DÁIL ÉIREANN

AN COMHCHOISTE UM AN OCHTÚ LEASÚ AR AN MBUNREACHT

JOINT COMMITTEE ON THE EIGHTH AMENDMENT OF THE CONSTITUTION

Dé Céadaoin, 22 Samhain 2017

Wednesday, 22 November 2017

Tháinig an Comhchoiste le chéile ag 1.30 p.m.

The Joint Committee met at 1.30 p.m.

Comhaltaí a bhí i láthair / Members present:

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

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

Business of Joint Committee

Chairman: As we have a quorum, we will commence in public session straight away. The draft minutes of our meetings of 15 November have been circulated. Are there any matters arising? Are they agreed? Agreed.

We have received six items of correspondence, all of which are noted. Is that agreed? Agreed. Arising from the correspondence received, Dr. Abigail Aiken has submitted a clarification on the research data in the presentation she made to the committee. I intend to read the clarification into the record at the conclusion of our public business today. I am conscious that we are under time pressure given that members want to deal with issues relating to bias on the part of the committee. I suggest we defer the second issue arising - proposed witness for module 3 - until after our public session in the interests of our witnesses today, one of whom can only be with us for a short time as she has a plane to catch. Is that agreed? Agreed.

Deputy Jonathan O'Brien: Which witness is under time constraints?

Chairman: The first witness, Dr. Patricia Lohr. We agreed at last week's meeting to review our proceedings as claims are circulating within the committee and outside. Deputies Anne Rabbitte and Catherine Murphy raised the issue and the latter suggested we have this discussion. The committee agreed. I intend that this be kept to as short a time as possible bearing in mind that we have witnesses to come in. I ask members to restrict their contributions to a maximum of five minutes and to avoid repetition. If we need more time, we can come back to it. If that is all right, it would be a good way to proceed. I call Deputy Murphy to speak first as it was she who suggested the statements. We can take it from there according to who indicates.

Deputy Catherine Murphy: This is a two-pronged process, of which the Citizens' Assembly was the first element. We were asked to consider the report and recommendations of the Citizens' Assembly on the eighth amendment of the Constitution and to report in turn to both Houses of the Oireachtas. Our brief does not say anything more than that. At the beginning, we decided that we would not repeat the Citizens' Assembly process but would instead consider the recommendations. The people who were invited here were invited to consider those recommendations.

Looking at those we have invited, the World Health Organization was one. It very definitely said it was not pro-pregnancy or pro-abortion but was rather concerned with how it is regulated if it is in place. If the evidence is cold, clinical evidence, stating the eighth amendment is damaging prenatal and maternal outcomes and one is simply presenting information, it does not make it biased; it makes it factual. A lot of the evidence has been factual. We had two witnesses from the Irish Human Rights and Equality Commission and two witnesses from the largest maternity hospitals in Dublin. Indeed, Professor Fergal Malone made a point of stating that he does not categorise himself. I would have said the two witnesses from the Irish College of General Practitioners were neutral health experts dealing with a legal situation and telling us what the impediments were. That was the questioning that happened. We had witnesses from the Institute of Obstetricians and Gynaecologists, someone from the HSE, the former Supreme Court judge who chaired the Citizens' Assembly, senior counsel and the UK-based obstetrician who wrote the report on the death of Savita Halappanavar. When one looks at the regimes around Europe, one sees that we have one of the most restrictive. It is very difficult to see where one would have drawn someone to write that report. He was based in the UK. We had psychologists and academics who presented us with facts. Facts do not alter and what was

presented was peer-reviewed, which is something we were very deliberate about. As such, this notion that there were 24 on one side and four on the other is utter nonsense. It is very important to respect the people who come before us in the context in which they come in front of us.

