnson to make his presentation and he has 12 minutes.

Dr. Ronald Johnson: Good afternoon, Chairman and members of the Oireachtas joint committee. We thank the committee for its invitation to the World Health Organization, WHO, to present our guidance on health system requirements for safe abortion and potential barriers for women wishing to access services.

My colleague, Dr. Ganatra, and I are staff members from the department of reproductive health and research and the special programme of research, development and research training in human reproduction. The department and the special programme provide leadership on matters critical to sexual and reproductive health and rights through shaping the global research agenda, co-ordinating research, setting norms and standards, articulating an evidence and human rights-based approach, and providing technical support to WHO member states on sexual and reproductive health and rights.

The Department's vision is the attainment by all peoples of the highest possible level of sexual and reproductive health. It strives for a world where all women's and men's rights to enjoy sexual and reproductive health are promoted and protected and all people, including

the most vulnerable, have access to sexual and reproductive health information and services. The briefing today falls under our technical support role and through the organization's aim to support member states to implement the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030, the strategy on women's health and well-being in the WHO European region, and the Action plan on sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe, which was adopted by European governments last September.

Today's briefing is about the provision of safe abortion services in the event that some or all of the recommendations of the Citizens' Assembly become national policy. While legal, regulatory, policy and service delivery contexts may vary from country to country, the recommendations and best practices described in WHO guidelines aim to enable evidence-based decision-making with respect to safe abortion care. Today, briefly, we will cover the following points, as described in the WHO guidelines: integration of abortion services into the health system; national standards and guidelines; the equitable distribution and availability of facilities and health care providers; preparation and equipping of health facilities; financing and costs to women; and potential barriers to women accessing services.

Abortion services should be integrated into the health system to acknowledge their status as legitimate health services and to protect against stigmatisation and discrimination of women and health care providers. At a minimum, abortion services should always include medically accurate information and, if requested by the woman, non-directive counselling, to facilitate informed decision-making; abortion services delivered without delay; timely treatment for abortion complications; and contraceptive information, services and referrals.

National evidence-based standards and guidelines for safe abortion should be developed and regularly updated to ensure that health services and standards ensure good access and quality of care. They should cover types of abortion service and where and by whom they can be provided; essential equipment, instruments, medications, supplies and facility capabilities; referral mechanisms; respect for women's informed decision-making, autonomy, confidentiality and privacy; attention to the special needs of adolescents; special provisions for women who have suffered rape; and conscientious objection by health care facilities and health care personnel.

Ensuring access to safe abortion requires the availability of facilities and trained providers within reach of the entire population. Regulation of providers and facilities should be based on evidence of best practices and be aimed at ensuring safety and good quality without compromising accessibility to services. First trimester abortion care can be provided using a simple procedure, vacuum aspiration, or through the use of medical abortion drugs, mifepristone and misoprostol. These interventions can be provided at primary care level and through outpatient services. Such care can also be provided by generalist physicians as well as primary care providers like clinical officers and nurses. In early pregnancy, after the initial assessment by a provider, women can manage the medical abortion process without direct supervision and outside of a facility setting. For abortions beyond 12 weeks of pregnancy, higher level services may be needed, although a surgical abortion can still be provided as outpatient care. Facilities for inpatient care are required for medical abortion beyond 12 weeks of pregnancy. In addition, referral hospitals should have the staff and capacity to perform abortions in all circumstances permitted by the law and to manage all abortion complications.

Abortion facilities and providers must be well prepared and equipped to provide safe care. Most of the equipment, medications, and supplies needed to provide vacuum aspiration are the same as those needed for other gynaecological services. In addition, medical abortion requires

registration, procurement and distribution of mifepristone and misoprostol. Supportive services, such as commodity procurement, supply chain functioning and financing mechanisms, are as important as training providers for introducing new services. Where services already exist, infrastructural upgrades can facilitate more efficient patient flow and increase privacy and user satisfaction. Quality approved abortion instruments and medications should be routinely included in the planning, budgeting, procurement, distribution and management systems. In addition to skills training, participating in values clarification exercises can help all health care personnel differentiate their personal beliefs and attitudes from the needs of women seeking abortion services. Values clarification is an exercise in articulating how personal values influence the way in which health care personnel interact with women seeking abortion. Despite health workers' attempts at objectivity, negative and predefined beliefs about abortions and the women who have them often influence professional judgment and quality of care.

In terms of financing and costs to women, health budgets should include sufficient funds for the following types of costs related to safe abortion: equipment, medications and supplies required to provide care; staff time; training programmes and supervision; infrastructure upgrades; record-keeping; and monitoring and evaluation. The respect, protection and fulfilment of human rights require that women can access legal abortion services regardless of their ability to pay. Financing mechanisms should ensure equitable access to good quality services. Where user fees are charged for abortion, such fees should be matched to women's ability to pay, and procedures should be developed for exempting the poor and adolescents from paying for services. As far as possible, abortion services should be mandated for coverage under health insurance plans. Abortion should never be denied or delayed because of a woman's inability to pay.

What are the critical barriers to accessing safe abortion services? Access to safe abortion depends not only on the availability of services but also on the manner in which they are delivered and the treatment of women within the service-delivery context. Services should be delivered in a way that respects a woman's dignity, guarantees her right to privacy and is sensitive to her needs and perspectives. Attention should be given to the special needs of women of lower socioeconomic status, adolescents, and other vulnerable and marginalised women. Barriers to accessing safe abortion services, even when legal, include the following: restrictive interpretation of legal grounds, including the conditions that fall under health; failure to provide public information on the legal status and availability of abortion; excluding coverage for abortion services under health insurance, or failing to eliminate or reduce service fees for poor women and adolescents; requirements for third-party authorisations from one or more health-care providers, or from a hospital committee, from a court or police, from a parent or guardian, or from a woman's partner or spouse; restricting the range of health-care providers and facilities, which may result in poor availability of services, especially in rural areas; conscientious objection by health-care facilities and by health-care personnel; requiring mandatory waiting periods; censoring, withholding or intentionally misrepresenting health-related information, in the context of abortion; failure to guarantee confidentiality and privacy; and requirements for medically unnecessary screening tests such as requirements for women to view ultrasound images or listen to the foetal heartbeat. Any of these barriers can deter women from seeking care and providers from delivering services within the formal health system; they cause delays in access to services, which may result in denial of services due to gestational limits on the legal grounds; they create complex and burdensome administrative procedures; they increase the costs of accessing abortion services; and they limit the availability of services and their equitable geographic distribution.

I will conclude by saying that health systems should aim to respect, protect and fulfil the hu-

man rights of women, including women's dignity, autonomy and equality; promote and protect the health of women as a state of complete physical, mental and social well-being; minimise the rate of unintended pregnancy by providing good-quality contraceptive information and services, including a broad range of contraceptive methods, emergency contraception and comprehensive sexuality education; prevent and address stigma and discrimination against women who seek abortion services or treatment for abortion complications; and reduce maternal mortality and morbidity due to unsafe abortion, by ensuring that every woman entitled to legal abortion care can access safe and timely services including post-abortion contraception; and meet the particular needs of women belonging to vulnerable and disadvantaged groups, such as women of lower socioeconomic status, adolescents, single women, refugees and displaced women, women living with HIV, and survivors of rape.

We have provided copies of several documents for every member of the committee. These include the policy brief on law and policy considerations and part of a policy on health worker roles in the health system. We encourage all members to familiarise themselves with the guidelines as well as with our newly-launched global abortion policies database, which has the abortion laws, policies, health standards and guidelines for all UN and WHO member states. One can go into this database to do comparisons and to see the laws and policies in each country. The concluding observations of all of the treaty monitoring bodies are also included in this database and are linked to the countries in question, so one can click on these and go straight to the concluding observations. Country penalties are included, as is a range of sexual and reproductive rights indicators for all countries. One can really get a picture of whichever country one wants in the context of the global community.

Chairman: There are four lead questioners today and they have ten minutes each. Deputy Durkan has five minutes on this and five minutes on the next speaker if he so wishes.

Deputy Bernard J. Durkan: I thank the witnesses for their very interesting observations. My first question is for Dr. Aiken, who has done a great deal of helpful research in this area. She showed us a chart displaying the number of women who were satisfied after the abortion, including cohorts who felt safe, who felt relieved, satisfied, happy, pleased, and empowered. The chart also showed groups of women who felt guilty, sad, had feelings of loss, felt low, or felt disappointed. To what extent what counselling and support available for that group of women? What was the extent of the follow-up care and what were the findings over the course of that care, if known?

Dr. Abigail Aiken: That is a very good question. When it comes to this graph, it was by no means the case that every woman was completely happy about the abortion. There is often a great mix of emotions and most women, as we can see on the graph, recorded more than one. In response to the question about the counselling made available, the Women on Web service itself has an online email support where women mostly ask questions about, for example, whether what they are seeing is normal and whether they need to get care. They also sometimes ask questions about how they are feeling and whether it is normal to feel the way they do. Women on Web does not, however, provide a full-on and comprehensive counselling service for women. One of the important issues raised here by Deputy Durkan is the fact that women rely on Irish health care professionals for this kind of counselling and I do not know if it is always readily available to them. We can see that many women are scared to talk about this, particularly if they have gone down the online telemedicine route, because of the fear of being prosecuted, reported, or even just stigmatised. What this illustrates to us is that it is very difficult under the law at present to know how to provide those services for the women who are struggling with

their feelings after an abortion, even if they are in the minority. My answer then, is that these women do not have full-on counselling through the online telemedicine service and have to go to find it elsewhere. It is not at all clear that the majority are able to do that.

Deputy Bernard J. Durkan: Has Dr. Aiken done any research into the countries with readily accessible abortion services as compared to those, like Ireland, that do not? To what degree does either group of countries rely on online service? How great is that reliance, for example, where abortion is readily available? I presume that follow-up counselling is available in those countries.

Dr. Abigail Aiken: That is another great question. The mission of Women on Web is to provide to countries where safe legal services are unavailable. In a country with readily available abortion service, in Great Britain, for example, most women are accessing abortion in a clinical setting. Some still write to Women on Web, however, because they are in a specific situation where getting to a clinic is very difficult. This may be because of an abusive or controlling partner or perhaps because of a physical disability that makes it hard for them to reach a clinic. The provision of a readily available service, then, does not completely eliminate the barriers to access that some women might experience. It is to the countries where abortion is not legally available through the formal health care system, however, that Women on Web and another online telemedicine service provide. This is where the demand is coming from. There is a correlation between the absence of service in a country and women writing to Women on Web for help. Counselling services are not mandatory in countries like Britain, where very few people need to contact telemedicine services because they have access to clinics. Where such counselling is required or desired by a woman, however, it is fully integrated according to best practice into the abortion care provided.

Chairman: Deputy Durkan is coming up on five minutes, should he wish to save some time for the second round of questions.

Dr. Bela Ganatra: I support what the Deputy said about the recent global estimates released by the WHO last week with which he might be familiar. They referred to safe, less safe and least safe abortions and their distribution globally. We have found that, by medical standards and WHO guidelines, the self-management of medicated abortion, as described by Women on Web, does fall within the safety criteria and would be considered safe. In Latin America, in particular, where access to clinic services is not available, a number of women are accessing abortion pills online, not specifically from Women on Web which is only one service which cannot reach the majority of women who need a service. They do so through a wide variety of often unregulated services which are of unknown quality. We call such abortions less safe simply because women do not necessarily have access to counselling, adequate information or follow-up care. It is still paradoxical that the mortality rate and the number of deaths in seeking this type of care are much lower than for the dangerous methods mentioned by Dr. Aiken such as the use of coat hangers and bleach. It might hide a situation where women are not receiving appropriate and adequate care, but we do not see it as a public health problem because deaths are not happening. It is, however, something of which we need to be aware and conscious.

Chairman: I thank Dr. Ganatra. I will save the rest of Deputy Bernard J. Durkan's time for the next session. Deputy Jan O'Sullivan wishes to share her time between this and the next session.

Deputy Jan O'Sullivan: I may use all of it in this session, although I might try to leave a couple of minutes at the end.

Chairman: The Deputy can suit herself.

Deputy Jan O'Sullivan: I thank the delegates for coming before the committee. I thank Dr. Aiken for the exhibits she has given to us. They give a good human picture of some of the dilemmas people face. I thank the WHO, in particular, because of its international standing. It is really welcome that its representatives have been willing to come and address the committee. I have a number of questions.

I refer to women who use online services to access abortion services. In that context, will the delegates outline their views on whether they think the women in question are entitled to a better level of care in their own health service?

The delegates touched on Deputy Bernard J. Durkan's question. To what extent is there an absence of the care which should be available when there is a risk of illegality? The presentation referred to the issue of cost in the context of excluding women from services.

My related questions are about women who travel outside of the jurisdiction and the health implications in seeking a termination outside one's country. I ask the delegates to respond briefly.

Chairman: Were the questions directed at-----

Deputy Jan O'Sullivan: They were directed at both delegates. The questions are related.

Dr. Abigail Aiken: I thank the Deputy for her questions, the first of which was whether women were entitled to a better level of care. When we consider online tele-medicine services and travelling, although clearly they are providing abortion services which stop women from having to use coat hangers, bleach and other very dangerous methods, they do not and cannot address all of their needs. Even though online tele-medicine services are very safe and effective, as members will have seen in the charts we have shown, and although women have satisfied feelings afterwards, they still have to avail of such services illegally. The climate of anxiety which hangs over the women to whom we have talked and researched would not be described as quality medical care, given that it is cloak and dagger and there is the threat of prosecution hanging over one's head. They are entitled to better.

Women who travel access services within clinics but they will still have to manage the symptoms and side effects of the procedure in public as they travel home. Those who live close to services can manage their symptoms quickly at home. There is a disparate level of care between the two systems.

As my colleague pointed out, there should be best practice in abortion services which should be accessible to everybody, regardless of cost and ability to pay, the reason or who someone is. There is a system in place under which women who have the resources and money can travel, although they may not have a great experience. We have heard from many women who had to travel back home while managing symptoms, who had to leave children at home and so forth. It is very difficult to integrate continuity of care when one cannot go to a health care professional, make the decision to have the procedure carried out and receive follow-up care within a continuum in the same health care service. When things are broken up, as is the case for women here, it is very difficult to have a cohesive service which meets everybody's needs.

Dr. Bela Ganatra: From the perspective of the WHO, self-use is a safe option as an active extension of the health system when it is a choice women can make and where they have ac-

cess to backup care services, if they want and should they need them. When they have to do this because of a lack of options or alternatives, it would not meet the criteria of what the WHO regards as safe. Although one can have a perfectly safe and medically safe abortion by travelling, it still does not reflect an active choice but a lack of safe options and alternatives. It creates inequalities because there are women who cannot afford to travel or who might be too advanced in the pregnancy to travel. It creates inequalities in terms of cost and, most importantly, delays. Although most Irish women who have abortions in the United Kingdom still have them early on, the statistics for the United Kingdom show that the level of abortions beyond 12 weeks is higher among non-residents and Irish women travelling to the United Kingdom than among local residents.

Deputy Jan O'Sullivan: Dr. Ganatra referred to recent research. It may be a document I have read. I would like to ask about comparisons and where Ireland sits with other countries in the rest of Europe and the world in providing access to abortion services, particularly in the context of safe and unsafe abortions to which Dr. Ganatra referred in reply to Deputy Bernard J. Durkan. The research I have read suggests the highest proportions of safe abortions are in certain sub-regions which also show the lowest incidences of abortion. I am very interested in teasing out whether sometimes there is a misconception that if something is not available in a given country, there is not a high incidence of it. I ask for some information on the relationship between safe and legal abortions in other countries.

Dr. Bela Ganatra: Our research and estimates are not broken down by country but rather by region. We do not have specific data for Ireland; we only have data for the region in which it sits. Unfortunately, one of the limitations of the research is the fact that Irish women who travel to the United Kingdom are masked within the sub-regional estimates. The issues specifically related to travelling do not show up in the sub-regional estimates.

On high incidences and safety levels, our information shows that rates of abortion do not vary owing to the degree of restrictiveness of the law. They are similar across the world and regions, despite how strict abortion laws are. The statistics also show that the level of safety changes as the restrictiveness of the law increases. Abortions move from being less safe, in terms of the option of using medication without appropriate information under certain conditions, in particular within the developing world, to the least safe. I would not say Ireland is immune from this based on the data from Dr. Aiken which suggested methods we considered to be the least safe were being used here.

The contrast in this picture is that in countries which have facilitative abortion laws there is often good access to contraception, overall good levels of development and gender equality, thus creating a climate within which women can access good contraception. As a result the rates of unintended pregnancies and abortion are low. When women are faced with a situation where they need an abortion, they can have one safely. We can have a situation where both low rates and high safety coexist and that, in fact, is the case in northern and western Europe.

Deputy Jan O'Sullivan: Do I have time left?

Chairman: Yes, you have a couple of minutes.

Deputy Jan O'Sullivan: I will take it so, because I have a question on the practicalities and it is for the WHO. It is on issues that might arise regarding bringing in a legal and regulatory regime. Dr. Aiken dealt with some of this. It is about the practicalities of training, facilities and integrating the system into the current health system. Is that a big issue? How would it be

dealt with?

Dr. Ronald Johnson: It is a difficult question, not knowing exactly what is already in place in the Irish context. Generally, as I said in the presentation, to do surgical abortion with vacuum aspiration, most health systems have to have the required instruments and supplies to treat miscarriage and spontaneous abortion or treatment of any sort of complication that might come from it. It is just one step more to provide an induced abortion in terms of cervical dilation or something like that. The added cost should not be that much more. In many countries where there is unsafe abortion there is no question that the costs of safe abortion are much less than treating complications, but it does not perhaps apply to Ireland so much, from what we know in terms of complications.

Deputy Jan O'Sullivan: All of the witnesses have said it is important to have contraception side by side.

Dr. Bela Ganatra: Absolutely.

Dr. Ronald Johnson: The issue with abortion is that it is the end result and we want to encourage countries to deal with the underlying determinants of abortion. Women have abortions because they have an unwanted pregnancy. If we can stop - or reduce, rather, as we cannot stop - unintended pregnancies then we can surely reduce the numbers of abortions. There will always be a need for abortion because contraceptives are not perfect. In the guidelines we have a model where we looked at contraceptive barrier rates and estimated there are approximately 33 million accidental pregnancies every year globally due to contraceptive failure. As Dr. Aiken said, many of the women who have abortions are trying to use contraception anyway. It is a critical component. No abortion service should be provided without offering post-abortion contraception to the women there on the spot.

Dr. Abigail Aiken: I echo what my colleague has said. According to a study that came out last year, the vast majority, at approximately 92% to 95% of people, who used the abortion services of the British Pregnancy Advisory Service, which provides one third of abortions in the country, left the clinic with a contraceptive method. The two services are often very well integrated. Very often, people who have come in who have had trouble accessing contraception or have had a failure from another method leave with a method that works better for them.

Chairman: Deputy Murphy is indicating that she want to come in briefly on this.

Deputy Catherine Murphy: I have a question for Dr. Aiken. Is it fair to say women using Women on Web might not disclose an underlying health condition because they risk not getting the medication, which may well put them at risk? How is this evaluated? Is it evaluated afterwards? What controls can be put in place?

Dr. Abigail Aiken: Women on Web relies on women filling in the online consultation form to give truthful consultations. Committee members have the full study, and can see the table which shows that very few women have any contraindications or comorbidities, and when they do, a doctor reviews it and has communication with the woman to try to work out a strategy to make it safe for her. There is very little incentive to lie about these things because women know that Women on Web is their option. Women who cannot access it are more at risk of trying something more dangerous, as we have seen from some of the consultations today. I do not think people generally are untruthful about these things, but it would be much better if they could come and see health care professionals in person.

Chairman: The Deputy has nine minutes left on the next session. I will now go to Deputy Chambers, who has indicated five minutes on this and five minutes on the next session. I will let her know when the time is up.

Deputy Lisa Chambers: I thank the witnesses for their presentation and engagement. My first question is for Dr. Aiken. I only became aware of Women on Web this year, and I was surprised to see it has been operating for so long. Increasing numbers are using the service. Does Dr. Aiken attribute the decline in people travelling directly to the increase in the number of women using the online service? The research has touched on very personal aspects. Dr. Aiken has spoken to women, engaged with those who have used the service and ascertained why they did so and how they felt afterwards. This is really important information for us to have, to speak about the people who are actually affected and what has happened to them and why they went there.

All the witnesses have touched on the issue of contraception. Do we need to do more in this country with regard to access to cheaper contraception and making it more widely available and having better education? Obviously, prevention is better than cure and perhaps we are failing in that aspect.

Chairman: There is a little bit of interference. I wonder if there is a mobile phone near the microphone.

Deputy Lisa Chambers: I am also particularly concerned about the example of Stacey, who spoke about her fear of not knowing who to trust and to whom she could talk. That is a major concern for us in this country. Should a person access services online and something goes wrong, and thankfully the figures have shown this does not happen very often but it does happen, how does Dr. Aiken view the criminalisation of taking the pills, in terms of the safety of women and girls in this country? The last thing we want is for a woman to be at home and experiencing complications and waiting and not seeking medical help. That is something we really need to address.

These are my questions for Dr. Aiken and I will direct my other questions to Dr. Johnson and Dr. Ganatra.

Chairman: Does Deputy Chambers want Dr. Aiken to answer now?

Deputy Lisa Chambers: It makes no difference.

Dr. Abigail Aiken: The Deputy's first question was whether the decline in the number travelling and the increase in the number accessing pills through Women on Web are related. If we look at the graph, exhibit 2, we could not put all of the years on the axis, so 2002 is the first year in the graph, which is the first year of the decline. This decline has been quite steady to 2016. Committee members will notice there is some compression on the axis between 2002 and 2009 so it looks steeper than it should be in the first part. The first years on the graph were prior to Women on Web becoming available in 2007. Of course, it took a little while for the service to get known and for people to start using it.

What we can say is there was a decline in people travelling even before Women on Web came along, but we see from the graph, exhibit 1, there was a tripling over the past six years. It could certainly be that some women are making a decision that it is better for them to use the online service than to travel. What could also be happening is there is a group of women for whom travel was never a possibility, that it was simply out of reach because it was too expen-

sive or they could not get away from home or tell anyone. For these women it is possible the online service has allowed them a way to access abortion that was not there for them before, if that makes sense. Although the decline could be linked, we cannot attribute it to one replacing the other.

The Deputy's next question was on contraceptive access in Ireland. It is the case, no matter whether one is privately or publicly insured in Ireland, that one will have a co-pay for prescription medication, and this includes contraception. If we look at the figures released by the Irish Family Planning Association, someone could be looking at €30 a packet of contraceptive pills times 12 times however many years they will be used for, so there are co-pay problems with access to contraception for most people. People looking to get an intrauterine device, IUD, such as Mirena, could be looking at an upfront payment of €350 to €400. There are still some access problems, and this is reflected in the unmet needs statistic, where the unmet need for contraception in Ireland is double that of Great Britain where those medications are free of cost to everyone.

As my colleague pointed out, even with better contraceptive services, and absolutely that is something to focus on, the need for abortion still does not completely go away. It can certainly help with reducing abortion rates, but the two things really are hand-in-hand services that both need to be encompassed.

The Deputy's final question was about criminalisation and safety. We do see from the exhibits that the outcomes in terms of safety from Women on Web and other online services are good. One thing that is not in the charts is that among the about 9% of women who experience the symptom of what could have been a complication that was serious, 95% of those women did report going to a hospital and seeking care. Those who did not, which was about two people, were okay; nothing bad happened to them so from the data we have, people do go when it is necessary. However, this does not mean that it is easy for them to go and it does not mean that they might go when something is not an absolute emergency but they still might need some care. They might need some follow up, they might need to talk to someone, they might need counselling or they might need to go for something that is not necessary going to cause mortality but could cause morbidity so criminalisation still stops people from talking to health care professionals, interrupts that doctor-patient relationship that should be happening and stigmatises even if it is does not always stop people seeking emergency care. When one stigmatises something and makes it seem wrong, one puts it behind a door so it is no longer in the open.

Deputy Lisa Chambers: I have one final question for the witnesses from the WHO. Again, it relates to decriminalising abortion, particularly because we are looking at people accessing the abortion pill, which is technically a crime. The Citizens' Assembly did not recommend this but it did not take a vote on it and it did appear in some of its closing remarks from individual members. Do the witnesses think it is important that this committee discusses that and recommends decriminalisation? If we want to reduce the number of crisis pregnancies or unplanned pregnancies, what do we need to do in terms of addressing the issue? As Dr. Johnson said, one of the ways we could reduce abortions is by reducing unwanted pregnancies. Have they any suggestions beside contraception about what we should be doing to tackle that?

Dr. Ronald Johnson: There are different levels of criminalisation. In Ireland, there is the criminal law but it is maybe not as enforced as often as it is in other countries. Even when one does not have enforcement, criminalisation creates a chilling effect on women seeking services because they are never quite sure if they might go to prison for it. It also creates a chilling effect on providers providing services, again because they are unsure of what might happen. It can

be worse if the laws are actually applied. I am sure members are all familiar with the situation in Romania back in the 1990s. Abortion was legal up until 1966. When it was criminalised in 1966, it was not just a policy matter. Many measures were put in place to enforce it. The importation of contraceptives was prohibited and people were sent to high schools to do gynaecological checks of young girls every month and if girls were found to be pregnant, they would follow them up, so it was seriously criminalised. Members can see the graphs. Abortion-related mortality skyrocketed to some of the highest levels we have ever documented. In 1991, the law was liberalised overnight. Ceaușescu was executed and the first thing the Romanian Government did was liberalise the law because it recognised the problem of unsafe abortions. Members can see that overnight, the mortality rate dropped considerably. The number of abortions went up because they had not been reported before and all of a sudden, women had access to safe abortion, but members can see that the number came down as contraception use went up because they started increasing contraceptive access. In addition to contraception, we also need comprehensive sexuality education. That, coupled with access to affordable contraception, is the best way to prevent unintended pregnancy.

Deputy Ruth Coppinger: I thank all three witnesses for very their interesting presentations. I will start with the presentation from the witnesses from the WHO. They stated that there is no difference between abortion rates where abortion is legal or illegal because we regularly hear claims in Ireland from people who oppose abortion that it saves lives. We have heard the claim that it has saved 100,000 lives. Based on the witnesses' study of countries around the world, do they agree or would they still put forward the argument that there is no difference in abortion rates?

Dr. Bela Ganatra: There is no statistically significant difference in abortion rates based purely on the association of the restrictiveness of a country's laws. Abortion rates are, of course, significantly lower in the developed world and Europe - they have declined over the past 25 years - than they have in developing countries. It is not one on one because a number of factors determine the rates of abortion but when compared by legal status, we did not find that rates varied based on how restrictive laws were.

Deputy Ruth Coppinger: Would Dr. Ganatra agree that in Ireland, we are very lucky that due to our close proximity to Great Britain and the availability now of telemedicine sites we do not have the type of backstreet abortions and unsafe things Dr. Ganatra has seen in other countries where abortion is banned?

Dr. Bela Ganatra: I would say that Ireland has been incredibly lucky not to have witnessed the mortality and the consequences we have seen in other places such as Africa but the WHO's definitions of "safe" and "unsafe" take into account the fact that services have to be available and women have to have information and choices. It is not about whether they die or have severe consequences. It is the conditions under which women can access care that make an abortion safe or less safe, so I do not think just the fact that women are not dying means that no problem exists.

Deputy Ruth Coppinger: I thank Dr. Aiken for giving voice to a lot of women in this country who are virtually silenced and at least bringing out their testimonies through her research. I want to ask her about a study by the University of Kent in March 2016 by Dr. Sally Sheldon. Dr. Aiken is obviously referring to Women on Web but Dr. Sheldon's study referred to two sites - Women on Web and Women Help Women. Dr. Sheldon reckons that there were 3,000 requests from people in Ireland to those sites alone every year. If we break that down in figures, which is really important for an accurate abortion rate in this country, let us say 70%

of them came from the Republic of Ireland which would mean that 2,100 requests for abortion were made through these two sites in the South. If we divide that by 52 weeks, that is roughly 40 requests per week. Let us say only 35 of those people actually carry it out because not everybody who orders the pills goes through with it - some people change their mind - that would be 35 women every week, which would be five per day in the Republic of Ireland. That is a much higher figure than anybody would ever have contended. Would those figures be accurate based on Dr. Aiken's research with just one site?

Dr. Abigail Aiken: As I stated when we looked at the exhibit that showed the tripling between 2004 and 2016 for Women on Web, we cannot do the same thing for both services because Women Help Women began in 2014 so, as I stated, those figures for 2015 and 2016 are lower bounds because they show figures for Women on Web only. I am glad that Deputy Coppinger drew attention to the fact that Dr. Sheldon's study looked at 2015 and 2016 and was able to come up with that estimate of 3,000. When one breaks that down by the number of people, that probably is per day and the rate of people who maybe do not go ahead and carry it out, I think five women per day would be quite an accurate statistic. One must then add the people who travel to that.

Deputy Ruth Coppinger: The last question concerns the reasons women gave for having abortions. Dr. Aiken said the most common age group was 30 to 34-year-olds and the second was 25 to 29-year-olds. A myth that is often put out is that if it became available, it would be a case of young single girls out on a Saturday night popping in for an abortion on the Monday, the concept of abortion on demand. In fact, however, 63% are mothers already. These are women who know what it is like to have children, have experienced pregnancy already and have decided that they cannot cope at this time with another child, which the witness said was the most common reason. The second most common reason was money. That puts paid to the idea people will be popping out every week to have one if it is made available.

On rape and fatal foetal abnormality, the witness said approximately 2% of people cited rape as the reason. I think she said that fatal foetal abnormality was the reason in 4% of cases in the UK. That would be 6% of abortions in Ireland. Some people are talking about those two reasons only for the basis of legislation in this country. How would she feel if the 94% of abortions, which the witness tells us are done in the timeframe of 13 weeks anyway, were not catered for? Will women still have to rely on websites?

Chairman: I thank Deputy Coppinger. I apologise to the witness but I have to ask her to be as brief as she can with the responses because we are already over time and many people have indicated that they wish to come in.

Dr. Abigail Aiken: I will be brief. When we consider the graphs - exhibit 3A and exhibit 3B - we see that abortion in Ireland is not restricted to any particular group of women or reason. Although cases of foetal anomaly and rape are the ones that are often talked about a lot, as they tend to be at later gestations, especially with foetal anomaly because those are not usually diagnosed until the 20-week scan, we are talking about the small number of abortions that happen at a higher gestation. As we said, the vast majority of abortions to people in Ireland are happening at 13 weeks. If those abortions - those 94% - do not form part of the conversation about what to do about abortion in Ireland, most of the problem that exists will not be addressed.

Chairman: I thank Dr. Aiken. Senator Ruane has six minutes.

Senator Lynn Ruane: I thank both of the witnesses for their presentations. Both presenta-

tions speak for themselves. They were thorough. I have two questions. One is for Dr. Aiken and the other for Dr. Ganatra to answer. In Dr. Aiken's presentation, she stated that 54% of women experienced a contraceptive failure and sought abortion access as a result. We spoke a little here about the importance of contraception and how it should be integrated in terms of abortion care as well. Can Dr. Aiken speak further to the relationship between contraception and abortion and, in particular, the accuracy of the claim in some quarters that women may use abortion as a primary form of birth control in a liberal abortion regime?

My second question is for Dr. Ganatra. In her presentation, she stated that one of the barriers to safe abortion services is the intentional misrepresenting of health-related information on abortion. In Ireland, many cases have arisen recently where rogue crisis pregnancy counsellors have given inaccurate and misleading information to women. Can Dr. Ganatra describe a best practice framework for how such services should be delivered and regulated to minimise any further risk of this?

Dr. Abigail Aiken: As I showed in the presentation, 54% of those women - the majority - had been using contraception at the time that they became pregnant. We know that contraception is not 100% effective. No method is. There simply is not one. However, if we consider countries, for example, Great Britain, where full abortion services are available to most people, we can see that the unmet demand for contraceptive use is lower than in Ireland. It is half the rate. Therefore, there really is no empirical evidence to support the claim that people would stop using contraception if abortion was available. If we consider Great Britain and other countries that have liberal abortion laws and their rates of contraceptive use, they are higher than the rate of contraceptive use in Ireland. I have no empirical evidence to support that kind of talk.

Dr. Bela Ganatra: If one looks at the graph, it shows how abortion rates have consistently declined in Europe between 1990 and 2014, and the majority of the countries have abortion laws that are fairly liberal. To address the concern about the misrepresentation of information and the setting-up of services, the key point would be to have national standards and guidelines which lay out clearly what the responsibilities are, how services should be delivered, how the legal grounds need to be interpreted and what are the medical standards.

Chairman: I call Deputy O'Connell.

Deputy Kate O'Connell: I thank the witnesses for attending today. My colleague, Deputy Durkan, referred to the slide - perhaps it could be displayed - with the feelings after abortions, including guilt, sadness, feelings of loss, low, and disappointed. I would assume that there is a correlation with the same feelings someone would have after a miscarriage. Are there any comparative data? Is data available to compare whether women have similar feelings after a miscarriage? I am trying to work out if there is a difference in that regard. There is no reference to a term that is thrown around a bit, which is "abortion regret". Was that considered or is that just one of those made up things? Could the witnesses qualify that for me?

On the evidence from Women on Web, have we any evidence that women are procuring pills online and saying that they are under ten weeks pregnant when, in fact, they are 14 or 16 weeks pregnant? Have we any data to show the complications that might arise out of off-licence use of the product and long-term health implications if a woman takes it too late?

Looking at this from outside Ireland, as the witnesses do, in an international global context would the approach taken by consecutive Irish Governments to women's policy be considered quite primitive? Are they surprised that as a modern country we are having this conversation

here today? I cannot believe we are having these conversations, but we are.

To clarify some of the matters-----

Chairman: Perhaps the witnesses could respond to some of those questions because there were a number of questions there.

Dr. Abigail Aiken: No, I do not have data on feelings after miscarriage. I am sure there are papers available on it. However, I do not have that, especially not to compare to these women. On abortion regret, the data in front of the Deputy is really the best data we have. It is from 1,000 women and looks at their feelings after an abortion. I think there are as many feelings after abortions as there are abortions because it is an individual and personal thing. However, looking at this graph, I do not see much evidence for an abortion regret. I know it is a term that is out there but it does not really exist in the medical literature. I have to emphasise that we really lack empirical evidence - real evidence - that it is actually a thing.

On whether people tell the truth about being ten weeks pregnant or under, I do not think we would see the kinds of outcomes that we see in exhibit 7 or exhibit 8 if people were being untruthful about their gestation. It is not as though people drop off some kind of a cliff after ten weeks, where it will all go terribly badly wrong. It really is a kind of a dose-response, where the further one goes the more likely one will need surgical help ending the abortion or to see some kind of a complication. It really is not a kind of a hard cut-point. That is just where the trials end, so at the moment that is where evidence goes to. If women were not telling the truth about this and not following the instructions they are given by the online telemedicines service, we would not see anything like the effectiveness rates that are there or the low rates of complications. This tells us people are generally following the instructions that they are given and not taking risks with their health. People generally know what is best for them when it comes to their health.

I will pass to my colleagues for the next question.

Dr. Ronald Johnson: The World Health Organization would never say that Ireland is living in the dark ages. Ireland is an outlier in the European region in terms of its abortion laws. However, every country has its unique historical context and social and cultural differences. The economics are different and the politics are different. All these differences are important in helping to explain the current situation. Regardless of that, women will have abortions. Therefore, Ireland has to ask itself if it wants to change anything at this point. If it does, the World Health Organization would be more than willing to engage with the Department of Health. We would really like to support Ireland to adapt our evidence-based and human rights-based approach.

Deputy Kate O'Connell: Finally, what approach would Dr. Johnson advise this committee to take in considering and making recommendations on gestational limits? We have discussed the fact that there is only 6% between fatal foetal abnormalities and rape, which leaves 94% to be dealt with. I would have concerns, based on the evidence we have heard at this committee to date, about how we can insert into legislation a requirement that people prove that they have been raped in order to access abortion. Has Dr. Johnson any advice for this committee on how we might proceed when it comes to setting gestational limits if we are going to have abortion in Ireland?

Dr. Ronald Johnson: We have looked at gestational limits in our policies database and

found that across the world, they range from eight weeks - and in this particular country, it is eight weeks to save the woman's life - up to no limit and everything one can imagine in between. If one looks at the database, one sees that in some instances, the numbers are *ad hoc* or arbitrary. I do not know why particular limits are set. It may have to do with trimesters of abortion. A lot of countries settle at around 12 weeks for on-request abortion but there is a group of countries at 14 weeks, another group at 18 weeks and then some are at 24 weeks. There are four countries with no limits.

The other point about gestational limits is that they vary by country for different legal grounds. There are gestational limits for abortion on request, without specification of reason. About 92% of countries have gestational limits that have abortion on request. When it comes to health, about 37% of countries have limits, with the rest having no limit. When it comes to life, about 20% have a limit, with the rest having no limit. Again, one must anticipate that whatever limit one sets, some woman will need an abortion who will be beyond that limit and one must ask oneself what that woman is going to do.

Chairman: Deputy Jonathan O'Brien is next. I must ask members to be as concise as possible with their questions.

Deputy Jonathan O'Brien: I just have two short questions for the representatives from the WHO. Is there any correlation between gestational limits and safe abortions? One of the difficulties we are faced with in terms of legislation based on the recommendations of the Citizens' Assembly is that the assembly referred to "risk", "serious risk" and "real and substantial risk". Does the WHO have any definitions for "risk" and "serious risk"?

Dr. Ronald Johnson: Okay, we will both give a quick response to that. Abortion is a very safe procedure. It is safe at any gestational limit but it is safest very early. There is some excellent data from the USA - Centre for Disease Control, CDC, data collected over a ten year period - which shows that the mortality rate is about 0.6 per 100,000 abortions at 21 weeks or more. All of that needs to be put into the perspective of the fact that abortion is still safer than carrying a pregnancy to term. The average abortion is about fourteen times safer than carrying a pregnancy to term. That helps to put it into perspective. Abortion is a very safe procedure. However, risk increases exponentially for every week, even though the numbers are very low. It makes sense, from an evidence point of view, to do it as soon as possible.

Dr. Bela Ganatra: Does Dr. Johnson want to address the risk question too?

Deputy Jonathan O'Brien: The Citizens' Assembly gave us a number of options in terms of risk.

Dr. Ronald Johnson: The WHO does not define "severe risk". We just talk about risk and health risk. Is this in the context of health?

Deputy Jonathan O'Brien: That is correct, yes. The Citizens' Assembly gave us a number of options including "risk", "serious risk" or a "real and substantial risk". I am asking how we would go about defining that in legislation.

Dr. Ronald Johnson: What the WHO says about that is on page 92 of our guidelines, as follows:

> The fulfilment of human rights requires that women can access safe abortion when it is indicated to protect their health. Physical health is widely understood to include conditions

that aggravate pregnancy and those aggravated by pregnancy. The scope of mental health includes psychological distress or mental suffering caused by, for example, coerced or forced sexual acts and diagnosis of severe fetal impairment. A woman's social circumstances are also taken into account to assess health risk.

In many countries, the law does not specify the aspects of health that are concerned but merely states that abortion is permitted to avert risk of injury to the pregnant woman's health. Since all countries that are members of WHO accept its constitutional description of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", this description of complete health is implied in the interpretation of laws that allow abortion to protect women's health.

Deputy Jonathan O'Brien: If we were to draft legislation which used the terms "serious risk" or "severe risk", we would not be in line with the WHO guidelines because the latter only refer to "risk". Would that be fair to say?

Dr. Ronald Johnson: I think one has to ask oneself, "How will this be defined?"; not only how it will be defined in the policy but how it will be applied in practice. At the end of the day, if a country does not have abortion on request without specification of reason, then the person who decides about the abortion is a third party; it is the health care provider. Not every health care provider thinks the same way. The criminalisation aspects and everything else will determine which ones are willing to broaden their interpretation of grounds. Some will do so but others will not. The question is, "Is that fair to women, if one health care provider will take an expanded interpretation and another will not?". Those are the kinds of questions that one has to ask when one starts talking about these qualitative terms that are not precise.

Dr. Bela Ganatra: It is also that risk is determined post-event. It is afterwards that we decide that something was serious or not serious. One cannot anticipate whether a particular health or medical condition is actually going to become worse as it is happening. It is a case by case decision that cannot be anticipated and written about beforehand.

Chairman: Senator Rónán Mullen is next.

Senator Rónán Mullen: My first question is for the first speaker from the WHO. Would I be right in thinking that he would support a law requiring those providing abortion to offer post-abortion contraception? Would he support a law that would make it a requirement for them to offer post-abortion contraception, given that he spoke about how important he thought that was?

Dr. Ronald Johnson: It is incredibly important.

Senator Rónán Mullen: I would like a short answer.

Dr. Ronald Johnson: It should be offered. In terms of a law, it would depend how the law is written because one does not want to force women-----

Senator Rónán Mullen: No, I am talking about requiring the practitioner to offer it.

Dr. Bela Ganatra: That would be good medical practice and-----

Senator Rónán Mullen: I find it surprising then that on the other hand, the WHO representative would have a problem with a law that would mandate that women would be offered ultrasound possibilities, foetal heartbeat monitoring or indeed, accurate information about pos-

sible mental health sequelae that apply in some cases. I am not speaking about mandating that but requiring that it would be offered. I thought there was such a thing as informed consent. It is concerning that the delgates seem to deprecate anything that might lead a woman to change her mind about having an abortion, but they are very happy to be prescriptive on the question of whether a good law would be required for a post-abortion contraception service to be offered. I thank them for their answer in that regard. Let me move on to ask another-----

Chairman: Excuse me, Senator, I am chairing the meeting and I would like to give the delegates the opportunity-----

Senator Rónán Mullen: I am anxious to cover quite a bit of ground. Will the Chairman afford me some leeway afterwards? It is my entitlement to seek answers.