The Citizens' Assembly went through a range of different hearings. We decided not to bring in advocacy groups. If one goes through the Citizens' Assembly report to look at who presented at the assembly, one sees that there were two sides. That is not what we are being asked to do here. We have been asked to look at the report the Citizens' Assembly produced which means we have had to get people who could help us to take it on and look at the issues that would present in the context of the recommendations, if implemented. I feel very strongly that we should not allow this to become a narrative that is a lie because that would discredit those who are sitting in this room. It is not going to be a constructive contribution to public discourse when we get around to debating this issue in the context of a referendum.

Deputy Kate O'Connell: I support Deputy Murphy in what she has just said and there is no need to repeat it. From the outset, our task was to examine the recommendations of the Citizens' Assembly. In the first few meetings, we were trying to get witnesses in to seek clarity as to how the Citizens' Assembly came to those recommendations and to open our eyes as to how it ended up as it did. It is obviously a challenge that we are an outlier in Europe in maternal health and the provision of abortion services. We looked at national people, urban versus rural, Irish versus international, and some people might say they were all pro-choice. Maybe the world is becoming slightly more pro-choice. It would be very difficult to get a medical expert with a lot of experience in the fields of obstetrics and gynaecology to come here to say the eighth amendment has been good for women's health. I support what Deputy Murphy has said. No one can say other than that all the members of the committee have worked very hard to come here prepared by reading statements beforehand and seeking evidence. Publicly, some members have come on a journey throughout the process. If that is so, it is evidence that the committee is doing its work. I will leave it at that.

Deputy Anne Rabbitte: I hear everything the speakers before me have said and I agree with what Deputy O'Connell has just said. It was to examine and have a good variation between urban and rural. We have had the World Health Organization and the best of people before us. The only reason for my fair, balanced and reasoned commentary last week was that there is a narrative out there. The last thing I want when I walk away from the committee when its work is done is to have it presented as one-sided. I cannot let that happen on my watch and it would have been remiss of me not to have said it. My only ask related to the fact that there were groups which declined the opportunity to come before us. That is not our fault but they are letting down a cohort of people they represent. I ask the Chairman if there is a way to give them the space or a slot that might be a particular viewpoint. Can the space be created? Who is next in the pecking order and who is further down to allow us to still afford the viewpoint to create balance? Let no one have the opportunity to say the committee was biased from the word go because, X, Y or Z was not here. That is not what I want. I have sat here and been open-minded and engaged all the way along with all of my colleagues, but there is a piece of the jigsaw that still needs to come in front of me.

Deputy Jan O'Sullivan: I support Deputy Catherine Murphy and others on the bodies that came before us. Bodies like the World Health Organization, the Irish Human Rights and Equality Commission and the Irish College of General Practitioners have status as representative bodies or, in the case of the commission, through statute. They are not there on any side of an argument. They are there because of who they are and what they represent. I agree that the

balance presented is untrue. However, I also share Deputy Rabbitte's concern on those people who have withdrawn and not come before us. One of the reasons is that they have misinterpreted the decision we made on not retaining Article 40.3.3° as it is. All that was doing was to say we would move on; in other words, that the *status quo* would not remain. If the *status quo* had remained, we would not have been making any recommendation for a referendum and there would have been no point moving to the next stage. That point was made earlier.

It might be no harm to go back to these people to say they have misunderstood what the committee has decided so far. I would like to have the opportunity to ask questions of those groups. I regret very much the deliberate attempt to misrepresent the committee in the public arena. What has been said about what the committee has been trying to do is not true. I do not know if it is worth contacting those groups again to tell them they have misunderstood the committee and the people who have come before the committee.