Chairman: Certainly, but I think the delegates wished to answer the question.

Senator Rónán Mullen: I have no problem with that, but, please, do not cut me off because I need to cover some ground.

Chairman: The Senator is supposed to be asking questions to get answers. With respect-----

Senator Rónán Mullen: I got the answer.

Dr. Ronald Johnson: Something needs to be corrected. We did not say "offered"; we said "forced". Women should not be forced-----

Senator Rónán Mullen: Therefore, Dr. Johnson would have no problem with a law that would require people to be offered ultrasound opportunities to hear about possible mental health sequelae and the possibility of hearing the foetal heartbeat? In the context of informed consent, he would have no problem with that being offered in a respectful way but one that accepts a possible refusal of the offer? Is that Dr. Johnson's position?

Dr. Bela Ganatra: The scientific-----

Senator Rónán Mullen: I just want a yes or no answer. It is a straight question.

Dr. Bela Ganatra: Medical practice is best not regulated at this level in law, whether for contraception or anything else.

Senator Rónán Mullen: Interesting.

Dr. Bela Ganatra: It is best determined by a medical practitioner.

Senator Rónán Mullen: I note the contrast in the delegates' answers. I turn to their claim, without producing evidence in front of us, although admittedly they did not have time to do so, that there is no evidence that a restriction in the law causes a lower incidence of abortion. Is it not strange that Britain which has a population roughly 15 times the size of Ireland's - 60 million compared to 4 million - nonetheless has an abortion rate at least 30 times the rate for Ireland? In Britain there is something short of 200,000 abortions a year. Borrowing Deputy Ruth Coppinger's figures for the likely incidence of abortions induced by medical pills, Ireland might have a figure of 6,000 a year. I find it difficult to understand how in their presentation the delegates did not address that glaring statistic.

I draw the delegates' attention to something that came up last week on which I was challenged, but I was correct. It is that in Northern Ireland which has a smaller population than the

Republic the Advertising Standards Authority upheld a billboard campaign that claimed that there was a reasonable probability that approximately 100,000 people were alive in Northern Ireland who would otherwise have been aborted had it been legal to do so. It stated, "On balance, we concluded that the evidence indicated that there was a reasonable probability" and "Because we considered that readers would understand the figure to represent an estimate, we concluded that the claim was unlikely to materially mislead readers". A similar conservative estimate has been made about the impact of Irish constitutional law. Would the delegates from the WHO accept that they are making a claim that seems bizarre in the light of the disparity in the abortion figures for Britain and Ireland?

Dr. Bela Ganatra: To clarify, we do not have country by country comparisons of abortion incidences. We have noted that we have data at sub-regional level and that they might mask what happens in Ireland, but we know from the research and other countries too that in circumstances where abortion is illegal, stigmatised and happening outside formal health services, the numbers are obviously not counted or well accounted for and abortion incidences could be completely under-reported, whereas in Britain there are extremely good statistics and reporting on the data. I do not think the comparison would be-----

Senator Rónán Mullen: I thank Dr. Ganatra for her answer. Let me draw her-----

Dr. Bela Ganatra: Dr. Aiken will answer the rest of the question.

Senator Rónán Mullen: I did not address her.

Dr. Abigail Aiken: May I quickly speak?

Senator Rónán Mullen: Okay.

Dr. Abigail Aiken: I will address the figure of 100,000. I have seen the billboard in question. A problem with the figure is that when one looks at the methodology of how it is calculated, it has taken the abortion ratio for Scotland between 2008 and 2012 and applied it to Northern Ireland from1967 onwards. In 1967 when abortion services first became available, not everyone rushed at once to have one. The methodology has taken a ratio from a different country that is too large and applied it to Northern Ireland. I agree that the Advertising Standards Authority upheld it, but there are many problems with the figure.

Senator Rónán Mullen: It is not that I do not want to give people an opportunity to answer my questions fully, but we are involved in a really restricted process which makes a nonsense of the life and death issues with which we are dealing. I am trying to cover important ground.

The preamble to the Convention on the Rights of the Child-----

Chairman: The Senator may make a final point of clarification.

Senator Rónán Mullen: I wish to ask the delegates from the World Health Organization for their views on two very important matters. The preamble to the Convention on the Rights of the Child of 1989 cites the Declaration of the Rights of the Child of 1959. It states the child "by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth". Does the delegates' presentation, in which they talk about how incredibly safe abortion is without once acknowledging that it is anything but safe for the unborn child, not make a nonsense of what is stated in the preamble?

Late-term abortions happen in places such as Britain and Canada where quite a number of

botched abortions have taken place in recent years and where children were alive after the procedure. What is the delegates' view on what should be done in that case? What do they think happens and what do they think should be done to provide pain relief for unborn children, if they have prescriptions to give us in that regard? I notice how unprescriptive they were in talking about gestational limits. It was remarkable compared to how prescriptive they were on the need to allow abortion wherever one was wanted. It makes me wonder whether they have ever observed an abortion taking place to see what is involved.

Chairman: The Senator will have to allow the delegates to respond. We have nearly reached nine minutes and need to be fair to everybody.

Senator Rónán Mullen: I appeal to the Chairman, given the seriousness of the issues involved and the imbalance in the committee's membership in the points of view held on this issue and also among those invited to address the committee, to at least show me the courtesy of affording me leeway.

Chairman: I have afforded the Senator leeway.

Deputy Ruth Coppinger: Where is the imbalance? It is not.

Chairman: I do not wish to get into a debate on that issue in the presence of the delegates. We are trying to make the best use of our time. I ask the delegates from the WHO to respond as briefly as possible.

Dr. Ronald Johnson: I do not think what we have said makes a nonsense of the statement made in the Convention on the Rights of the Child. I do not think that statement addresses the interests of the foetus in the context of those of the woman.

Dr. Bela Ganatra: There is an issue with unsafe abortion, given the rise in the number of unwanted pregnancies among young adolescent girls who do not have access to safe abortion. The incidence of unsafe abortion is much higher in that age group. If one is talking about protecting children, one has to talk about ensuring access for adolescent girls also.

Senator Rónán Mullen: The preamble refers to the protection of the child before birth.

Dr. Bela Ganatra: I think Dr. Johnson has already answered that question. I do not think we have any evidence of foetal pain about which the Senator is talking.

Deputy Clare Daly: Without making points, the discourtesy shown to people whom we have invited is unacceptable, regardless of their views. There should be an intervention to deal with that issue. It is not on.

Senator Rónán Mullen: On a point of order, I showed no discourtesy to anybody. I asked questions forensically and sought the right to persist in asking a number of questions. I object to fellow members of the committee seeking to up the ante in this way in dealing with what is a very sensitive issue of human rights and human dignity. I will make contact with the Chairman to put these objections more clearly without taking up more time today.

Chairman: I would like us to use our time as well as we can and ask Deputy Clare Daly to pose questions to the delegates. We will note her comments and return to the matter at another time.

Deputy Clare Daly: I find the information provided incredibly helpful. Some of my ques-

tions have been answered and I will ask a few more.

It is quite obvious that, regardless of our deliberations, the use of abortion pills by Irish women will continue and actually increase. The delegates have given us evidence that it is safe and cheaper. Has any analysis been made against the backdrop of criminalisation, the threat of arrest and prosecution in Northern Ireland, for example, or here, to show that people are because of this prospect, putting off this more convenient or easier to access option and instead travelling at greater expense and inconvenience? Is it the view of the witnesses that for us as a committee to look at this issue and not to take on board decriminalisation we would be only doing half the job? Related to that is the fact that we have a module for dealing with ancillary recommendations. It strikes me, based on what the witnesses are saying, that we would be doing an incomplete job if we did not look at the whole area of contraception. It is utterly shocking to think that 44% of people are not using contraception. We have a huge problem in this country in not supporting people and dealing with the issue of unplanned pregnancy. Do the witnesses think that in order to deal comprehensively with abortion, we need to take those two aspects into consideration in our findings?

Dr. Abigail Aiken: In terms of decriminalisation, there is no evidence at present that women in Northern Ireland, where there have been some prosecutions, have decided that they will travel instead because so often travel is out of their reach. Although it is an option that risks prosecution, it is the option. If the committee did not deal with decriminalisation one of the problems is the lengths to which women for whom travel or even abortion pills might be out of reach will resort to end their pregnancy. Those things are also covered under criminal law. If the committee did not take that into account its members would still have to worry about those people who end up doing things that are blatantly unsafe because they are not able to access any other kinds of services.

On the contraceptive question, again, if one looks at the co-pays that women are having to pay to keep contraception going between the approximate ages of 15 and 45 when they are potentially able to get pregnant, the cost adds up to quite a lot of money and if trying to break down the barriers to contraception is within the ancillary recommendations that would be a very sensible thing to do.

Deputy Clare Daly: I was struck by Dr Ganatra's point about the issue not being about death or serious ill health to the woman, but that one looks at the question on the basis of the conditions under which women can access health care. That struck me as quite important. How does the WHO classify the issue of health and the definitions one uses in that regard? Based on what has been said Ireland would be very much out of kilter in terms of some of the guidelines in regard to this area of women's reproductive health. Does Dr. Ganatra know if Irish medical policy and practice generally follow the WHO guidelines in terms of other areas of women's health? Perhaps she could give more information on how she came to those views because there was an inference at last week's meeting of the committee from one of our contributors that there is an international conspiracy of pro-abortion advocates who have taken over international organisations to promote an abortion agenda. Could Dr. Ganatra deal with that inference? How did the World Health Organization, as a health organisation, come to a position that the safest option for women is the provision of abortion with less barriers as part of the health care system?

Dr. Ronald Johnson: I can start and then Dr. Ganatra can add to what I say. I would like to be very clear that the WHO does not promote abortion, just like we do not promote pregnancy. What we promote is the safety in each of those contexts. Perhaps Dr. Ganatra will respond to

the health question.

Dr. Bela Ganatra: The committee has heard Dr. Johnson give the WHO's definition of health as a complete state of social well-being. Reproductive health needs are part and parcel of a woman's health needs during the course of her life. The need for an abortion is also part of reproductive health needs during the course of life for many women. As far as the WHO is concerned, it is a health issue and needs to be addressed just like any other health issue is addressed. Medical standards have to be talked about just as one would for pregnancy care or anything else.

Dr. Ronald Johnson: To put this in a historical context, unsafe abortion was identified by the WHO as a public health concern in 1967 and there was a world health assembly resolution signed by most if not all of the countries. It has been a huge problem over time. It is becoming less unsafe as Dr. Ganatra mentioned and as this paper indicated, but it is a huge issue for women. The safety spans physical health, mental health and social well-being as well. It has not gone away and it will not go away.

Deputy Clare Daly: I think the witnesses' clarity strengthens the points they are making. They come from the background of public health. I note that last week the WHO released figures showing 25.1 million abortions in the world are unsafe. We are talking, largely, in this section although not exclusively about first trimester abortions, which the witnesses said are very simple and they can be provided at primary care level on an outpatient basis. I agree with the witnesses. There was an article last week in *The Guardian* written by the head of obstetrics and gynaecology in Britain. The point was made that the service should be provided by nurses and midwives. Medication is prescribed in cases of missed miscarriages anyway. On the issue of access, which seems to me to be the key issue which we as a committee need to address, that approach would be one way in which the service could be made available and it would address overcoming some of the barriers. Do the witnesses have any comments on that or have they had any dialogue on the issue?

Chairman: Deputy Daly is over time so I ask the witnesses to be very brief in their response.

Dr. Bela Ganatra: What Deputy Daly said is very much in line with what our guidelines also say.

Dr. Abigail Aiken: Deputy Daly is correct about the safety. I want to bring this up because botched abortions were mentioned. That statistic on Canada is for later gestations where sometimes people deliver a live baby, because that is what they have chosen to do because of the foetal anomaly, to give them time to spend with the baby before it expires naturally. Calling them botched abortions is very disrespectful and I just wanted to put the record straight.

Chairman: I call Deputy Naughton. She has six minutes. I am very keen for people to keep to their allotted time because we have other witnesses coming in at 4 p.m.

Deputy Hildegarde Naughton: Dr. Ganatra made an excellent presentation and I thank her very much for that. I accept that the figures cannot be broken down by country. Is there a disparity in regard to the maternal mortality rates in countries where abortion is freely available compared to countries where it is not freely available? Perhaps the question has already been answered in the case of Romania. Could Dr. Ganatra comment on the situation in general terms in regard to an estimate for what impact it would have on maternal mortality rates if abortion

were freely available in Ireland? Are there other reasons implied in the figure we were given?

In a country where abortion is freely available are there any data on whether there is more screening in regard to minor disabilities and, if so, is a greater number of abortions sought thereafter?

Dr. Bela Ganatra: In terms of maternal mortality one thing to realise is that measuring the proportion of abortion deaths as a part of maternal deaths is not necessarily the best way to think about abortion safety, because it is relative to other causes of maternal deaths and abortion can be particularly unsafe but not contribute to a large proportion of maternal mortality or *vice versa*. We do look at case fatality rates and we have seen that case fatality rates, that is, the number of abortions that lead to death, are the highest in contexts where they have been most unsafe.

One also has to know that complications from unsafe abortion can occur but where health systems are good and treatment for complications is available death might be prevented so that one does not see that as a death but then again one has masked a problem that occurred. We have to be careful with the focus on deaths but that is why our focus is now shifting to the standards of care and the morbidity aspect, and not just focusing on the outcome of death for all health issues, not just for this one.

Deputy Hildegarde Naughton: In terms of the question on screening, are there any data on that which we could look at?

Dr. Bela Ganatra: I do not have that at the moment.

Chairman: I thank Deputy Naughton and call Senator Gavan. He has six minutes in total.

Senator Paul Gavan: You will be pleased to hear, Chair, that I will not need six minutes.

Chairman: That is good.

Senator Paul Gavan: I have a couple of questions. I wish to get rid of a couple of myths that have been spun on one side of the debate. Will someone on the panel, please, tell me what are the risks associated with abortion? Does it, for example, result in a higher risk of breast cancer or mental health problems or are these ill-informed myths? Would Dr. Aiken say there is a dereliction of State responsibility in Ireland in providing post-abortion services? In her report she states "the current Irish abortion law limits the information and support that Irish health care professionals can provide to women." Will she expand on this for us if she has time?

Dr. Ronald Johnson: As far as we know - this is on page 49 of the guidelines - there are no known risks for breast cancer, future reproduction or mental health. The risks are no greater for women who have an abortion than among the general population.

Dr. Abigail Aiken: Although the law in Ireland does allow health care professionals to treat post-abortion complications or provide counselling and allows the provision of information on travelling for an abortion, there is what my colleague has referred to as a chilling effect. The Senator will see in some of the quotes included in the packet that health care professionals do not feel comfortable or feel there is a risk in going too far because the law does not prescribe exactly what they can say. When it tries to legislate for what is really within good informed consent or between a doctor and a patient, it runs into trouble. That is why there are medical oversight bodies to decide that rather than governments. It has been made very difficult for providers to do post-abortion services well because there is no continuity of care. If someone

says he or she has carried out an abortion, he or she may not be telling everything. He or she may have done something that is illegal and does not feel he or she can say that. As someone quoted in the packet says, their first thought should not have been how they were going to lie. It interferes with what should be a good trusting relationship between a patient and a doctor, whether before or after an abortion.

Senator Jerry Buttimer: I thank the delegates for their presentations and apologise for having to leave to vote. One of the most significant statements they have made is that they are coming from a public health perspective and not promoting abortion. I am very happy to hear that. What proportion of a health budget would Dr. Johnson say the cost of abortion services would be to the State from a public health perspective? I am not asking him to be prescriptive on the actual cost. From his experience, given that in this country we have a private health insurance model, how can we encourage or mandate health insurance companies to provide cover or a plan for women? Who, in his opinion, should oversee or inspect clinics? In this country the Health Information and Quality Authority oversees and inspects different parts of the health system. Who should do it if we change our model?

I thank the delegates for their excellent presentations which were breathtakingly interesting.

Dr. Ronald Johnson: In most countries oversight is by the Department or Ministry of Health. The WHO would be very willing to work with the Department of Health to help to develop the systems of supervision and oversight.

I cannot answer the question about costs. The cost of an abortion varies across the world from being free to $1,000. Women in New Zealand and the United Kingdom receive a free service. The cost of an illegal abortion can be astronomical. There are so many technicalities in estimating the cost for a particular system and we do not have the information necessary to process it, but we could certainly sit down and work with the committee on that issue.

Senator Jerry Buttimer: What about inspections and quality control, if I can use that phrase?

Dr. Ronald Johnson: The Department of Health.

Dr. Bela Ganatra: Or professional medical societies which regulate all other clinical practices.

Dr. Ronald Johnson: There are different models in different countries.

Dr. Bela Ganatra: That is generally how it works in most places.

Senator Jerry Buttimer: If we were to change our policy or laws to begin a new regime, how long would it take to put everything in place to allow the termination of pregnancies to take place?

Dr. Ronald Johnson: That is a tricky one because there is a culture of health care and service provision and, like all cultures, it is different. There has to be an enabling policy environment and people who are willing to implement the change. I do not know if there are such persons here, but that is the big question. If there are people here who are committed to implementing it, it should be easy. It is simple. Abortion is simple. Adding it to the health service would be very simple, but there have to be the personnel who are enthusiastic about doing it.

Deputy Ruth Coppinger: Dr. Aiken would know the cost of mifepristone and misoprostol.

Chairman: If Dr. Aiken wishes to respond, she is welcome to do so.

Dr. Abigail Aiken: One thing to consider is that pregnancy care is extremely expensive and more expensive than abortion care. The price of mifepristone and misoprostol varies widely by country, but they are not expensive medications to manufacture and the price would depend on who was providing them.

Dr. Ronald Johnson: Misoprostol is a generic drug and very inexpensive - the price is cents per tablet. Mifepristone is now also very inexpensive. It can be sourced in bulk for approximately $3.50 per tablet. There are models in the world in which the ministries of health procure it directly from the manufacturers. That is the cheapest model. As soon as it is run through the private sector, there are import taxes and a mark-up at approximately five places along the way. It should be and can be cheap, but it is not always.

Deputy Peter Fitzpatrick: I thank all of the delegates for coming. I do respect them. I have listened and learned. The focus, however, was on abortion and how to introduce it in Ireland.

Dr. Johnson has said that if we reduce the number of unwanted pregnancies, we can reduce the number of abortions. Dr. Aiken has said that when women leave clinics, they are helped with contraceptives. I believe in life and living. I have a little quote: "Enjoy the little things in life, for one day you may look back and realise they were big things". If I google the term "unwanted pregnancies", what comes up is information on abortion treatment in private clinics in Manchester which includes the words "call privately on your mobile", "book an appointment", "request a call back", "trained advisers", "services", "consultation" and "sterilisation". Moving down, the next thing I come across is "emergency contraceptives" which must be taken within 72 hours of unprotected sex in order to prevent an unplanned pregnancy. It is then indicated at what stage it should be done with tablets. It feels as if abortion is being pushed into people's faces. Dr. Johnson has mentioned that safety is his priority. To me, having a baby is the safest way. Ireland is one of the safest countries to a have a baby. I have been getting a lot of flak for the past four weeks at these sessions, but I trust women. The most important people in my life are my wife and my family. I am trying to be honest. I do not believe in abortion. The first option should be to have the baby. What can we do in Ireland to try to educate people? To me, abortion should definitely be the last option for anybody. When people are looking for help, they have many means of communication. If a woman who does not want to be pregnant is looking for help, the first thing she will do is google and this will be pushed in her face. What can we do to give such people a far better option? I again emphasise that I trust women.

Dr. Abigail Aiken: I thank the Deputy and appreciate his opinion. I will say a couple of things in response to him.

Maternal mortality rates are very low in Ireland. The Deputy is right when he says Ireland has extremely good obstetric and maternity services. However, this presumes that people want to go through with pregnancies and end up giving birth to babies. That is great and there are excellent obstetric services here. The problem we are discussing involves people who are not in that position. The figures for them are not factored into the maternal mortality rate because they are able to go to England or use the Women on Web website. Ireland has a low maternal mortality rate which is great, but it really does not offer many options to those who are deciding what to do about their pregnancies.

One of the problems is that although there are many opinions in this room and Ireland on

this issue, it is very difficult to legislate for opinions. Everyone has a different opinion. We came to present evidence to the committee in order that its members would learn more about the people who were relying on us to do something. It is not so much about our individual opinions but more about those who need help from the committee as it decides what to do. Although pregnancy is nice and joyful for many, it carries many physical and anatomical risks. It is an awful lot to expect a woman to do with her body, especially if it is something she does not want to do and would choose not to do. While pregnancy has been made very safe by the excellent obstetric services available in Ireland, it has to be recognised that it is not inherently very safe.

Chairman: That concludes our questions. I thank the delegates for their attendance. They have given us excellent information and I thank them for responding to all of the questions asked by members. We really appreciate the effort they have made in travelling to this country to be here.

Sitting suspended at 4.25 p.m. and resumed at 4.35 p.m.

Health Care Issues Arising from the Citizens' Assembly Recommendations: Masters of the National Maternity Hospital, Holles Street and the Rotunda Hospital

Chairman: I welcome the viewers who may be watching on the Oireachtas television channel.

I want to make a brief request before I introduce the two delegates who are in attendance for this part of the meeting. The technicians have asked me to remind members to ensure their mobile phones do not go off. Apparently, there has been some interference and, according to RTE, much of the footage is not usable. It is really important for those speaking to keep their mobiles turned off. They should be turned off at all times.

On behalf of the committee, I extend a warm welcome to Dr. Rhona Mahony, master of the National Maternity Hospital, Holles Street, and Professor Fergal Malone, master of the Rotunda Hospital. Professor Malone will also represent the Royal College of Surgeons in Ireland as chairman of its department of obstetrics and gynaecology. Dr. Mahony and Professor Malone will address health care issues arising from the recommendations made by the Citizens' Assembly. I will not repeat what I said earlier about the provisions of the Defamation Act 2009. As they have both been here before, I am sure they are aware of the issues surrounding privilege, etc. Therefore, I will not repeat what I said earlier, unless they wish me to do so. I ask Professor Malone to make his presentation.

Professor Fergal Malone: I am the master of the Rotunda Hospital in Dublin and chairman of the Royal College of Surgeons in Ireland's department of obstetrics and gynaecology. I am a practising consultant obstetrician and a sub-specialist in maternal-foetal medicine. My particular area of expertise is prenatal diagnosis and the treatment of foetal abnormalities. The Rotunda Hospital is the largest provider of prenatal screening and diagnostic services in the State. Patients are referred to the hospital from all other maternity hospitals in the country. Therefore, I may be in a position to assist the committee in providing a factual context in the prenatal management of foetal abnormalities and considering the potential options for change.

I want to clarify that I am not here as an advocate for either a pro-choice or pro-life agenda. As a practising specialist, I understand it is absolutely crucial that patients trust their doctors to

be completely objective in their professional medical advice and that they are not perceived in any way to have a political agenda. For this reason, I have always been cautious to keep my personal views out of the public realm. I am here to answer questions of a factual nature that the committee may have on foetal abnormalities and to discuss potential options for change in this area.

In the interests of brevity, I will not provide an overview of foetal abnormalities or prenatal diagnosis in Ireland. In addition, I will keep my descriptions of the care pathways followed by patients in this situation as short as possible. However, these matters are covered in detail in the written position paper I provided for the committee.

Currently, when a patient at the Rotunda Hospital is given a prenatal diagnosis of a fatal foetal abnormality, all options for management are discussed in a non-judgmental manner. The specific diagnosis is explained, together with what exactly is meant by the term "fatal". It includes quoting statistics for the chances of survival to birth and thereafter. There are two options for pregnancy management, the first of which is to continue with the pregnancy and provide perinatal hospice care. This care journey involves regular support from a multidisciplinary team. When the mother delivers, the parents generally hold their baby until such time as he or she passes away. This care journey is very well organised at the Rotunda Hospital and works in a tremendously supportive manner for families in terribly tragic situations.

The alternative option for pregnancy management in this situation is not to continue with the pregnancy, which means undergoing a pregnancy termination. This involves travelling outside the jurisdiction, most often to the United Kingdom. Patients who select this course of action are supported to the extent that is permissible by our legislation. We do not make direct referrals for a pregnancy termination, nor do we advocate for one management option over another. Parents must make their own appointments and travel arrangements. This particular journey is clearly associated with significant additional challenges for patients, including travelling for health care to an unfamiliar city and without family support. There is a significant financial cost of, typically, €800 to €1,500, not including travel costs. Limited autopsy or genetic testing is performed, as the cost of such testing must be paid for separately by the parents. In addition, there is significant distress for parents associated with leaving their baby's remains in a foreign country. In 2016, 55 patients from the Rotunda Hospital travelled to the United Kingdom to undergo a pregnancy termination following a prenatal diagnosis of foetal abnormalities.

The current legislative status of termination of pregnancy in Ireland poses significant practical challenges for obstetricians when faced with a prenatal diagnosis of fatal or complex foetal abnormalities. They include an inability to directly refer patients for care. The Regulation of Information (Services Outside the State for Termination of Pregnancies) Act 1995 prohibits our staff from directly making an appointment for a mother at a hospital outside the jurisdiction. We cannot contact staff in such hospitals directly on behalf of a particular patient but must rely instead on patients relaying potentially complex medical information.

Another challenge is the inability to access care in a timely manner. Recently we have been faced with a number of patients with fatal or complex foetal abnormalities who were unable to secure a timely appointment with a centre in the United Kingdom for a pregnancy termination because that centre had been too busy.

Another challenge is the lack of continuity of care associated with travelling to another jurisdiction. There is a distinct lack of fairness in that patients with complex foetal abnormalities who chose to continue with their pregnancy have prompt access to continuous care within a

single health care team, while those who choose not to continue with their pregnancy are forced to endure split care across two jurisdictions, completely undermining the ability to provide for continuity of care. One of the main concerns in splitting care across two jurisdictions is the potential risks to the mother's physical health when travelling. Risks associated with pregnancy termination include infection and haemorrhage which has, tragically, already resulted in the death of one of our patients while travelling to the United Kingdom.

Another challenge is the threat of imprisonment for staff. As prescribed under section 22 of the Protection of Life During Pregnancy Act 2013, a term of imprisonment of up to 14 years may be applied if a doctor is convicted for participation in a procedure to "intentionally destroy unborn human life". There is a lack of clarity among some doctors on whether they may have a vulnerability to such a conviction if they are involved in any way in the management of a patient who has a pregnancy termination in another jurisdiction.

Given these practical challenges facing obstetricians and maternity hospitals in Ireland, I suggest the committee might consider supporting the decriminalisation of pregnancy termination in the setting of foetal abnormalities. Obstetricians and maternity hospitals in Ireland should be able to provide complete health care services for their patients without the threat of a criminal conviction. When faced with the practical reality of caring for mothers with complex foetal abnormalities, it is difficult to justify retaining a threat of criminal conviction for doctors or hospitals providing appropriate health care. Obstetricians and maternity hospitals in Ireland should be able to provide for a legal termination of pregnancy in the setting of fatal or complex foetal abnormalities if a patient chooses to follow that course of action. This would allow both pathways of care to be provided equally to all patients when faced with the traumatic situation of a prenatal diagnosis of complex foetal abnormalities.

With any proposed legislative change, it would not be appropriate to provide a list of specific foetal diagnoses that should be considered "eligible" for a pregnancy termination. Lists of foetal diagnoses are not static over time, just as any list of "eligible" diagnoses today would likely to be outdated in a number of years. Similarly, combinations of foetal abnormalities are commonly seen such that while, individually, a particular abnormality might not be considered "lethal", in combination with multiple complex abnormalities, the overall prognosis would effectively be fatal. It is recommended instead that the individuals best placed to make such a decision are the patient and her doctor, without the direct involvement of external agencies.

We do not consider it appropriate to specify a precise gestational age limit in weeks beyond which a pregnancy termination would be illegal. This is because the definition of foetal viability is not precise and is likely to change. Additionally, foetal size and foetal health are independent predictors of foetal viability, separate from defining viability based solely on gestational age in weeks. Again, it is recommended that the individuals best placed to make such a decision are the patient and her doctor, without an arbitrary legal cut-off.

I endorse the ancillary recommendations of the Citizens' Assembly which call for equal access for all patients to early pregnancy scanning and testing, improved counselling and support services for patients and detailed consideration of how a pregnancy termination should be resourced. Maternity services in Ireland remain significantly under-resourced. If we are to take on board the provision of pregnancy termination services, this will require a significant improvement in resources, both in terms of personnel and physical infrastructure.

I hope my observations, together with the more complete position given to the committee yesterday on the current status of the diagnosis of foetal abnormalities, are of assistance to the

committee. I hope, too, that my observations on the practical challenges and options for change will be informative for the committee's future deliberations.

Chairman: I thank Professor Malone. I invite Dr. Mahony to make her opening statement.

Dr. Rhona Mahony: I thank the joint committee for giving me the opportunity to come before it. I hope my contribution will be helpful in its deliberations.

I am the master of the National Maternity Hospital which is one of Europe's largest maternity hospitals and in which 9,000 babies are delivered every year. It is a major Irish tertiary referral centre which provides advanced obstetric, neonatal and gynaecological care. I am a specialist in maternal and foetal medicine and an honorary clinical professor with the Royal College of Surgeons in Ireland. My submission is based on my clinical experience as both an obstetrician and a master practising in the Republic of Ireland under the terms of the Protection of Life During Pregnancy Act 2013 and Article 40.3.3° of the Constitution, commonly referred to as the eighth amendment. These legal instruments govern the circumstances in which a termination of pregnancy can be lawfully performed in this country.

Termination of pregnancy is defined as the intentional procurement of a miscarriage. In other words, it occurs when a pregnancy is interrupted prior to foetal viability and neonatal intensive care is not provided. At present, 24 weeks of completed gestation represents the threshold of viability, whereby the provision of sophisticated neonatal intensive care is associated with approximately a 50% survival rate of the foetus. This is not an absolute cut-off point and some babies will survive at 23 weeks, while others will not be viable at 25 owing to complications of extreme prematurity. When a baby is delivered, in whom viability has been reached and for whom intensive care has been provided, we refer to this as a delivery, not a termination of pregnancy.

The subject of termination of pregnancy is deeply complex and, not surprisingly, it provokes strong views and many differences of opinion. We know approximately 3,000 women travel to the UK every year from this country to obtain termination of pregnancy. Our Constitution protects women travelling abroad for termination of pregnancy in circumstances that would be a criminal offence in their own country. In effect, this means that women in Ireland have similar access to termination of pregnancy as women in the UK, with the exception of children and women of limited means who do not have the ability to travel. It is impossible not to be affected by the personal testaments of individual women and their partners and, although every case is unique, it is evident that with the current position in Ireland, women will continue to travel to the UK or access unknown medication from potentially unregulated sources using the Internet with all the attendant clinical risk.

Somewhere in the midst of public opinion is the need to ensure that women in Ireland have access to sound clinical care, and I would like to address the following clinical issues. In Ireland, a woman qualifies for a termination of pregnancy if there is a real and substantial risk to her life that may be removed only by termination of pregnancy. The process that determines this qualification is cumbersome and complicated, and despite the fact that it relies on clinical judgment delivered in good faith to save a woman's life, it is framed in a criminal context. An error in clinical judgement is potentially punishable by a custodial sentence of 14 years for both the mother and her clinician in the event that an identified risk is deemed not substantial enough. Equally, waiting for a woman to be sufficiently ill in order that she is perceived to be at risk of dying is potentially dangerous. It assumes we can accurately predict the risk of dying. Haemorrhage, infection, heart disease, liver disease and a host of other disorders can make one

very ill but they can also kill a person. It is not always possible to predict clinical course with precision. In medicine we deal with probability informed by available clinical evidence and experience.

In women with underlying morbidity, such as cystic fibrosis, portal hypertension, corrected congenital heart disease, renal disease and other conditions, the additional physiological burden of pregnancy can create significant maternal risk. The question arises as to how a substantial risk of mortality is defined. As I have asked, is it a 10% risk of death, an 80% risk of death or a 50% risk of death? A woman would also have a view as to what constitutes a substantial risk to her life and her view deserves consideration. It is not considered currently. This is real-life medicine. We frequently counsel patients about a range of risks and potential outcomes. We arrive at a decision with our patient's input, which we believe is in the best interest of our patient, but I cannot think of any other circumstances in medicine where risks to life are balanced in the shadow of a custodial sentence for both the clinician and the woman.

In my experience, one of the most challenging conditions we experience clinically is the development of chorioamnionitis prior to foetal viability. For example, if the waters around a baby break at around 14 weeks of gestation, there is really little chance the baby would be born alive and survive. We must wait until a woman develops infection or chorioamnionitis before we can intervene in the pregnancy. When the woman is at significant risk of developing such infection, we are tasked with ensuring we can terminate the pregnancy, which has become the source of the infection, before she becomes so ill that she dies.

In pregnancy we deal with two lives inextricably linked by a complex physiology. This is dealt with in the Constitution by a balance of rights. There is the equal right to life of the mother and the foetus. From a medical perspective, this provision creates difficulty in its presumption that the implications of a range of complex medical disorders can be reduced to a matter of individual right. If the legal world explores the balance of rights, the medical world explores the balance of risk. In a pregnancy complicated by serious disease, it is not a question of right but rather a question of risk. Once foetal viability is achieved, we have the option of delivering the baby and attempting to save both lives. We do this all the time in clinical practice and over 2% of babies in Ireland are born before term because of medical indication in the context of foetal or maternal disease. However, prior to foetal viability, we do not have the option of delivering a foetus because the foetus cannot survive, and if a pregnant mother dies, her baby dies too. Therefore, prior to foetal viability, this constitutional provision makes no clinical sense. Its presence facilitates a real possibility that clinical decision-making may be delayed or distorted as clinicians ponder the law rather than medicine.

Unfortunately, there is evidence of this. I will never forget the High Court case that dominated Christmas 2015 when somatic function was maintained in a dead woman so that her foetus could be incubated in what was described as a "macabre experiment". The woman in question was approximately 14 weeks' gestation when she died, which is weeks away from foetal viability. Her father had to apply to the High Court in order to switch off the machines and let his daughter be laid to rest with dignity. The overwhelming clinical judgment in the High Court attested that this foetus would not survive. It was a "futile exercise", according to the High Court, but it happened because of a medico-legal interpretation of the eighth amendment and it could happen again.

In addition to being an obstetrician, I am a specialist in foetal and maternal medicine. The National Maternity Hospital, NMH, is a large tertiary centre for foetal medicine and we are fortunate to have a large multidisciplinary team, including neonatal, midwifery, bereavement,

radiology, paediatric, obstetric, genetic, social work and pathology experts to provide guidance and expertise required in the context of complex foetal anomaly. A care pathway has been developed that adopts a multidisciplinary approach to provide individualised care to families. We see women from all over Ireland and we know it is very difficult for families who have to travel long distances for care in the context of foetal anomaly. In 2016, 195 women with a foetal anomaly were referred to our hospital from units around the country.

The specialty of foetal medicine is increasing in complexity, and our ability to identify genetic and structural anomalies in the foetus *in utero* is increasing. New techniques include the ability to detect chromosomal abnormalities by testing free foetal DNA carried in a mother's bloodstream from as early as ten weeks of gestation. This is done using a simple but expensive maternal blood test. Micro-array technology allows us to examine the chromosomes and see genetic material more clearly and foetal imaging has improved, including enhanced ultrasound and, more recently, magnetic resonance imaging provided at NMH. Interestingly, a third of units in Ireland do not provide routine anomaly scanning, which is hard to justify in 2017. In 2016 at NMH, we identified 400 significant structural anomalies and more than 60 chromosomal anomalies. The diagnosis of a major foetal anomaly and particularly a foetal anomaly in which survival is unlikely after birth is a really difficult part of my job. I know when giving such devastating news that I change a family's life irrevocably. Counselling is always non-directive but includes the variety of options available in each individual case. Even where there is a strong likelihood a foetus will not survive, women wish to continue their pregnancy knowing what will be but they tell me that whether their baby survives for a minute, an hour, a day or a week, the time is of infinite importance. The foetal medicine team and multidisciplinary neonatal teams, in conjunction with our bereavement team, support parents in this context as best we can in each individual circumstance. We now have national standards of bereavement care that address anticipatory bereavement. Strategies include individualised care, memory-making, support and advice for family members, as well as bereavement counselling. Some people call this concept perinatal hospice care.

For some women the decision to continue with a pregnancy can be associated with increased maternal risk. For example, in a case of conjoined twins where separation is not possible because of organ sharing, there are significant technical difficulties in delivering the conjoined babies requiring high-risk caesarean surgery. In the context of a really severe lethal anomaly in which a baby is unlikely to survive, some women will not wish to continue their pregnancy. They will choose to navigate these tragic circumstances in different ways. I understand people will make different choices when faced with really difficult personal circumstances.

Sixty women attending our service travelled to the UK for termination of pregnancy in the context of foetal anomaly in 2016, and to date this year at Holles Street, 43 women have travelled in this context. The majority of women had pregnancies complicated by chromosomal or genetic anomaly, multiple anomalies, anencephaly and ventriculomegaly. UK data indicate that in 2015, 135 women travelled from Ireland to the UK in the context of foetal anomaly where they terminated their pregnancy under clause E, "substantial risk of physical or mental handicap as to be severely handicapped". Women who chose this option must travel to a different jurisdiction. The Constitution protects women who decide to travel but a termination in this country in this context would be a criminal offence.

As an obstetrician I can give limited practical support in this decision. This includes contact details of foetal medicine centres in the UK. We do not make direct referral for pregnancy termination and we certainly do not advocate for one management option over another. Parents

must make their own appointments and make their own travel arrangements. Families must find this especially cruel. Parents also bear the cost of treatment in the UK, which can run to more than €1,000, including medical treatment, flights, accommodation, laboratory bills and the cost of bringing their baby's remains home. In this context, parents frequently report feeling abandoned and the tragedy of their loss is exacerbated by the practical difficulties of bringing their baby home, navigating a different city and jurisdiction, being separated from their families at such a difficult time and the shame and stigma associated with travelling to England for a termination of pregnancy.

From a clinical perspective, care between two different jurisdictions is inevitably disjointed and clinical risk is increased. I am struck by the findings of the UN Human Rights Committee which on several occasions has found that the current criminalisation and restrictive abortion provision in Ireland today violate women's human rights, including the right to freedom from cruel, inhuman or degrading treatment, the right to privacy and the right to freedom from discrimination.

I have raised a number of difficult issues which I have encountered in my medical career. No law will ever adequately address the reality of the ethical dilemmas generated by human reproduction but we have to acknowledge the real risks that women face in clinically complicated pregnancies. I believe there are two main domains that need to be addressed from a clinical perspective. We must address the criminalisation of medical care in Ireland. At present a woman must have a substantial risk of dying before she can qualify for a termination of pregnancy to save her life. Failure to adhere to this is punishable by a 14-year custodial sentence for both the woman and her doctor. I believe this has the capacity to create clinical risk by distorting clinical decision-making.

In September 2017, the council of the Royal College of Obstetricians and Gynaecologists voted strongly in favour of supporting the removal of criminal sanctions associated with abortion in the UK. They said: "We believe that the procedure should be subject to regulatory and professional standards, in line with other medical procedures, rather than criminal sanctions." It is also very difficult that our Constitution protects women to travel in the context of a baby that has a foetal anomaly that is unlikely to survive and yet to terminate a pregnancy at home in this country in this context is a criminal offence.

Second, we must address access to safe clinical care. Women require safe health care and sound clinical decision-making in the context of pregnancy complicated by severe maternal disease. A women herself should have an input into her care management and both she and her doctor must have the flexibility to make sound clinical decisions in good faith. It should not be a requirement that she is dying prior to these decisions being made. Timely appropriate clinical decision-making in pregnancies associated with significant maternal risk will make women safer. Children require special consideration in relation to risk.

In the context of severe foetal abnormality, in terms of access, women are travelling to jurisdictions outside Ireland to access complex medical care. While doctors provide non-directive counselling and can provide information on termination of pregnancy, doctors cannot make appropriate clinical referral. Care delivered between jurisdictions raises all kinds of risk, including lack of continuity of care, inability to access timely care, incomplete evaluation and confirmation of prenatal diagnosis, and incomplete analysis of the implications for future pregnancies. Patients would much prefer to have the option to access this care at home close to their families and friends.

The presence of the eighth amendment in our Constitution creates unacceptable clinical risk and it should be removed.

Chairman: I thank Dr. Mahony for her presentation. I will now move on to questions. Our first questioner is Deputy Catherine Murphy and she has eight minutes.

Deputy Catherine Murphy: The witnesses are very welcome to the committee and I thank them for their papers and giving us the benefit of their expertise. My first question is for both witnesses. Dr. Mahony said that about one third of hospitals do not provide a certain type of screening. Is the eighth amendment any influencer on that or is that just related to how we deliver health care?

Dr. Rhona Mahony: I believe that is a resource issue but, in reality, there are two main opportunities for women to have prenatal screening. The first would be in the first trimester when chromosomal anomalies can be diagnosed using a maternal blood test, but that is very expensive. It costs about €350 and it is an opt-in test, so women who do not have the means to pay for that will not access that test.

Regarding the reference to one third of hospitals, I was referring to ultrasound scanning. It is a standard of care obstetrics in 2017 that women would have anomaly scanning. The primary reason for anomaly scanning is that if there is a difference or a challenge picked up for a baby, it is really important that we identify that in order that we can provide the best possible care to a mother and her baby. For example, if we diagnose that a baby has a congenital heart problem, we can connect the mum and the baby with the services that will be required after the baby's delivery with the surgeons and all the multidisciplinary care because we know that there is a problem. That is the most important reason for providing ultrasound scanning. It is to our shame that a third of units in this country do not provide routine anomaly scanning.