Senator Lynn Ruane: I will not go back over the calibre and professionalism of the speakers or discuss bias because none of this is about bias. It is about tactics and undermining a process. It is about the *status quo* losing a grip on what they feel is the moral standard in any given country or over women's access to health care. This is the sting of a dying wasp and we do not need to discuss whether it is bias or not. We can see the calibre of speakers we had before us. If anything in relation to bias, I left the room many times looking at the level of time some speakers were given. One week when speakers were supposed to have six minutes, Senator Mullen had three times that and I had my own six minutes. However, I do not leave here screaming "Bias" and saying that my voice was not heard. This room was representative of the mandates of the membership. All parties and technical groups are here. We all have a mandate to be here and we should all abide by the same rules. If one looks at the list of speakers, I submitted six and only two of whom were chosen. Deputy Mattie McGrath had three or four chosen. We all put our individual speakers in and I am sure the proportion is spread according to the people in the room. There is no bias. It is not our fault if some of those speakers have pulled out.

Deputy Bríd Smith: I understand that people believe there may be a misunderstanding by groups out there after the vote was taken, but I find it difficult to accept. I am not rejecting it entirely, but I find it difficult to accept. If we are going to speak in that vein and ask for groups to come back, we need to spell out what groups we are talking about. We need to name them rather than just to have a nebulous reference to groups who are misunderstanding something. It is important that we identify and name the groups we think should be given a second chance and invited back again while we are having this discussion.

There has been a deliberate attempt to paint the Chairman as somehow biased and I find it extremely disturbing and wrong. It is evidentially untrue. It is a false perception. There was even a complaint to the Committee on Procedure and Privileges, of which I am a member, accusing the Chairman of repeatedly calling a member of the committee a liar. The committee was about to write to the Chairman to remind her of her duties when I asked that we see the transcripts of her saying repeatedly that the person was a liar as I knew it had never happened. I do not know where the matter has gone since then. It is important that we defend the Chairman and her role and fairness otherwise there will be this attempt to say the entire exercise here is flawed and its outcome must therefore be flawed. I want that on the record. The majority of the committee agrees with me but we need to find a way to express it as a majority.

Deputy Louise O'Reilly: There has been a deliberate attempt by members of the committee, who know very well who they are, to undermine its work. Much of it is pathetic. We issued invitations to people but perhaps they feel the weight of their argument is not sufficient or they

feel unable to articulate it. There were some fairly eminent people on the list who pulled out who I know are more than capable of holding their own in the cut and thrust of debate, but if they felt their arguments would not stand up in the face of the facts and felt unable to come in, we did enough in issuing the invitation. If it is the view of the committee that another chance should be given to people to present an alternative view, I would not object. However, I am not necessarily convinced we need an alternative view. What we have heard very clearly are the facts. As was pointed out previously, there is not really an alternative to the facts because they are the facts.

I echo Deputy Smith's points in relation to the Chairman. No member of the committee who takes his or her work seriously, attends meetings and pays attention to what is happening would in any way, shape or form accuse our Chairman of bias. It is not fair. The Chairman enjoys the support of the vast majority of the members of the committee.

Deputy Lisa Chambers: I mean this as no criticism but I agree with Senator Ruane that in terms of bias and speaking time, Senator Mullen and Deputy McGrath have had far more speaking time allocated than was given to other members. I believe the Chairman gave extreme latitude to those members to the committee, and I understand why she did so, but it was not appreciated, which is regrettable. There are certain groups that appear before this committee - medical professionals operating in this State - who hold more weight than medical professionals operating outside this State because they are operating within the current legal regime we are seeking to change. The general practitioners' group, the Master and former Master of the National Maternity Hospital, Holles Street and the Master of the Rotunda Hospital are individuals who are working every day with mothers, pregnant women and children. The suggestion that they are somehow motivated by some sort of less than honourable motive is totally discredited. I believe their motivations are sincere, honest, genuine and in the best interests of women's health. It is very difficult to ignore medical professional after medical professional appearing before this committee telling us that the eighth amendment is not in the best interests of women's health. It is very difficult to ignore that.

Regarding the suggestion that the committee is biased because somehow we are not 50-50, the country is not 50-50 on either side. It is my view that a majority in this country wants at least some change and I believe this committee is representative of that. Every member of this committee had an opportunity to suggest witnesses, which we all did. We had to justify why those witnesses should appear before this committee and why the State should foot the bill for them to travel if they were going to travel. There is nothing wrong with that. It is the same process as happens with every committee. Regarding the witnesses who chose not to attend, that was not this committee's doing. We invited them to attend but they chose not to do so. Regarding the suggestion that a statement from those particular groups would be read into the record because they did not want to come here and take questions, we cannot question that evidence so it is clearly not the same as evidence given to a committee when a person physically attends and can take questions.

There is no doubt in my mind that there are certain members of this committee who have sought at every opportunity to undermine the work of this committee and, quite frankly, I found the consistent attack on the Chairman to be unbelievable. I think she deserves a medal at the end of this for her patience. She has been consistently under attack at every opportunity and it is not a personal thing. It is part of the process that has been engaged in by certain members to undermine our work. I believe the public has seen through that. At the end of the day, this committee will not decide on what happens to the eighth amendment and whether it is retained,

amended or repealed. The people of this country will decide and that is something we must bear in mind.

Senator Ned O'Sullivan: I echo everything Deputy Chambers has said. Any time the question of abortion has come into the Oireachtas, and I am in my eleventh year, everybody prefaces the debate by saying that we will be reasonable and sensitive and act with responsibility. All these pious statements are made. However, this committee has experienced very little of that. In fact, I must say that some of the aggression shown towards our witnesses has bordered on the unchristian. The idea that anybody who states that this committee is a set up to rubber stamp matters, that it has already decided and that there is a majority of whatever it is, is not being fair to the public and is definitely being very unfair to their colleagues on the committee. If people really feel that this is the situation, perhaps they should ask why they are remaining on the committee if they have such little faith in the process, their colleagues and the Chairman, who has been eminently fair. The public knows she has been fair.

I have nothing against anybody here. Everyone here has the right to their opinion and beliefs. Many of us are on a learning curve. Some people came in here very decided on their position. I find my position has changed since I became a member because of the information I have received. I really regret that one cohort of witnesses has decided for whatever reason not to give us the benefit of their wisdom. The people who might have an influence on such people should go back to them and ask them to come back in. We would like to hear what they have to say, we would learn from what they have to say and we are open enough to listen to them. This should be the last debate about the credibility or otherwise of this committee. Every Oireachtas committee is entitled to be taken very seriously and responsibly. People must make their minds up. Are they going to engage with the committee in a productive manner or should they be here at all?

Deputy Peter Fitzpatrick: I think the Chairman mentioned that our first witness, Dr. Patricia Lohr, was in a hurry to catch a flight. I am not trying to be smart but, to me, that is not a good start to the committee meeting today. How much time do we have to ask questions?

Chairman: I am trying to ensure members have ample time by ensuring that this discussion is no longer than it needs to be, but I do not intend to have a shorter debate than is necessary. I am just bearing in mind that it is necessary for that witness to get to the airport. It is a matter of practicality.

Deputy Peter Fitzpatrick: The reason I asked that question is because this witness has come all the way over here today and it is very important that we all get an opportunity to put questions to her.

Chairman: Absolutely, and nobody thinks that more than I do.

Senator Rónán Mullen: I have to confess that I would certainly need more than five minutes to go through the various allegations, implications and inaccurate assertions I have heard in this session alone. I will try my best to address the main points, which is that this committee has hastily but all too belatedly convened a session because it knows that the cat is out of the bag about the flawed processes and attitudes that have existed within this committee from the start.

As far as possible, I have tried to avoid a criticism of the Chairman. I think I used the word "bias" on one occasion because I have not always felt that she was impartial but, by and large, my criticism would be that she probably had a very difficult job in the first place but she has

failed to preside over a process and make the necessary proposals that would try to procure objectivity as far as possible on this very difficult issue. I say that as somebody who has been in the Seanad for ten years. I have known the Chairman for a long time and I like her, but I cannot be dishonest about the way I feel this committee has operated. I can only act with integrity if I tell it as I see it.