Deputy Catherine Murphy: I totally agree with Dr. Mahony on that. In terms of the issue of criminalisation, I found myself, probably like others, faced with whether we supported legislation after not being able to amend it. I can understand why it would be incredibly difficult to work in that kind of an environment and make the judgment calls in real time. That legislation was around legislating for what is in the Constitution - the equal right to life.

I would like to move on and ask about the right to health, which is deemed by international human rights organisations as a right, but it is very difficult to see how the right to health can be provided for in the context of the eighth amendment. Dr. Mahony might speak a little on that and how she might differentiate between serious risk or risk, whether she should be differentiating, and whether that ought to be something that is very much down to the clinician and the woman involved.

Dr. Rhona Mahony: I really believe this is where clinicians and their patients need flexibility to look at the implications of health issues during pregnancy. Some women come into pregnancy with conditions of cystic fibrosis or portal hypertension and there may be a significant risk of that woman dying because of the additional physiological burden of pregnancy. Similarly, women can become ill during pregnancy and we need to interrupt the pregnancy prior to foetal viability. Once foetal viability is achieved, we can deliver a baby because of either maternal or foetal disease, and as I said, we do that all the time. A total of 2% of deliveries in this country occur early before term because a woman or baby is ill and we can deliver before term. It is prior to viability that the problem arises when we do not have the option of delivering a woman's baby. In those cases, we have to look at the risks to that woman and that is where

clinicians need flexibility. I do not think it is appropriate that we somehow have to wait until a woman is at a substantial risk of dying because how does one define that? As I said, what is a substantial risk? Is it 5%, 10% or 50%? What of the woman's view? If I say to a women that she has a 10% chance of dying but I am okay with that, she might disagree with that and say: "Well, doctor, I am not okay with that." This is real-life medicine. We cannot predict the clinical course all the time with exact precision. We have clinical evidence, likelihoods and probabilities. Therefore, what clinicians and their patients require is flexibility.

Deputy Catherine Murphy: I want to ask Professor Malone about the point he made about limitations, gestational limits, and that it is something that should be a clinical issue as opposed to something that is set down. He was talking in the context of foetal abnormalities, but does he believe that should be the approach generally or only in the context in which he was speaking?

Professor Fergal Malone: I was making my comments today in the context of foetal health and foetal abnormalities, because that is what we deal with at the Rotunda Hospital and in the maternity hospitals. As I pointed out in my paper, viability based on gestational age is just one aspect of viability. One could have a baby with severe growth restriction at 25 weeks who is 300 g and has no prospect of survival, yet one could have a 23-week foetus who is 600 g and has a prospect of survival. One could have a 25-week foetus with a very severe heart defect that has no prospect of survival if that foetus was born, yet a 23-week foetus that is completely healthy might have a chance of survival. To focus our definition of viability on some arbitrary gestational age week is just one piece of the equation. It is not possible to define viability in the total context of health. That is why one needs all the other pieces of information. The doctor together with the patient are the best placed to make that decision.

Deputy Catherine Murphy: I thank Professor Malone for that response.

Chairman: The Deputy can ask one further brief question.

Deputy Catherine Murphy: On the issue of continuity of care, prior to the legislation I travelled to Liverpool and it was helpful meeting the team there. One of the questions one of the group asked was whether there was a difference between Irish women and women from the UK attending. This was in the context of Doctors for Choice in regard to foetal abnormalities. The response was that the one difference they could see was that Irish women felt that they would be judged, which in that kind of environment was an added pressure in addition to the travel, etc. In an earlier session, we heard about women sometimes not talking to their doctor and opting for online medication because they feel that they would be judged. In regard to the medical profession, is there a discussion on how, when women present they are handled non-judgmentally and for people to expect it to be non-judgmental?

Professor Fergal Malone: At present when patients come back to us after going to the United Kingdom, they are managed in a completely professional and non-judgmental way. We understand the terrible journey that they have made. One has to realise these are very much wanted pregnancies where everything was going along well and suddenly the rug was pulled out from under them, they were diagnosed with this major abnormality, and they found themselves on this journey to another country with a sense of shame and, as the Deputy points out, being judged. It is tremendously traumatic for them. We feel strongly that patients, when they return, get the complete care that they would have received had the procedure been performed here. We try to pick up the pieces as much as we can, given that the procedure happened elsewhere. We work closely with our colleagues in the United Kingdom. Our team generally have gone to visit the units in the United Kingdom. We try and demystify it as much as possible by

telling our patients who they are likely to meet to try and make the terrible journey just that little bit easier, and help them when they come back, but it is tremendously difficult.

Dr. Rhona Mahony: It is so difficult to travel when one's pregnancy is complicated in a way that it is very unlikely one's baby is going to survive, or the baby is going to have a really severe challenge. It is really very difficult to have to go to a different country, to doctors in a hospital one does not know, to be away from one's family and to have that stigma of getting on the plane to access a termination of pregnancy, and to know that in one's own country it would actually be a criminal offence.

Chairman: I thank the doctors. Deputy Durkan has approximately five minutes left from his previous time.

Deputy Bernard J. Durkan: I thank the witnesses for coming before us and for their informative opening papers.

In regard to the determination of fatal foetal abnormalities, are there any particular situations that come to mind, given the previous history of medical conditions, where it might be possible to indicate to the potential mother that she could be in danger and how often have they occurred? In regard to the women who found themselves in the situation of having to travel overseas - Dr. Mahony mentioned 60 who so opted in the last year - how many in the same period opted not to travel with similar situations? In the event of there being a change in the legislation taking the criminalisation out of equation, might there be a reluctance on the part of some professionals to participate in terminations?

On the question raised by Deputy Catherine Murphy in regard to the threat to life arising from a health condition, have these doctors been able to identify particular health conditions that will eventually lead to a life-threatening situation, and one or two that come to mind straightaway?

Professor Fergal Malone: Specifically, on numbers of cases, I told the committee that in 2016, 55 women with foetal abnormalities from the Rotunda travelled to the United Kingdom for pregnancy termination. As regards women who decided not to travel, for example, Down's syndrome, in 2016, we had 26 cases in which we diagnosed prenatally Down's syndrome. Some 57% of patients chose to travel to the United Kingdom and 43% chose to stay and continue with their pregnancy. There were 24 cases of trisomy 18, known as Edwards' syndrome, a fatal foetal abnormality, diagnosed in 2016. Twelve chose to travel to the United Kingdom and 12 chose to continue on with their pregnancy. In general, it depends on each abnormality, approximately 50:50 is how it splits out. That reflects the balanced counselling that is done. It reflects the fact that when we make a diagnosis, we give patients the full facts as to what it means. They meet various support organisations, as needed, and they make their own individual family-based decision. Those were the numbers in 2016.

Deputy Durkan asked on fatal foetal abnormalities and how often maybe the mother was in danger. There are some conditions, such as trisomy 13, or Patau syndrome. Patau syndrome is strongly associated with severe preeclampsia and the foetal condition can actually make the mother sick. There is another condition called Mirror syndrome where the foetus gets heart failure called hydrops and that could have the same effect on the mother, and the mother goes into heart failure. There are definitely cases in which the foetal condition can have a tremendously negative effect directly on the mother.

The Deputy asked are we concerned that there may be reluctance on the part of some medical personnel to participate in procedures should there be a change in legislation. We have never had a survey done of doctors in Ireland to see where would they personally stand on this issue.

The issue of conscientious objection is a valid one and we would generally always accept that. In large hospitals, such as the Rotunda, the Coombe and the National Maternity Hospital, I would be confident that we would always have sufficient numbers of personnel available that, even if an individual doctor chose for personal reasons not to participate in a case, we would be able to provide care for the patient. I would perhaps be a little bit more concerned, if one were in some of the smaller hospitals where one had more limited personnel, would the conscientious objection clause prevent a patient accessing appropriate care. That remains to be seen.

Dr. Rhona Mahony: Similarly, in regard to fatal foetal abnormality and danger for women, there are the medical disorders, such as preeclampsia, as discussed, but there can also be significant surgical complication. I cited the example of a case of conjoined twins where, if this pregnancy goes to term and significant organs are shared, there is no prospect of survival for the conjoined twins but in order to deliver them, there is great technical difficulty and very complicated surgery which can create a high risk indeed for a patient.

In terms of travelling, we diagnose approximately 400 foetal anomalies a year in the National Maternity Hospital and approximately 60 women travel. A lot of women would choose not to travel. Among those 400, there will be anomalies that are less severe, for example, a number of heart issues, that are amenable to treatment and to surgery. That is why we work so hard to pick up an anomaly so that we can offer the best possible care to babies when they are born because that can really improve outcome.

Of the 60 women who travel, they tended to be chromosomal and genetic anomalies. They tended to be neural tube defects, cranial abnormalities and complex heart abnormalities. They tended to have abnormalities that were at the very severe end of the spectrum indeed.

In regard to criminalisation and reluctance of clinicians to participate, women should be very much reassured in the first instance that when it comes to a risk to a woman's life we will do all that we can to save her life. That is normal obstetric practice. We will always endeavour to save a woman's life, and that is really important. There are underlying maternal conditions that do create a very high risk in pregnancy, for example, portal hypertension, very advanced cystic fibrosis where there is very reduced lung function, some congenital heart disease, some cancers and some very complex haematological disorders. There will be very rare disorders as well of which we have limited experience but there is no doubt that there are underlying maternal diseases, and when the physiological burden of pregnancy is added to them, it creates substantial risk for women.

Deputy Bernard J. Durkan: Very quickly-----

Chairman: Unless it is a clarification.

Deputy Bernard J. Durkan: I will be a very good boy and be very quick. Why should a woman's life be artificially prolonged, for want of a different expression, to facilitate the development of a foetus? Would it not be obvious to most people regardless of the law that it was an abuse of the system? Why should it take place? How has this taken place?

In respect of a baby who dies prematurely before the normal gestational period, what is this

thing we have come across from time to time where the woman has to wait until the normal gestational period has passed before the baby is born even when the baby has been dead for maybe six or seven weeks or two months? Does that still continue or has it been discontinued?

Chairman: Will both witnesses address those questions as briefly as possible?

Professor Fergal Malone: Regarding the latter point about a foetus dying in the womb and a woman waiting to deliver that baby for many weeks, generally that does not happen now. Once a diagnosis of intrauterine demise is made, we would generally get on with the appropriate medical management of that fairly quickly.

Deputy Bernard J. Durkan: Generally but not always.

Professor Fergal Malone: I will give the Deputy an example of when we might not do so. This would be when there was an intrauterine demise in the setting of a twin pregnancy. If there is another live foetus there, clearly, we do not want to endanger that foetus by delivering it early so that is why I cannot give the Deputy an "always" on that.

Chairman: Does Dr. Mahony wish to address the other question?

Dr. Rhona Mahony: The first question.

Deputy Bernard J. Durkan: It relates to prolonging the mother's life artificially to protect the life of an unborn baby.

Dr. Rhona Mahony: There are very limited-----

Deputy Bernard J. Durkan: The 2015 case.

Dr. Rhona Mahony: As the Deputy can imagine, there are, thankfully, very limited case reports in this area. We might ask how it happened, but the point is more that it did happen. It happened in this country and it happened in 2014. It happened because of an interpretation of the eighth amendment under which doctors felt that there was an equal right to life of that foetus.

Deputy Lisa Chambers: I thank Professor Malone and Dr. Mahony. In respect of that grotesque case, that is all one can say about it. It was utterly disgraceful and I hope to never to see it happening in this jurisdiction or anywhere else again.

In respect of fatal foetal abnormality or severe abnormality, one of the concerns often put out there is that there could be many misdiagnoses - that doctors are getting it wrong essentially. That is the fear that is put out there so will the witnesses address that concern? Will they elaborate on the impact on the parents and the mother of having to travel in those circumstances? Do they think it has a long-term severe impact on those individuals and how they feel afterwards? Dr. Mahony spoke about having to wait until the woman was at risk of death. Will she elaborate on that process? Who decides? How close to death does the woman have to be before we act? Who is making that call? I was shocked to hear Dr. Mahony say that the woman has no say in that process. How many people are involved in that process?

Professor Fergal Malone: Regarding getting the diagnosis wrong and terminations being performed on foot of an incorrect diagnosis, I do not believe that this happens in contemporary obstetric practice. Genetic diagnoses are black and white. Some people mistake screening tests for diagnostic tests. It is possible that a screening test that assesses a patient's risk for having a

baby with Edwards' syndrome or trisomy 21 may say there is a high risk. That does not mean the foetus has the condition. We would never suggest that a woman travel or see a woman travelling for pregnancy termination for a risk of a condition. We would always recommend in 100% of cases that a patient would have a formal diagnostic test done such as amniocentesis or chorionic villus sampling, CVS, so that we do not get the diagnosis wrong. It does not happen in that situation. In terms of structural abnormalities diagnosed by an ultrasound, we are very careful in our counselling with parents as to the accuracy of what we see and the limitations of what we see. Commonly, I will say to a patient that there is an abnormality with the heart, or that there is a hole in the heart and the blood vessels are lined up in such a way but that is what it looks like to the best of our knowledge, or that there is an abnormality of the brain but I cannot tell the patient exactly what effect that will have on brain function. We always express the limitations of the diagnostic test. If it is 100% certain, we will say that. If it is just a set of findings and we do not know what it means, we will also say that so there is no question of people having pregnancy terminations for a wrong diagnosis.

It is very difficult to specify the impact on parents travelling because it would be very useful to have longer-term follow-up questionnaires and studies of depression scores and anxiety scores afterwards. My gut feeling is that there are significant long-term effects from the trauma of travelling. It is very hard to distinguish between how much of the subsequent anguish was due to the original diagnosis, which is understandable, and how much was added to it by the subsequent practical challenges. We do not have any data on that so I cannot give the Deputy a direct answer as to how often that happens. My gut feeling is that it is common.

Dr. Rhona Mahony: The risk of dying is covered in sections 7 and 8 of the Protection of Life During Pregnancy Act 2013. Section 7 covers the substantial risk to maternal life while section 8 covers emergencies. In the context of an emergency like a haemorrhage, a doctor can make a decision on his or her own and interrupt the pregnancy to save a woman's life. They do not need a second opinion but can go straight ahead. In respect of a substantial risk to life, it requires two doctors to come to that opinion, one must be an obstetrician, one can be another relevant practitioner and preferably a general practitioner would be involved as well in the decision-making. Again, it comes down to the determination of what is a substantial risk to life. We will have patients presenting who may have a disease like advanced cystic fibrosis or portal hypertension. They may not have planned to get pregnant but now they are. When the question arises, we are not quite sure what the clinical course will be. We know there are risks but is there really a risk of the woman dying or will she just become ill? How do we factor that in and what is our opinion? What is really required in these situations is the ability for the doctors and patients to look not just at the risk of dying but at the risk of a serious impact on a woman's health in order that they can make a sensible and timely decision. I believe that the definition of substantial risk to life can provide problems for doctors who are worried that if they make a wrong clinical decision, a custodial sentence of 14 years is hanging over both them and their patient.

Chairman: I remind members that we are moving to the general questions where everyone will have six minutes. I ask members to ask questions rather than make statements. I do not mean to preach but it is very difficult for me to manage the time here. Our witnesses are giving their time to come here and we want to get as much information from them as we can. I do not like to interject with the witnesses when they are giving us information we need to get from them, so I ask members to be mindful of that when asking questions.

Deputy Peter Fitzpatrick: I welcome the witnesses. I note that, in his submission, Pro-

fessor Malone advocates neither a pro-choice nor pro-life agenda but he wants very strongly to call for abortion to be made available where babies have a disability. I note that he stated very clearly that no specific disabilities should be excluded from that list. He called for the decriminalisation of abortion where babies have foetal abnormalities. At the top of page seven of his opening statement, he suggests that the committee should consider decriminalisation of pregnancy termination in a setting of foetal abnormality. This is a disability where the baby is necessarily likely to die. I think Professor Malone made his position very clear here today and what that actually would mean, and I note that he referred to having the facilities available in Ireland in order that patients can access care. It is clear that what is meant by "care" is a procedure that would lead to the ending of a baby's life and I appreciate the honesty of the witness. Nevertheless, I find it very disturbing and I point out that families in very vulnerable positions place their trust in doctors. I note the witness referred to the sensitivity that doctors are obliged to have in dealing with families. I do not doubt he knows that. I know families which have found themselves in very vulnerable positions and any word from a doctor is treated with the utmost seriousness and can influence a decision. I find it disturbing that the witness refers to the abortion procedure as "care" as it is certainly not care.

Chairman: Please ask questions.

Deputy Peter Fitzpatrick: Is it true that the witness is describing the abortion procedure as care? At what point is it decided that the baby is no longer the patient?

I have some questions for Dr. Mahony about abortion on health grounds. If abortion is introduced on health grounds, even very restricted health grounds, there is definitely no way back. It is not a case of not trusting women. I trust women and so does everybody with a concern in this regard. We must look at other countries, like the UK, where there are 200,000 abortions per year, mostly on health grounds. One can use any restrictive language in legislation but there is no way to stop abortion happening on more wide-ranging grounds. Will Dr. Mahony comment on abortions done on health grounds?

Professor Fergal Malone: In my paper I did not state there should be no exclusions for foetal abnormalities; it was the opposite. I said we should not have an inclusive list as the problem with such a list is that we cannot be that prescriptive. It is possible to have an abnormality, such as hypoplastic left heart syndrome, for example, which in itself is not necessarily fatal but is very severe. If it is combined with a foetus that has severe growth restriction and a major intracranial abnormality, the combination would create a case where there is no meaningful prospect for survival. That was my point about not having an inclusive list. I certainly do not hold the position, and I have not stated as much in our paper, that we do not exclude any abnormality. There are practical problems with trying to create an inclusive list. It cannot be done.

With regard to termination of pregnancy as an example of care, we look after our patients to the best of our abilities. Patients of all types and backgrounds come to see us for care. Of the patients faced with these tragic cases, many will decide to continue their pregnancy. I have given the committee figures on that. We support them every step of the way and help them in the most caring possible way. There is another group of patients for whom it is just not possible for them to continue with their pregnancy when they see the case as being futile. We are not allowed to care for them to the best of our ability now and we are forced to care for them in a split way. They go to the United Kingdom or elsewhere for a pregnancy termination, with the associated stigma, shame and physical risk. We have had a woman from Ireland die on her way back from a complication of the procedure after travelling to the United Kingdom for a pregnancy termination. We cannot care for these people who make that decision in the way we

want to care for them. That is why I am here today to suggest we should be allowed care for all of our patients, irrespective of their personal, religious or moral background.

Dr. Rhona Mahony: I appreciate the Deputy's concerns about the health grounds factor. There is the question of what is health and what is dying. As I keep coming back to it, clinical courses are very difficult to predict with precision. An illness in a woman can very quickly kill her. It is our difficulty in exactly predicting a clinical course, so we should therefore err on the side of ensuring women are safe and appropriate and timely decisions can be made. It is not appropriate that a woman must be dying before she qualifies for a termination of pregnancy.

When we look at maternal deaths, a significant proportion are related to women with other diseases during pregnancy, like cystic fibrosis and bleeding disorders. We must acknowledge that when we consider risks to women. What is required is sound clinical judgment. There must be trust in society that doctors and women will come to make a good decision that will keep women safe.

In most cases of pregnancy women really want to be pregnant and I have seen women risk their lives in order to have a baby. It is not really the risk of dying that makes women suddenly want to terminate a pregnancy. These are often babies that are really wanted but the women become too ill or are at risk of dying. As clinicians, we are charged with getting complex clinical diagnoses right in what can be a very narrow therapeutic window.

I will bring the committee back to the example of ruptured membranes at 14 weeks. There is very little chance a baby in that scenario will survive but there is a significant risk for that woman that she will develop an infection called chorioamnionitis. This is where the pregnancy itself becomes the infection and the woman would be at a substantial risk of dying. The only way to treat the infection is to terminate the pregnancy and give an antibiotic. When we have a clinical suspicion of chorioamnionitis, we might not get microbiology results as confirmation for 48 hours and we must make a clinical decision. Therefore, doctors are concerned that if they intervene too early, it might not really be chorioamnionitis and they might have got it wrong. They might be at risk of a custodial sentence. They may wait too long. Women and young women in particular often decompensate very suddenly and can appear much better than they are. They can appear quite well and have very advanced infection. If they decompensate, the clinician would be in a position where he or she must conduct a termination of pregnancy in a woman who would be very ill. It can be a very narrow therapeutic window and doctors are charged with getting it right. Somewhere in society we must accept that women and their doctors will make responsible decisions there to protect life.

Deputy Hildegarde Naughton: I thank Professor Malone and Dr. Mahony for their presentations today, which are very clear. It is important we get the clinical view and practice on the ground so as to under the concerns of the witnesses, particularly the question of what point clinicians should intervene to save the life of the mother and ensure she has no long-term health implications because of that wait and the legal fear influencing it. It is very important to have that clarification today.

Professor Malone mentioned a split care between the two jurisdictions in the case of fatal foetal abnormalities. Have the witnesses heard of any experience with aftercare with regard to abortion pills? I know there are legal implications around that as well, as Professor Malone alluded to in his opening statement when he spoke of a clinician's fear about being seen to treat people who have taken abortion pills when aftercare was required. Will the witnesses expand on the types of personnel and expertise needed in the event of abortion being available in Ire-

land under whatever circumstances?

Professor Fergal Malone: We have experience of aftercare following patients taking medication to bring on a pregnancy termination as patients present to us in the accident and emergency room of the Rotunda Hospital, for example, with bleeding or an incomplete procedure. There may be some placental tissue, for example, left inside. I assure committee members and patients at large that when patients present in such cases, they will never be judged and will always get absolute top-quality care immediately. There is no question of patients being quizzed as to what their motives were or adding to their difficulty. They will always get appropriate care. Unfortunately, we have significant experience of patients coming to the accident and emergency room having taken medication and perhaps not doing so in the appropriate way. The other problem, as I noted in my position paper, is that when one sources medication like that on the Internet, one would have absolutely no idea what is received. It can be a very challenging issue.

The Deputy asked about the personnel needed should there be legislative change such that pregnancy termination would occur in Ireland. In general, there is no significant difference I foresee in terms of skill set. Medical termination of pregnancy is very similar to what we do now when patients present at 12, 14 or 16 weeks with the unfortunate situation where a baby's heartbeat has stopped. The same medical process occurs. Surgical pregnancy termination earlier in pregnancy, meaning at less than 14 weeks, is, technically, the same procedure we do at present when patients present with what is called a missed miscarriage. I do not foresee any significant difference in the need for qualifications of personnel. I do, however, foresee a significant increase in resources needed. Last year, 55 women went from the Rotunda to the UK for pregnancy termination for severe complex foetal abnormalities, which is one case a week. I am reasonably confident the Rotunda would be able to absorb that workload into our current situation. If many more patients who terminate for other reasons were to have those procedures performed in Ireland, there would be a significant resource implication for us. By "resources" I mean personnel numbers and a physical environment in which to care for patients such as these in an appropriate manner. The Rotunda is a wonderful place and a wonderful building, but it was built in 1757. We do not have much expansion room to care for those large numbers, so there would be a significant requirement of resources.

Chairman: I call Deputy O'Reilly, who has six minutes.

Deputy Louise O'Reilly: I thank both of the witnesses for coming in. We appreciate how busy they are and we are very grateful for their time and expertise in this matter because we are politicians and they are the experts. It has been very informative so far. Professor Malone referred to the need to provide complete health care services for women. For the avoidance of any doubt, and I want to keep this brief, that includes the provision of access to abortion and the aftercare that goes with it. I am not trying to put words into Professor Malone's mouth, but I want to clear that up first.

Foetal anomaly scanning is very hit and miss, and this is something I have spoken about on numerous occasions. Dr. Mahony is nodding. It is unfortunate that a woman may find out very late in her pregnancy that the foetus has a fatal or lethal anomaly. Does having to travel on top of this add to the complications? Clearly, it will increase the stress, but does it add to the complications? Were the woman able to access abortion services here in Ireland it would considerably decrease the stress and, as Professor Malone outlined, the potential for physical harm, as happened in one very unfortunate case.

My final question relates to a reference in Professor Malone's evidence to post-termination autopsy and genetic testing. Will he speak to us briefly about how important this is and what we can potentially learn from it? Is that information completely unavailable because the procedure is carried out in another jurisdiction or is some of it available? I ask Professor Malone to tease out how it works.

Professor Fergal Malone: The Deputy is absolutely correct in her initial characterisation of my comments. When I call for access to complete health care I do indeed mean the pregnancy termination procedure in Irish hospitals followed by the aftercare, because that is the only appropriate way to perform any medical care. I do not know of any other aspect of medicine where we suggest that people would go to another country to have part of their care but we will look after them afterwards. As a general theme this is what we mean.

As regards a late diagnosis of the foetal abnormality and a patient travelling then, I absolutely agree it is true there will be more potential complications if the patient travels then. The uterus is much bigger. There is much more blood supply to the uterus later in pregnancy. There is much greater chance of significant bleeding. A patient travelling later in pregnancy is absolutely associated with much more risk. We would never like to see that happening but, unfortunately, it does.

As regards a perinatal autopsy, this is an absolutely crucial point. At present, since patients have to pay for everything themselves when they to go to the United Kingdom for termination of pregnancy they are often in a dreadful situation, having a certain amount of money to spend on the flights, hotel and basic procedure, and they just cannot afford an autopsy and special genetic testing. Unfortunately, they will decide they cannot do it. If the procedure was done in Ireland, public or private would make no difference as complete testing is done as part of the public health service. Patients in Ireland would have a total diagnosis.

Having a total diagnosis is crucial. Some genetic conditions have as much as a 25% or 50% chance of coming back again, whereas other conditions may have less than a 1% chance. I would think most families would want to know if the condition they have just gone through had a 25% or 1% chance of recurring. Additionally, the advent of preimplantation genetic diagnosis means that after certain types of genetic diagnoses are made, if a patient undergoes IVF, on the next pregnancy before the embryos are reimplanted it is possible to biopsy those embryos and find the ones that have the genetic condition and, crucially, the ones that do not, and then only replace an embryo that has been proven not to have the genetic condition. When a patient does not have this information as she cannot afford it because she is forced to undergo a procedure in a different jurisdiction, it has profound implications for her future fertility.

Dr. Rhona Mahony: As a supplementary, and coming back to the last two questions on aftercare, particularly on the taking of abortion pills, I re-emphasise to patients that if they present our primary consideration is to provide care for them. It is not just the physical consequences. There are also psychological consequences, and the circumstances in which a young person might choose to obtain tablets from a source she does not know and take them with all that risk, and why she is doing that on her own without accessing good medical care. I am referring to children, women of limited means who cannot travel and the other components and complexities that can exist for women who find themselves in a position where they do not want to be pregnant.

I re-emphasise the primary reason for foetal anomaly scanning is to identify treatable conditions in foetuses so when the babies are born we can optimise the care we give them. We know

this can have a significant impact on survival. The classic example is congenital heart abnormality, where we are ready for the baby, we can institute the correct therapy, and the surgeons meet the mother in advance of delivery when plans can be made. It makes a big difference with regard to diaphragmatic hernia and gastroschisis for us to know the conditions are there so we can plan for the baby and enhance survival.

The Deputy is right that anomaly scanning is performed at 18 to 22 weeks. There is a cut-off limit in the UK at 24 weeks in general for termination of pregnancy. This can mean patients suddenly have to grapple with a diagnosis in which we say to them our experience tells us the baby will not survive. If they choose to make the decision to travel to the UK for termination of pregnancy they must make the phone calls, find the appointment and organise their travel, their children, their jobs and other elements of their lives. Unfortunately, there are big resource issues not just in Ireland but in the UK, and increasingly women face delays in the UK in areas such as Liverpool, which have provided a great deal of service to women in this context.

With regard to post mortems, we do not have very good perinatal services in Ireland. We have a very limited number of perinatal pathologists. It is a very specialised area. We are lucky in Holles Street and the Rotunda to have such specialised doctors and laboratory technicians, but this is not the case throughout the country. In many hospitals in Ireland there is a real difficulty at present in accessing post mortems. As Professor Malone said, this can make a big difference because some diseases have a significant recurrence rate and parents need to know this if they are going to embark on another pregnancy. The same goes for genetic services. We have very few perinatal clinical geneticists in this country, but if we look at how the technology is progressing, there is microarray and the ability to look at chromosomes and genetic material. We can now characterise the entire human genome. All of this technology is coming down the track, including the ability to edit the human genome, and we have very limited genetic services in this country.

Chairman: I call Senator Ruane, who has six minutes.

Senator Lynn Ruane: I thank the delegates for their presentations. My first question does not arise because I consider it to be in any way attached to the issues concerning women who do not want to continue their pregnancy. However, as it has been a recurring theme in recent weeks, I am interested in the delegates' views on it. We often hear that Ireland is one of the safest countries in the world in which to be pregnant and give birth. Will the witnesses indicate how safety is assessed in Irish maternity care and whether we measure maternal morbidity as well as mortality? To reiterate, I see this as a separate issue, but the delegates are probably the best people to address the matter so that we do not have to hear it every week.

In his presentation, Professor Malone said that the Rotunda Hospital provides 10,000 20-week to 24-week scans for foetal anomaly and noted that many hospitals do not have the resources for such scanning. If all pregnant women are not undergoing such scanning due to inadequate resources, what are the factors determining which women are offered it and which are not?

In regard to conscientious objection, reference was made to how this might become a problem in smaller hospitals. What role do the delegates see for integrated services, including a role for GPs, in the future provision of termination of pregnancy services? Apart from cases of foetal anomaly and in a scenario where we are looking at an earlier stage in pregnancy - say, up to 12 weeks - and cases where termination of pregnancy is being entered into willingly, might there be a role for GPs in the provision of medications? How do the witnesses envisage

the handling of conscious disagreement or objection in cases where a patient might be facing waiting lists to access a different GP? What types of issues might arise in such circumstances?

Dr. Rhona Mahony: On the question of maternal mortality and morbidity, we monitor those issues very closely. Indeed, the three Dublin maternity hospitals have been producing annual clinical reports for decades. In the case of the Rotunda, in fact, it probably has been done for more than 100 years or even 200 years. In addition to the year-to-year information, we can also plot the trends. At the moment, the maternal mortality rate is somewhere between eight and ten per 100,000, which compares very favourably with statistics internationally. In the United States, for example, where a much larger proportion of GDP is spent on the health budget, the maternal mortality rate is 17 per 100,000. In the United Kingdom, the rate is ten to 12 per 100,000, with similar rates in France and throughout Europe. In the Scandinavian countries, the rate is six to eight. We have, therefore, very low maternal mortality, although there are small differences there. Some 99% of maternal deaths occur in the developing world where mortality rates can be as high as 350 per 100,000 in any one country, which is a staggering figure.

In terms of maternal morbidity, approximately two women in every 1,000 pregnancies will have a very severe morbidity issue. These include massive obstetric haemorrhages, clots, venous thromboembolic disease, uterine rupture, etc. We have a list of very severe morbidities and we keep a record of their incidence nationally in conjunction with the National Perinatal Epidemiology Centre, NPEC, at University College Cork. Again, we can see certain trends from these data. If I were to comment on one such trend, it would be the rise in cases of haemorrhage. That is what worries me most as Master of the National Maternity Hospital, in particular the increasing incidence of postpartum haemorrhage. The other striking trend in terms of maternal morbidity is the increase in maternal age and maternal obesity, both of which have a significant impact on delivery and risk.

Professor Fergal Malone: The Senator referred to the prospect of more integrated services, perhaps at the primary care level and earlier in pregnancy. We are strong supporters of that concept. We want normal obstetrics to be delivered in the community as much as possible, by midwives and GPs, with the involvement of hospital obstetricians occurring only on an as-needed basis. That is the more efficient way to do things. However, that does leave open the potential, as the Senator observed, for situations where the local GP has a conscientious objection. The Medical Council is clear on this in that while doctors are entitled and allowed to have their own personal viewpoints and conscientious objections, there is an obligation on a doctor to ensure a patient is not disadvantaged as a consequence of any such view or objection. In such cases, there is an obligation to refer the patient to another doctor. I hope that would be done as efficiently as possible.

On the factors which dictate which patients receive scans, a crucial concept with foetal anomaly scanning is that it needs to be provided to all patients. Only a minority of foetal abnormalities occur in the setting of a previously affected pregnancy or a patient who has a strong family history. The vast majority of foetal abnormalities occur on a once-off basis where the couple in question had no previous idea such a problem might arise. We will only find those abnormalities if the scan is made available equally to everyone. It is not appropriate and not efficient to take just a certain age group or a certain disease category and provide a scan for those patients. That is one of the challenges we have in our health care system at the moment. In the RCSI hospital group, for example, of which the Rotunda is part, a new programme has been rolling out over the past month to resource foetal anomaly scans for Cavan General Hospital

and Our Lady of Lourdes Hospital by way of the provision of a certain number of contract hours by newly appointed hospital group staff at those locations. We will see some improvements in that regard but it is a major deficit of the Irish health care system at this time.

Deputy Clare Daly: The observation that services in the United Kingdom are under strain was made several times. Do the delegates have any particular concerns in that regard? I noted their points about the extra trauma caused to families by the need to travel. Has any consideration been given to the further trauma that would arise if parents have to travel beyond to the UK to a jurisdiction where English is not the first language? Are there possible implications in this regard arising from Brexit?

The delegates have raised very strongly the need to decriminalise the provision of pregnancy termination services. It is not one of the recommendations we are looking at, although I am increasingly of the view it will absolutely have to be centre stage. The witnesses described very clearly the chilling effect of the eighth amendment on clinicians. How is that issue addressed in gynaecological training? Is it something that comes up in the course of training young doctors?

We need to be somewhat careful when discussing resourcing issues. Do the delegates agree there already is an under-resourcing of maternity services? I am aware that claims for hundreds of millions of euro have been lodged against the State. Against that backdrop, we must be careful of saying that the provision of anomaly scans and abortion services will have resource implications. It is not an either-or situation. I am not saying the witnesses were suggesting otherwise, but we do need some clarity on the necessity of having adequate resources in place to provide best care for women in that context. It would be helpful if this issue were addressed today. The delegates' presentations were very clear and their standpoint as clinicians and medical practitioners, where they have said there is a risk to women and women's health by our continuing with current policy, could not have been clearer.

Dr. Rhona Mahony: On the resource issue, the fertility rate in Ireland is approximately 14 per 1,000, which is at the upper limit of European fertility norms. Yet we have the lowest number of obstetricians in the OECD, comprising some 140 to 150 whole-time equivalent posts. By any reasonable international standard, that number should be at least twice if not three times as large. In terms of midwifery services, last year we conducted a national study called Birthrate Plus which identified that Ireland's complement of midwives is 140 short, including a shortfall of 25 in my own hospital. That is a very serious deficit. The problem, however, is not confined to a shortfall in staffing provision. We also have a huge problem recruiting and retaining staff, which is a major issue, particularly outside Dublin. In fact, it is a global problem which exists across a range of countries and represents a real risk over the next ten to 20 years. We have just done a survey of doctors in training which found that very few of them want to work outside Dublin. Already, there are units outside the capital with very high locum dependency and experiencing great difficulties in attracting obstetricians. On the midwifery side, we have a particular problem recruiting midwives who are trained to scan and midwives or nurses qualified to work in theatre and in neonatal units. Again, these are very specialised areas and one cannot just go to market. These are people who trained for a long time and have very good skill levels.

On the one hand, then, there are these difficulties with resources and the fact the units are all very busy. Professor Malone and I each work in units delivering almost 9,000 babies per year. Arising out of that resourcing issue is a related problem. Last year, the State paid €1.6 billion settling medical negligence claims. Some 60% of that was in obstetrics although internationally our outcomes compare favourably. Our health budget is approximately €13 billion. We do not have a direct budget for obstetrics but I estimate that it is not more than €1 billion. It is

likely that we are now paying more money to settle medical negligence claims than we are using, despite the deficit, to resource our service in the first place.

I believe there is a need to decriminalise. A complex medical decision is being made and I am not aware of any other area of medicine where people are charged with making complex medical decisions under the shadow of a custodial sentence of 14 years. We had an opportunity in the Protection of Life During Pregnancy Act to decriminalise but we did not take that opportunity, which is a pity. I support the Royal College of Surgeons in Ireland's statement that medical procedures pertaining to women in pregnancy should be treated with the same regulation as any medical procedure and not in a criminal context.

On training, first we have a problem recruiting trainees to do obstetrics because it is such a high-risk area. It is a punitive area in Ireland in which to practise. People are becoming increasingly fearful of practising obstetrics in this country, which does not make women safer. We need to support the clinicians at the coal face who are delivering difficult care. Our primary aim when training young doctors and midwives is that they will be good clinicians and that their primary objective will be to provide good, sound clinical care.

On the strain in the UK, this year on International Women's Day, the Royal College of Obstetricians and Gynaecologists held a meeting dealing with issues surrounding termination of pregnancy. I was at the meeting. Much of it focused on the resource issues in the UK, which is also struggling to recruit doctors. It is a big issue for it too.

Professor Fergal Malone: To give a specific example of the strain in the UK, for a period of time one of the major units that we work with and which our patients attend was limiting Irish patients to one new Irish patient per week. That was for all of Ireland. We had quite a few examples of patients calling up and trying to make an appointment to find out that the one Irish appointment had already been taken. Then they would have to wait until the following week to try calling again and maybe it would be able to fit in the patient then. As the committee can imagine, it was a completely intolerable situation.

Deputy Daly asked about trauma for patients if they had to go farther afield. I am concerned about the impact of Brexit. If there are further practical impediments to patients travelling freely between Ireland and the United Kingdom, I would see some significant added traumas and challenges for our patients. It must be remembered that those who are must vulnerable to being traumatised are those who are non-English speaking. They are perhaps refugees who do not have the wherewithal or the common sense to be able to find other avenues for their care. It is a potential significant problem for us.

Deputy Kate O'Connell: I thank both the witnesses for their presentation here today. We have met before at the health committees. Many of us here sit on the Joint Committee on Health where we discussed the national maternity strategy and its under-resourcing and how the outcomes we have in this country are miraculous given the low ratio of obstetricians to patients and the risks associated with our poor scanning. I think it was Professor Kenny from Cork who said one a week cannot be triaged so there are random instances of foetal abnormalities which one would not imagine would happen. We also have one child a week being born in circumstances that are not ideal. Under-resourcing of our maternity services has a massive knock-on effect, as the two witnesses know.

For the benefit of those listening in and members of the committee, will the witnesses clarify why the term "miscarriage" is used before a certain stage in foetal development and "stillbirth"

used after? Why do doctors advise women not to announce their pregnancies until after the 12-week scan or the 12-week stage? What percentage of pregnancies end in miscarriage? How is a miscarriage recorded on a woman's medical chart in a hospital? It may be of value to the committee to know that, as a pharmacist, I have dispensed plenty of misoprostol in my time for people who have diagnosed miscarriages. It has been nailed down by medical professionals such as the witnesses. Therefore, on the idea that misoprostol is a drug that is not available, it is cheap and it is readily available. Perhaps the witnesses could elaborate on that for the benefit of the members of the committee.

It is obviously an area of specialty, but we have had claims at this committee and in public about foetal heartbeats developing at 21 days and foetuses jumping around. If they could to some extent and as broadly as possible, will they outline when the central nervous system of a baby develops and, with that, the ability to feel or sense things? When does a foetus become sentient? We have spoken about the earliest point at which a child has survived. Was it 24 weeks? I had not considered before the differences in the presentation at 24 weeks, where one could have weights of 700 g or 250 g. That was interesting and something I learned today. That it is not as simple as putting time limits on it is information of great value to the committee.

Chairman: I thank the Deputy. We should allow-----

Deputy Kate O'Connell: If I can finish, probably the most important thing the witnesses said here today is that it is a decision between a woman and her doctor. It will never become part of this committee's work unless we have a few obstetricians among us of whom I am unaware. The diagnosis of a fatal foetal abnormality is a complex procedure. From the witnesses' evidence today, it could involve a multiple of factors coming together. All of that can be helped by proper scanning as well as the maternal blood tests that are now available at eight weeks. We have heard in the Joint Committee on Health that some people may regard that as giving people options to perfect the child. However, what we have learned is that it gives the doctors dealing with the child all the necessary information to make the interventions that they need to make. I assume both witnesses entered medicine to save lives and that they specialised in obstetrics because they like handing people live babies. I thank them both for the work they do under very challenging circumstances.

Chairman: I ask the witnesses to be brief as there is very little time remaining.

Professor Fergal Malone: With regard to the Deputy's last point on decision-making between the woman and the doctor, we want to preserve that as much as possible. I do not know of any other aspect of medicine - for instance, an oncologist sitting with a patient who is dying from cancer and his or her family - where they must involve outside agencies or legalities in the decision on when to stop offering further care. In paediatric care, when an unfortunate baby in the neo-natal intensive care unit is dying from prematurity, the paediatrician, the neonatologist and the family speak to each other, rationalise what is going on and together make a decision on when to withdraw care. That does not involve external agencies or any legal impediment. It is a common sense doctor-patient relationship and we want to do whatever we can to preserve it. Yet, in this aspect of foetal care there is an external force or cloud hanging over what can or cannot be done.

The Deputy asked about the terms "miscarriage" and "stillbirth". Traditionally, miscarriage is the loss of a pregnancy before viability at 24 weeks or 500 g. Stillbirth is the term beyond that. It is for that reason many obstetricians say and families decide not to tell other people that they are pregnant until after 12 weeks. It is because most spontaneous miscarriages will reveal

themselves by then.

The Deputy asked for a percentage. About 30% to 40% of all human conceptions will end in a miscarriage. If the patient reaches 12 weeks, they can generally be very confident that at that stage it is highly unlikely to be a miscarriage. The Deputy asked how that is recorded. It is simply recorded as a miscarriage; that is the term we would use.

Deputy Kate O'Connell: I am aware some hospitals use the term "abortion" on a chart.

Professor Fergal Malone: Not any more. We would use the term "miscarriage". We would be sensitive to that. In other countries, and in some textbooks, "spontaneous abortion" is a term that is used. It is synonymous with miscarriage. Most people here do not like to use that term and prefer to use the term "miscarriage".

The Deputy asked a very pertinent question, which was when central nervous system, CNS, development occurs in the foetus. About two years ago, the Royal College of Obstetricians and Gynaecologists convened a working group, bringing together various neurologists and physiologists, to specifically examine that. It was about the sense of pain and when a foetus might feel pain and it was clear from the consensus among a wide range of disciplines that that does not occur before 24 weeks and is probably closer to 30 weeks. It is a mistake to assume that just because an ex-25 week foetus in the neonatal intensive care unit can show signs of feeling pain that the same 25-week foetus *in utero* will feel pain. That is a very different environment and the consensus from that working group was that it is certainly beyond 24 weeks gestation, if not closer to 30 weeks.

Dr. Rhona Mahony: I would make one brief comment relating to the 12 weeks and miscarriage. The first trimester, the first 14 weeks of pregnancy, is when the risk of miscarriage is highest. It is about one in five pregnancies and the vast majority of those cases, about 80% or 85%, are related to chromosomal abnormality. Miscarriage is much less common in the second trimester, which is between 14 weeks and 24 weeks, but we can have issues like antiphospholipid syndrome or sticky blood syndromes, infection and cervical incompetence, but it is much rarer. Stillbirth after 24 weeks is very rare. We are looking at instances of about two to three per 1,000. The 12 week issue comes from the fact that at least one in five pregnancies will end in miscarriage in the first trimester.

Deputy Kate O'Connell: Could one of the witnesses clarify the position about the heart or the heartbeat?

Dr. Rhona Mahony: The heart begins to develop as a tube very early on in pregnancy but then it must develop into the chambers. Although much of the development is complete by 12 weeks, it still has to grow and develop normally, so it is not sufficient to say that just because a heart starts to beat that its development is complete.

Chairman: I call Senator Buttimer, who has six minutes.

Senator Jerry Buttimer: I am okay.

Senator Rónán Mullen: I thank the witnesses for coming in to share their knowledge with us. Dr. Mahony spoke a lot about the criminal law but I think she would accept that even in Britain there is a criminal law restricting abortion, that doctors are subject to the criminal law in Britain and that, in general terms, the criminal law is part of helping society distinguish between rogue and good doctors. Would she accept that the fact that there is no case law in

Ireland showing that doctors have been found wanting or have been subjected to the criminal law suggests that the balance has been got fairly right and that, in general, there is a reluctance to second-guess a judgment made by a doctor, particularly given that the risk to life does not have to be imminent? The balance seems to be well struck if the witnesses are not able to cite case law about how doctors found themselves in trouble in this area.

This is an issue about balancing risk, and the witnesses are experts in that, but it is also a question about values and it seems to me that how they view abortion generally will impact on their views about how to manage risk in this area. Are there aspects of the British abortion law that they find unethical or that shock the witnesses? I may have misunderstood Dr. Mahony to say that 24 weeks was the cut-off point where there was a question of a disability and that that was exercising pressure. My understanding is that the relevant ground in the British law, and please correct me if I am wrong, does not specify a time limit and that is why there have been cases of children with disabilities as minor as cleft palate being aborted very late term in Britain. I would like the witnesses to tell us where they are coming from because it is not just about medical expertise. There is an interaction with values, particularly as it seems that it is only in recent years we hear expert doctors in Ireland talking about all of these matters. Ten years ago when, presumably, we knew less in medicine, and I am asking both witnesses to address these questions. Doctors seemed to be happy that there was this balance in our law that allowed them to care for two patients. I have not heard that kind of narrative in what the witnesses have said today.

On the question of foetal abnormality, and I think Professor Malone excludes the term "fatal" from what he is seeking to be lawful - please correct me if I am wrong - do the witnesses accept the testimony of families who believe that where their child was diagnosed with what has been called fatal foetal abnormality, it was not just a matter of their choice as parents being respected in terms of whichever road they took but that they felt that their child had a right to be respected until their natural end? Do the witnesses accept that there is nothing they can say to convince those people because they see it as a right their little child had, particularly when we think that what might happen to that child in the context of a termination would be the injection of potassium chloride into the child's heart preparatory to the termination? Please correct me if I am mistaken about that. Would they accept that they find that impossible to relate to any notion of respect for that child?

Regarding choreoamnionitis, I am a little confused. I would like to know first whether Professor Malone is completely of one view with Dr. Mahony on this issue. I have spoken with some midwives, and the witnesses might tell me who is wrong on this, who have been surprised by Dr. Mahony's claim that doctors must simply wait until an infection occurs. They cite, for example, the Health Service Executive's 2015 guidelines on chorioamnionitis, which state that women with clinical signs of chorioamneonitis should be commenced on broad spectrum intravenous antibiotics and that delivery should be undertaken. Given that this is not an issue, and the witnesses can correct me if I am wrong, where I imagine a person would have to go abroad - they would be too sick - it appears to be the case that the current legal architecture is allowing doctors to do what they have to do.

Do the witnesses believe that 48 hours is reasonable in terms of blood culture results? Is that reasonable or a sign of an inadequacy in terms of resources? Could that period be shortened? Is it desirable that it be shortened? Would that be a help? However, the main question is whether there is a problem here if the witnesses appear to be dealing with this situation very well. We have not heard of sad cases.

Dr. Rhona Mahony: The Senator asked a lot of questions.

Chairman: We have very little time left for answers.

Dr. Rhona Mahony: Very briefly, in regard to the UK, the Senator is right. There are situations where termination of pregnancy in the UK is a criminal offence. In fact, that is currently the big debate in the UK and, as I said in my position statement, the council of the Royal College of Obstetricians and Gynaecologists have voted strongly in favour of supporting the removal of criminal sanctions associated with abortion in the UK. They say that they believe the procedure should be subject to regulatory and professional standards in line with other medical procedures but not criminal sanction.

As for helping society distinguish between rogue and bad doctors and there being no case law of doctors being arrested and put in prison, the point is that the law is there and we must, and will, abide by the law. In my practice I will abide by the law but to my mind the law is unclear in regard to determining when a woman is sick enough to qualify for the substantial risk to her life provision. It is not enough to merely say that in the past couple of years no doctor has been prosecuted. Doctors have been prosecuted in Northern Ireland, but the law remains as it is and that is the law under which we practice medicine today.

Senator Rónán Mullen: What have they been prosecuted for in Northern Ireland?

Dr. Rhona Mahony: In regard to termination of pregnancy, and one could look at UK law, but there have been one or two cases where doctors have been accused of inappropriate termination of pregnancy-----

Senator Rónán Mullen: On their assessment of the risk or on a completely different ground?

Dr. Rhona Mahony: On different grounds, yes.

Senator Rónán Mullen: That is different from assessment of risk.

Dr. Rhona Mahony: The point is that the law exists in this country that a woman qualifies for a termination of pregnancy in the case that there is a substantial risk to her life that can be removed only by termination of pregnancy. I have outlined very clearly the challenges that creates medically. Whether anybody has been put in jail is not the point.

Senator Rónán Mullen: Prosecuted.

Dr. Rhona Mahony: The point is what is the law under which we practise.

In respect of ruptured membranes, when I say it takes 48 hours to obtain a microbiology culture, that is not a deficiency. It is just what it is. Some more rapid tests are becoming available in which we can look at polymerase chain reaction, PCR, or viral material directly in the laboratory and get quicker results, but at present, for practical purposes, it takes us 48 hours to get confirmation on a laboratory specimen, to actually grow the bugs to determine that there is chorioamnionitis. Therefore, we make our clinical decision based on clinical signs and symptoms that might suggest there is chorioamnionitis. It is most likely to occur in the case of a ruptured membrane and the signs and symptoms of infection we look for are temperature, rapid pulse rate, hypotension, all of the things we measure all the time. The difficulty is that infection can be sub-clinical and when it does take hold, the clinical course can be very rapid and women can become very sick.

Senator Rónán Mullen: The HSE guidelines, therefore, are not enough. Is that what Dr. Mahony is saying? They do not protect the doctor.

Dr. Rhona Mahony: No. It is about clinical care. My point is that one cannot predict a clinical course with precision. Some women will get sick gradually and not very sick. Some will very quickly become very ill. In that context, one is facing performing a termination of pregnancy on a woman who is unstable, has major sepsis and is very ill. That can happen when the membranes have ruptured at 14 weeks when there is little prospect of foetal viability.

Senator Rónán Mullen: Is that Professor Malone's view also?

Professor Fergal Malone: I completely agree with Dr. Mahony that when the clinical signs of chorioamnionitis are present, it is a very easy diagnosis to make. The HSE guideline, as the Senator quoted accurately, is to get on with providing care and carry on with a pregnancy termination. The point is that sub-clinical chorioamnionitis is a real issue. Patients often do not show they have a temperature or tachychardia, fast heart rate, foul-smelling fluid or a tender abdomen until much later in the course. If a patient has ruptured membranes for 14, 15 or 16 weeks, she could well be developing it. She has virtually no prospect of getting to a gestational age at which she will have a live baby, yet brewing inside her, without showing any sign of clinical infection, there can be a serious infection. It is a real issue.

Senator Rónán Mullen: The doctor is not permitted to intervene at that point. Is that what Professor Malone is saying?

Professor Fergal Malone: Absolutely because on a reading of the guideline, as the Senator quoted correctly, the clinical signs are present, but the point is there can be an infection much earlier. We will take that risk if the patient is at 23, 24 or 25 weeks, on the cusp of viability and we might just get there. Let us take that risk together. When the patient is at 14 or 15 weeks and has another ten weeks before there is even a chance of viability, the balance is very hard to justify. It does restrict us.

The Senator expresses surprise that some families who have carried a baby with fatal abnormalities and have had those special moments after birth would have a hard time reconciling with the idea of a termination for fatal foetal abnormalities. I agree completely with him and absolutely accept that there are some parents who follow that journey who would find what we are talking about appalling and could never conceive of the idea of terminating their pregnancies, but equally there are many patients who when they are told at 12 or 14 weeks that, unfortunately, their baby has no head and no upper brain, that there is nothing we can do about it, that they must wait another four, five or six months before we can, find it equally appalling. I am here to tell the committee that we would like to care for all of our patients, irrespective of what is their personal, moral, religious or ethical background. One group of patients has a care pathway that it can follow, but another does not.

Deputy Anne Rabbitte: I thank the delegates for their presentations. Do they think palliative care or hospice services for those who wish to continue with a pregnancy where life after birth is likely to be short are equal throughout the country? How difficult is it for staff to provide appropriate non-directive counselling for a woman seeking an abortion under the current legislation and what impact does it have on the clinical care and best practice in caring for women and children?

Professor Fergal Malone: Perinatal hospice care is a very well developed concept, but like

all aspects of the health care system, it is subject to limitations on resources. It is not a surprise that there would not be similar resources around the country. Some aspects of perinatal hospice care are quite specialised. The HSE has recently published bereavement standards in which they are trying to make clear the minimum standards for personnel required to help and support families who are following that journey. It will allow hospitals to measure themselves against those standards. Where it is clear that there is a deficit in numbers of personnel, at least we will be able to address that issue. I would not go so far as to say it is equal around the country; it is not.

Providing non-directive counselling is part of one's professional training. We train midwives and obstetricians and show them how to leave their own opinions at the door, to not reveal their own personal viewpoints. It can be hard as we are all human, have our own sets of beliefs and, as Senator Rónán Mullen said, values. They are real and heartfelt, but when dealing with a patient without knowing what her value system is or her moral, religious or ethical viewpoint, our value systems and views have no place in the discussion. Training is required and we provide that training for our staff.

Dr. Rhona Mahony: I agree. We are just starting to develop really good perinatal hospice care services in terms of the ancillary multidisciplinary care we need to provide. It is not just a matter for doctors and midwives but also involves social workers and bereavement counsellors. We are seeing lovely developments in capturing memories for couples, a sort of anticipatory grief when we know that it will be a very difficult time for them. We are learning from patients' experiences and engaging with patients and trying to understand what has made a good positive difference and where perhaps we have said the wrong thing or not done the right thing. Part of the conversation in Ireland in the past few years has also focused our minds on improving care for those women who do stay at home to continue with their pregnancy. We increasingly understand the difference providing really good care, not just for the woman but also for her family, can make. That is a very positive development.

As doctors, our job is to provide the information, make the diagnosis and provide the benefit of what information and clinical experience is available in order that patients are informed to make their decisions. If I have a value system, it is absolutely the provision of safe clinical care for women and infants in this country.

Deputy Mattie McGrath: I welcome the two delegates. Professor Malone told the *Irish Examiner* that in the majority of cases in the Rotunda Hospital where babies had been diagnosed with anencephaly or trisomy 18, parents travelled to Britain for an abortion. That is in sharp contrast to the findings of research from Cork University Maternity Hospital where more than 90% of parents who had received a diagnosis of trisomy 18 continued with the pregnancy. Cork University Maternity Hospital also found that most parents continued with the pregnancy after a diagnosis of anencephaly. What is the Rotunda Hospital doing wrong? Do parents feel unsupported in the hospital?

Are the delegates aware of findings in a study by Duke University in 2015, published in the peer reviewed journal *Prenatal Diagnosis,* that women who underwent an abortion after a diagnosis of anencephaly were significantly more likely to suffer from depression and even despair than those who continued with the pregnancy? If Professor Malone is aware of this, did it influence his clinical practice?

On his statement that he leaves his views at the door, medicine has always been about values. Does he believe preborn babies with a disability have less of a right to life?

I also have some questions for Dr. Mahony.

Professor Fergal Malone: I believe the Rotunda Hospital is providing services to the utmost level of quality and could be easily standardised or benchmarked against international best practice. I will not comment on the experience of other hospitals with pregnancy termination because I am not in a position to do so. I can tell the committee the statistics I quoted, which show that about 57% of our patients with a prenatal diagnosis of Down's syndrome do travel for a termination of pregnancy and 50% with a diagnosis of trisomy 18 travel for a termination of pregnancy but 50% do not. To me, this demonstrates absolutely good and balanced counselling of patients. Almost an equal number of patients who are diagnosed with trisomy 18 or trisomy 21 in the Rotunda choose to continue as compared to those who choose not to. One cannot get any more balanced that. If I had statistics that were 99%, 1% one way or the other, that would raise the question of someone else doing something wrong in terms of their balance. I do not think our numbers could be any more balanced than what we are seeing.

The Deputy referenced the study in *Prenatal Diagnosis*. I am very familiar with the study by Cope and colleagues that suggested that there was an increased incidence of various measures of psychological trauma or upset after they terminated for various abnormalities. I would not accept that paper as being a good example to learn from. When one looks at the methodology in that paper, one can see that many of the patients who were recruited came from social media campaigns or were tracked down or recruited through social media. As a clinician scientist, and I carry out and have published a lot of research studies, how one recruits patients into a study is crucial to the outcome. If one recruits patients who might have a certain viewpoint already and go to social media to recruit them into the study, it is not all surprising if the results are in a particular direction. The unbiased recruitment of patients is crucial to any science in any speciality. That would be my concern about the Cope paper cited by the Deputy.

I believe all of our patients have rights to health, well-being and dignity and that is what we strive to do day in and day out with our patients. We listen to our patients and what their personal values are and provide them with the information. One set of parents might decide in one direction while another might decide in another direction and that is okay. That is acceptable because it is our job to be professional and I think we continue to do that.

Deputy Mattie McGrath: I have some questions.

Chairman: The Deputy should ask one question if possible to keep somewhere near his time.

Deputy Mattie McGrath: Dr. Mahony said previously that abortion should be legalised on health grounds. For what specific conditions would she recommend that women undergo an abortion on health grounds? Has it been her experience in her clinical practice that she has delivered sup-optimal care to a patient or patients because she could not perform an abortion on health grounds?

Dr. Rhona Mahony: It would be impossible and would not be wise to provide a comprehensive list of either conditions that can kill someone or cause adverse health outcomes. The point is that in any clinical course, doctors are able to make sensible clinical decisions that will result in a woman maintaining good health and staying alive. There are times in pregnancy when complications occur that can put a woman's life at risk and can cause serious disorder. The difficulty sometimes is ascertaining the difference between someone being very sick and someone dying. That can be difficult to predict with precision. What doctors and their patients

require is the flexibility to work together in the context of clinical disease in pregnancy to make good sound decisions that will ensure that women are safe.

Deputy Mattie McGrath: Just one brief question.

Chairman: Brief.

Deputy Mattie McGrath: In 2013, 15 obstetricians who had been practising in Ireland for many years under the eighth amendment wrote to the Oireachtas committee, of which I was a member, strongly disagreeing with Dr. Mahony's claims regarding fears of a prison sentence for intervening to save a mother's life. One went on to describe those claims as histrionic. At those Oireachtas committee hearings in 2013, in answer to Senator John Crown, Dr. Mahony and other obstetricians agreed that they did not know of any instance where a needless maternal death had occurred because doctors had felt unable to act to save a woman's life under the eighth amendment. Is it fair to say that Dr. Mahony may be ideologically motivated in calling for abortion to be legalised in Ireland?

Chairman: I think that question may already have been addressed.

Deputy Mattie McGrath: I did not-----

Dr. Rhona Mahony: The word "histrionic" is quite interesting in respect of a female gynaecologist.

Deputy Jan O'Sullivan: I have two questions, which are follow-ups from answers the witnesses gave to previous speakers. We are all aware of the costs of travelling and the fact that they are prohibitive for some women. If I understood Professor Malone correctly, he said that in some cases where there was a fatal foetal abnormality, the cost factor in terms of autopsies and further testing might deter a woman from having testing done that might have facilitated her to have a successful pregnancy thereafter and a baby that could be delivered and would live. Could he clarify that because that is something I certainly had thought about before?

My second question is a follow-up to Deputy Daly's question about training. Both witnesses are both Masters and senior clinicians but in terms of people not wanting to go into the profession partly because of the criminalisation issue and also having to make those decisions around when it is a risk to health and when it becomes a risk to life, does that also deter people coming from other jurisdictions who would not have grown up under the eighth amendment from taking the risk of taking a job in obstetrics and gynaecology in Ireland because of the issues around the eighth amendment?

Professor Fergal Malone: The Deputy's initial question is a very real concern and we have had experience with it. A patient goes to the UK, has a pregnancy termination and we do not have a clear diagnosis when she leaves. What would have happened in Ireland is an autopsy with some extensive genetic testing. In respect of some of the newer genetic tests, an individual genetic test can cost €500, €600 or €800 for one test so that would be done here and in many cases, we get an answer. However, if the patient is in the UK and is not entitled to free care on the NHS because she is not registered as an NHS patient - she is an Irish patient - and she wants that testing, she will have to pay for it. Some parents will pay for it because it is medically crucial information but we know some patients already struggle to reach the €800 to €1,500 a termination in the UK costs and now also have to find another €500, €1,000 or €1,500. We have had parents who have decided not to have the relevant testing done and are then left with an incomplete diagnosis - "my baby died because of a brain abnormality but we are not exactly sure

what kind of brain abnormality" - and they have no idea what the chances of it coming back again are so it is a real issue and would be one that would not be there if we could undertake the complete care for our patients here.

As regards training, it is important to differentiate between doctors in training and a senior consultant of 60 or 65 years of age who has been around the block for 20 or 30 years. The self-confidence that comes with being a clinician who is 60 years of age and who can make a stand and say, "This is what I am going to do" is very different to a 24 or 25-year-old intern or SHO. It is expecting a young inexperienced doctor to have such a spine as to say, "You know what, I don't care what the criminal code says. This is the right thing to do and I'm going to do it". I can see a 60 or 65-year-old experienced clinician saying, "That is what I am going to do" and the legislation not having a chilling effect on them but it is very different for a doctor in training, so I do think it has an impact. One of the earlier questions suggested that other doctors have come into the committee and said that they do not see that as a problem. That is great and that comes with 20, 30 or 40 years of practice but these are not necessarily the doctors at the coal-face at 2 a.m.

Dr. Rhona Mahony: It is important to note that we generally work as a team and if there is a complex medical issue, consultants and trainees work together and, generally, consultants have a really big input when a patient is unwell or where there are complex clinical issues, so I would like to think that it is very rare that a trainee would find themselves on their own in this context. We generally work very hard to work as teams but there is a broader issue regarding training. It is not just the chilling effect of the eighth amendment. There are broader issues relating to obstetrics, recruitment into training and attrition rates. That is because obstetrics is very high risk. We have long hours. It is a surgical specialty. Complications can arise, not necessarily due to somebody's fault, but they can arise unpredictably and they can be very profound.

In terms of adverse outcome, our specialty experiences maternal death, the death of baby or a baby who is very damaged and has cerebral palsy. These are very high-risk stakes. For some young people, these kinds of outcomes will make them wish not to practise in obstetric medicine. On top of that, it is quite punitive to practice in Ireland. We have a good deal of regulation, which is a good thing but, at the same time, if there is an adverse outcome, one can face into a High Court litigation, a civil litigation, or a Medical Council hearing. Perhaps one of the most difficult aspects is the fact that Medical Council hearings or other cases are covered in the media, and that is very difficult when one lives in a country with a population of 4.7 million and one sees one's name regarding a case or very intimate details of cases being published.

Ireland is a little different with respect to women and women's health regarding the intimate details about women, particularly in the area of termination of pregnancy, that find their way into the newspapers. At times I have been quite shocked at the level of the detail because it makes women readily identifiable. Also, we do not tend to see similar reporting with respect to men, for example, having prostate surgery. There is a bias there. That can frighten young doctors. Certainly when we see cases like the Y case or other very high-profile cases, no doctor wants to find himself or herself as part of the next media sensation. We never want to be part of an adverse outcome, but they will happen because our specialty is very high risk, and even though we do our very best, we will have complications and adverse outcomes. Ireland is a punitive place in which to practise medicine, and that puts some of our young people off doing so.

Deputy Billy Kelleher: Most of my questions have been answered. The Protection of Life During Pregnancy Act, which is on the Statute Book, provides for a 14-year custodial sentence both for clinicians and for people who procure abortion through abortion tablets. I spoke on

that legislation in the Dáil and I opposed that measure, but I still cannot get my head around the idea or perception of a young girl in a bedroom in some part of this country, frightened, fearful and pregnant, taking abortion tablets, and the potential chilling effect, because it is a criminal offence, that has on that girl seeking medical help afterwards. As clinicians, do the witnesses believe that is potentially detrimental to a girl's health or life? Does it drive a wedge between the girl's relationship with her doctor because of the fact that it is a criminal offence? The witnesses might elaborate on that. In view of what is happening in Northern Ireland in the context of the seizure of abortion pills and prosecutions, do the witnesses believe that is putting at risk the health or lives of young girls especially because they might be fearful of going to a doctor thereafter?

Dr. Rhona Mahony: That is really good point. The first thing I would say to any young woman, no matter what has happened and if she has taken these tablets, is bleeding and in trouble, is to go hospital and have appropriate care. We are not going to prosecute her. Our primary objective as doctors in a hospital is to keep her safe and provide good clinical care. That is an important message to send out to all young women.

I agree with the Deputy that I worry about vulnerable young women who find themselves in such circumstances and have resource to the Internet to obtain tablets that will induce a termination of pregnancy. Apart from the fact that one does not know what one is taking when one gets tablets over the Internet, which is a very important public health message because people get all kinds of tablets over the Internet, on top of that, there is not the support for women to navigate those circumstances. I think particularly of children and young women who are making these decisions on their own and the psychological impact such decisions might have on them. It is important that, when required, women, access health services. We are in business of providing safe health care for patients. That is absolutely paramount.

Chairman: I call Deputy Coppinger and she has six minutes.

Deputy Ruth Coppinger: I will start with the last point because in the previous session we had a presentation about abortion pills and the research that has been done. Obviously, they are used for 80% of abortions in Finland and are medically extremely safe, but I am sure the witnesses would agree it would be much better if women in Ireland could go to their GP, have a discussion and be prescribed them, as they can be prescribed to women in practically every other country in Europe. We might be sending out the message that they are quite safe. According to the research that we heard about earlier, about 4% of women had to seek help because they were not sure if they had completed an abortion.

My questions relate to the hospital system. Why do the witnesses think the level of testing in Ireland is so poor? Obviously, cost must be a huge factor, but is the position of the Catholic Church a factor as well in the sense that pregnant women getting tested for abnormalities of any kind has been definitely discouraged. That certainly was my experience. Different hospitals have different positions on it. Given the level of such testing is very poor and many women do not get access to the system until 23 or 24 weeks, would the witnesses agree that there cannot be a time limit if abortion is legalised for a fatal foetal abnormality? Otherwise, we would be excluding those people who have been disadvantaged through an accident of where they happen to be situated.

Professor Malone said in his presentation that it is now possible to detect to 95% to 99% of foetal chromosomal abnormalities as early as nine to ten weeks of pregnancy. Therefore, we could be detecting these issues much earlier and making the whole trauma for a pregnant

woman completely different. What would be the cost involved in testing? As it involves just a blood test, it is hard to understand why it costs so much.

Have either of the witnesses encountered women who were not able to access a termination because they could not afford to go to England, and what has happened to those women who were so diagnosed? Would they have encountered women in their clinics who are pregnant and where there is not a fatal foetal abnormality but who would like to have an abortion because, as in the case of the 62% of the women who have used abortion pills, they are mothers already, they have children and they know what it is like to be pregnant, to give birth and to bring up a child? Would they have encountered such women or are they just too afraid to talk to the witnesses about that?

On the issue which has been raised of the chilling effect on doctors, I was struck by Professor Malone saying in his presentation that doctors cannot even pick up a phone and make a referral. That says it all to me. The procedure is perfectly legal in Britain but yet he is not allowed to ring another doctor in Britain and make a referral. Is that not going beyond the bounds of the eighth amendment, or is it just that doctors are too afraid to challenge it in any way?

On the issue of maternal deaths, we regularly hear that Ireland is the safest place in the world in which to have a baby, but generally it is not people who have had a baby in Ireland who say that. There has been an increase in maternal deaths. Dr. Mahony gave some of the reasons for that in terms of women being older, obesity being a factor, etc. Are the witnesses very concerned that migrant women and non-Irish women are showing up disproportionately in those deaths? Does that not say something about perhaps their having less access to health care or getting it later? Are the witnesses happy that those women are being listened to? Are there cultural issues involved as well? Even in the case of Savita or other women, perhaps their wishes are being listened to and they are being told this is the Irish situation.

Chairman: The Deputy might need to let the witnesses respond.

Deputy Ruth Coppinger: I wish to ask one last question about Down's syndrome, because it is something which is constantly raised in the committee. It was said at this committee that Denmark has a goal of eradicating Down's syndrome. That might be news to people in Denmark. In a debate in which I took part with Ms Cora Sherlock from the pro-life campaign it was claimed that 90% of pregnancies in which Down's syndrome is diagnosed are aborted. My figure was 44%, which is quite near to the percentage given by Professor Malone. I am raising this issue because this is a parliamentary committee and we should be able to fact check and challenge claims.

Professor Fergal Malone: The Deputy had some specific questions on the cots of the blood test which is done at nine or ten weeks. It currently costs about €350 per blood test, but that is partly because the intellectual property and patent is owned by some international genetic companies which have a certain amount of profit built in to the tests. That is business.

If we could have a genetic sequencer and the required laboratory technology here, I am confident that the test could be performed at as low a cost of €150 or €100. The cost could be reduced considerably if we developed an appropriate genetic laboratory here. At the moment, patients have to pay about €350 because a sample is sent to commercial laboratories in the United States or London.

On the comment that doctors cannot even lift a telephone to make a referral, that is true.

There is a ridiculous situation now whereby some doctors are using euphemisms. They will write a letter to another doctor in the United Kingdom and ask him or her to see a patient with anencephaly for a second opinion. It is a euphemism for saying that he or she is not sending a patient over for a termination of pregnancy because that would be a referral, but is instead asking for a second opinion. That is the cover people are trying to use because they are concerned about how the legislation is written. It is real and changes how communication happens.

Migrant women and women who come to any country from another country are probably more at risk in terms of maternal health and well-being and are probably over-represented in statistics for maternal morbidity and mortality because they have a hard time accessing services or trusting that they can access services. We would like the message to go out, as Dr. Mahony said, that if a patient takes medication at home to bring on a pregnancy termination and runs into trouble, we want her to present to a hospital immediately. We will certainly not be looking to refer or report a patient to authorities. Rather, we just want to care for patients.

The reality is that some patients from other countries may not be comfortable with the fact that the doctor or health care system may be somehow complicit with the justice system and they will be reported. We would not do that. We care for patients.

Deputy Ruth Coppinger: Might some doctors make such reports?

Professor Fergal Malone: I can tell the Deputy the practice in the Rotunda. We are here to care for patients. We are not here to police the system or anything of that nature.

The Deputy's figures are correct. I quoted the 2016 figures in the Rotunda for cases of Down's syndrome. We have no goal of eradicating Down's syndrome. As said, nearly 50% of our patients choose to continue and value their pregnancies. I have seen patients with more than one baby with Down's syndrome and we embrace and support that. It is a wonderful thing. We have no goal of eradicating from society any group of patients. We are here to care for patients. That is all.

Senator Rónán Mullen: On an important point of order, a reference was made to a third party, Ms Cora Sherlock of the pro-life campaign, who I happen to know. I would be fairly sure that she was referring to 90% as the figure for Britain, which makes its own point about what happens once this is legalised. Whether I am correct in that, it is utterly unfair that it would be alleged that a third party got her facts wrong. I am fairly sure she did not, but she should not have been referred to in any event by my colleague. I ask the Chairman not just to note that but to agree with me in regard to references to third parties.

Chairman: I would agree with that in respect of references to third parties. That is a long-standing practice in the Houses of the Oireachtas.

Senator Rónán Mullen: I thank the Chairman.

Chairman: I would request that perhaps the Senator invite Ms Sherlock to write in and clarify the position if she wishes to do so.

Senator Rónán Mullen: She does not need to, in fact.

Chairman: It is something which Ms Justice Laffoy did and I was quite happy to read out a clarification.

Senator Rónán Mullen: Okay. I appreciate the Chairman giving me the opportunity to

make that a point of order.

Chairman: I am happy to clarify any particular issue.

Dr. Rhona Mahony: I wish to make a couple of points on medication and abortion pills. There is a safety record when the correct tablets are taken correctly. However, when medication is obtained over the Internet, its source is not known, which is a risk.

In addition, occasionally people have ectopic pregnancies, where a pregnancy has occurred in the tube and not the womb. That can cause significant risk in terms of misdiagnosis. It is much better that care is offered with a degree of expertise and women are not completely going it alone in terms of care during pregnancy.

On perinatal testing, first trimester screening looks at chromosomal anomalies, specifically trisomy 21 or Down's syndrome, Edward's syndrome and Patau syndrome. The test is currently about €350. The number of women accessing it in Holles Street has increased. When the test was first introduced three years ago, two or three women requested it and now more than 1,000 do so. There is a significant cost which means that women of limited means are not able to afford the test.

The commonest prenatal diagnostic test is ultrasound. In my experience, most women will opt to have a foetal ultrasound. Very few women refuse or decline ultrasound during pregnancy. The reason we have ultrasound is to be able to give the best possible care to a baby where an anomaly has been identified and we can prepare for birth. It is an important reason we look for foetal anomaly.

In terms of maternal mortality and morbidity, we looked at morbidity and I agree with Professor Malone that people of different ethnicities have different outcomes. There is no doubt that it is not enough to look at maternal mortality because those numbers are small and have been relatively stable over recent triennials.

Women of different ethnicities are disproportionately represented in terms of morbidity for all of the reasons outlined by Professor Malone. These include access to care and perhaps not coming for antenatal care. Some women, by virtue of their ethnicity, naturally have an increased risk of pre-eclampsia or fibroid uterus which poses attendant risk.

On the idea that Ireland is the safest place in which to give birth, I do not think people would say it and it is not a sensible approach. The point is that we monitor the data and check outcomes constantly. One should not practise clinical medicine unless one is looking at outcomes. We are trying to identify trends. I referred earlier to my concern about the trend of increasing haemorrhage, for example. We are trying to monitor such trends in order that we can safeguard women in the future and plan our services to provide the best possible care given the current challenges faced by any health service.

I wish to make a brief comment on Down's syndrome. It is not one condition. There is a spectrum of disorder in Down's syndrome. Some children with Down's syndrome will be born very healthy. Others have very serious cardiac or other defects which mean they will not survive *in utero* or will die very soon after birth. We have to take that into account. It is very likely that it comes into account when women are making decisions regarding termination of pregnancy. It is not simply one disorder. Infants with Down's syndrome can have a broad spectrum of challenges.

Chairman: I thank Dr. Mahony.

Deputy James Browne: I thank the witnesses for their contributions. They have been very informative and helpful. In terms of the *status quo*, there is a difference between decriminalisation and legalisation. Professor Malone and Dr. Mahony are professionals. There is the Medical Council, the Constitution and so on. Does decriminalisation add anything to the regulatory regime? If abortion were decriminalised tomorrow, would doctors suddenly start acting in a legal matter?

Dr. Rhona Mahony: Decriminalisation would have an impact. I quoted the High Court case of 2014. It is a direct effect of the law which pertains. If we did not have the prospect of a custodial sentence, the decision-making in that case could have been very different. At times, doctors would be a lot more comfortable with intervening earlier in cases where there is substantial risk to the health and life of a woman if they did not face a custodial sentence. Criminalisation has the capacity to distort and delay clinical decision-making, which is very important. That is not to say, like any other medical procedure or practice, that it should not be regulated appropriately. Nobody should or would argue any differently on that. I am not a lawyer so all I will say on legislation is that what we as doctors are seeking is that the law of our country allow us the flexibility to make the best clinical decisions for our patients.

Deputy James Browne: The Citizens' Assembly has recommended 12 different sets of circumstances. How would the witnesses deal with the introduction of extensive, complex legislation from a professional perspective? They are not judges or lawyers and decisions often have to be made very quickly. Do obstetricians get training? Does the Medical Council provide advice? Do situations arise where different hospitals might take different positions? How, on the whole, do doctors deal with complex legal situations like this?

Dr. Rhona Mahony: The first thing to say is that doctors are very regulated. We have not just Medical Council guidelines but also HSE and national guidelines to help and assist us to provide optimum care to our patients. We cannot be negligent: we have to provide good, sound clinical care and there is good regulation in this country to ensure that doctors practise appropriately. The issue with obstetric medicine is that not a lot of other areas of medicine have an insert in the Constitution that has such an effect on clinical practice. Going back to the 1983 referendum, there was difficulty in choosing that wording and trying to determine its consequences. The number of subsequent referenda that have taken place - on the right to information, for example, or the right to travel - shows that we have done more or less everything to circumnavigate this issue without actually dealing with the effect of the eighth amendment on clinical care. This is something that Ireland really needs to deal with because I believe that the presence of the eighth amendment in the Constitution creates substantial clinical risk.

There are other options. There are many different examples all over Europe of countries choosing to legislate in different ways, from highly restrictive legislation in countries like Malta; fairly restrictive legislation in Germany; to more open legislation in other countries. It is really for the people of Ireland to decide on the legislation. Whatever path is chosen, what we as doctors require is clinical flexibility in order that women and their doctors can make appropriate decisions in the very difficult circumstances that arise from complications in pregnancy.

Professor Fergal Malone: There are very clear mechanisms in place for new guidelines and changes in legislation to be rolled out, particularly in obstetrics and gynaecology. The Institute of Obstetricians and Gynaecologists works with a national clinical programme office in updating guidelines. The Medical Council will regularly review its own ethical guidelines in

light of legislative changes and there are regular meetings at which obstetricians review and update new guidelines. These can generally be disseminated quite quickly across all 19 maternity units. There are systems in place, then, that will allow for a fairly rapid roll-out of a change in guidelines or practice.

Deputy James Browne: What is the rate of maternal death in the total absence of maternity care? In other words, how inherently dangerous is pregnancy?

Dr. Rhona Mahony: That is a great question. I have spent time in Sierra Leone, Malawi and Tanzania, countries with very little by way of assisted childbirth or antenatal care. Those countries have maternal mortality rates of approximately 350 per 100,000 women. A total of 99% of maternal deaths occur in the developing world.

Senator Jerry Buttimer: We have been tremendously well served by the attendance today of Professor Malone and Dr. Mahony. Their evidence, candour and professionalism in their work deserves our praise. Deputy Mattie McGrath made a glib comment about what the Rotunda Hospital is doing wrong. While I agree with Senator Mullen that we should not allow third parties to be named here, equally we should not allow members of the committee to make glib one-line statements or to quote reports like that from Duke University, which is open to all kinds of interpretation when it comes to data collection, as Professor Malone quite rightly pointed out. If we are going to use statistics and reports then there is a duty on all of us, whatever our position on the matter, to do so in a manner that is honest and credible. We can all use statistics to bolster any argument we want.

Senator Rónán Mullen: I will just say a few words seeing as I have been drawn into this. I have no problem with an analysis of the quality of evidence being produced by Deputy McGrath but I object to the motivations of any member-----

Senator Jerry Buttimer: I am not questioning his motivation.

Senator Rónán Mullen: Words such as glib are unhelpful. Senator Buttimer has a point but is being unfair-----

(Interruptions).

Senator Jerry Buttimer: I am fairly balanced in my approach.

Chairman: I point out to Senator Buttimer that we have been here since 1 o'clock today.

Senator Jerry Buttimer: I have been here too.

Chairman: I do not wish to get into any arguments at this point in the day. The witnesses have given up their time and we want to get some information from them. If we want to pick up this sort of conversation then we can do so on another day.

Senator Jerry Buttimer: What I wanted to say, to assist Senator Mullen and the members of the committee, is that the people who work in the Rotunda and in the other maternity units are doing exceptional work. We should not allow them to be portrayed otherwise on the record of this committee. I previously chaired the Joint Oireachtas Committee on Health and Children and I must say that Dr. Mahony is a credible and excellent witness. On the six days of hearings that she appeared before that committee to discuss the Protection of Life During Pregnancy Bill, she was an extraordinary witness and never controversial or unhelpful to the committee or

to the preparation of that legislation.

Dr. Mahony made a very good point about vulnerable women. Part of what we must do as a committee, even if we do nothing else, is to show particular support to the young vulnerable women to whom Dr. Mahony and others referred. What pathways of care and support can we offer there? What should we be doing outside of the work here on the eighth amendment? We can all agree that Ireland is a very safe place in which to have a baby. Professor Malone referred in the last paragraph of his presentation to the impact on resources in our maternity services if we were to change our current position. Could Professor Malone elaborate on this?

Dr. Rhona Mahony: The Senator asked a good question on what else we can do for young and vulnerable women in society. We must start at the beginning. If we are going to equip young men and women for adulthood then we really need to provide them with good sex education. This should begin in school and continue throughout their lives. Sometimes the programmes in our schools can be quite limited, however. It is not just a matter of learning the biology of how a woman gets pregnant but also all of the other issues surrounding that, such as alcohol and drug use, for example. That is very important. It is also important that we have supports there for young women who do find themselves pregnant. There needs to be good support and good counselling and they need to be able to get access to care. In our hospitals, for example, we have adolescent clinics in order that young girls can, first of all, meet one other, and second, not go through a system with much older women causing them to feel even more excluded. Nor is this just a matter for women. We also need to equip men to deal with human sexuality. I think Senator Buttimer has asked a great question and that as a society, we need to work really hard with young boys and girls in order that they can have respectful, healthy and responsible intimate relationships. This means that if people do not want to get pregnant in the first place they do not become pregnant, and that if they eventually do become pregnant they are healthy and able to deal with the pregnancy. I think that there is a lot more that we can do in this area.

Professor Fergal Malone: We could talk for a long time about the resource issues. Personnel is clearly one. We are still very much in deficit when it comes to operating theatre nurses and midwives, although that situation is improving. It is great that the National Maternity Hospital will be moving to a new space in the near future and Cork University Maternity Hospital has a beautiful new building in recent years but the physical structure of many other hospitals is not conducive to providing the best possible care for patients. One could have a situation where a patient recovering from a surgical management of a miscarriage - and in the future that might be recovery from a surgical management of termination of pregnancy - wakes up from anaesthesia in a recovery room separated from a woman recovering from a caesarean section holding a crying baby. That is an appalling vista but those are the physical structures of some of our hospitals currently. The resources we need are not only in the area of personnel; we need all 19 maternity units to have as good a physical construct as Cork University Maternity Hospital or the new National Maternity Hospital. They are the standard we should aim for. There is a very significant capital infrastructural requirement.

Dr. Rhona Mahony: Infrastructure in obstetrics really matters because we need to transfer patients really quickly from one unit to another. In the design of the new hospital in Elm Park, a big part of that was the clinical input to ensure that when a woman arrives into the hospital, she can get to the labour ward quickly, to theatre quickly and her baby can get to the neonatal unit quickly. There is an idea of a hot core where patients who require it can be transferred really quickly throughout a building. Infrastructure is very important in the provision of obstetric

care.

Chairman: I sincerely thank Dr. Mahony and Professor Malone for their very helpful and insightful contributions and for answering all members' questions. We are very appreciative of their time as we know they are very busy people.

There are Standing Orders, rules and precedents when it comes to motions and voting in committee and I want to take some advice on, or at least be apprised of them, before tomorrow's meeting. I propose we revisit that issue tomorrow at 2 p.m.

The joint committee adjourned at 7.13 p.m. until 2 p.m. on Thursday, 12 October 2017.