While I had intended to address what various speakers had to say seriatum, I do not know at whom the notion of unchristian behaviour was being levelled. Speaking for myself, and I am sure, Deputies McGrath and Fitzpatrick, as one of those on the committee who has opposed the motion, all I can say is that I have certainly tried to respect every person's dignity at all times. I do not think I have ever attacked it. I have sought to robustly question in extremely difficult circumstances where there was nothing like the time needed to address various tendentious stuff going on where experts came in and then lashed into their views to a very considerable degree. Although I was grateful on those occasions where, on a grace and favour basis, the Chairman allotted more time, probably because she perceived that I was representing a minority view, as do Deputies McGrath and Fitzpatrick, at least within this committee, it is too much to expect that we would regard as removing all of the problem when time after time, there were questions that desperately needed to be asked which people here were simply not interested in asking because they would tend to undermine advocacy for abortion and which I would have asked had I received the time. Time and again, I have made the comparison with the Committee of Public Accounts where there is serious inquiry into what is being said. This committee has failed almost at all times to engage in that kind of inquiry and that is simply not my fault or the fault of Deputies McGrath and Fitzpatrick. It perhaps reflects the fact that we are in a serious minority on the committee and that most other members did not see that they had a need even to ask questions that would go against the grain of their own point of view.

From the outset, I stressed that the mandate given to the committee by the Houses was to consider the report and recommendations of the Citizens' Assembly. I stress that there should be an opportunity to consider in detail the approach taken by the Citizens' Assembly to its work and the strengths and weaknesses in that regard. There was little support for this among committee members. The committee clearly wished only to examine whether and how the assembly's recommendations should be implemented. We heard that from Deputy Murphy here today. She started off by saying that we were asked to consider the report and recommendations and decided that we were not going to repeat the Citizens' Assembly but were going to consider its recommendations. What is that if not a direct admission that she, and the committee, wanted to truncate the mandate given to it by the Houses of the Oireachtas? As far as I can recall, the Chairman failed in that instance to propose that the committee needed to address the full mandate given to it by the Houses. That is just for starters.

Much was made by the Chairman and others of the need to avoid repeating the work of the Citizens' Assembly. This was simply unsatisfactory because it presupposed that there was no need to analyse how the assembly had done its work. I pointed out the danger at one point that the committee wanted to do less rather than more work, which caused indignation and was rejected by several members. However, it was on the basis of not wanting to repeat the work of the assembly that a consensus was arrived at - I looked at *The Irish Times* report on the matter earlier - to the effect that the committee would not hear from advocacy groups, just from so-called experts. I opposed that exclusion of advocacy groups and my objection was noted. The committee then went on to invite numerous pro-abortion advocacy groups. No pro-life advocacy group was invited. What more evidence do we need of a flawed process, flawed attitudes and closed minds coming from within the committee? Only one pro-life advocacy group,

which clarified an issue relating to its own work - I am referring to Both Lives Matter - offered to come before the committee and this offer was declined by the secretariat on the basis that advocacy groups were not being invited. The latter was despite the fact that the group in question had been invited.

Despite concerns I expressed on numerous occasions, and I will stop when I am out of time and if the Chairman wants to-----

Chairman: The Senator is out of time.

Senator Rónán Mullen: I will resume this at a later date if that is possible.

Chairman: It will not be possible so I will allow the Senator a bit more time.

Senator Rónán Mullen: I do not want to hold up our guests. We have a guest who wants to go to the airport.

Chairman: The Senator can take another few minutes.

Senator Rónán Mullen: I would need at least twice as much of the time I have used to speak so far, so I would favour a more extended debate on this issue. I am happy to oblige the Chairman and the guest who must get to the airport.

Chairman: Does the committee agree that we should return to this?

Deputy Hildegarde Naughton: On a point of order, if there was a way to invite further guests, perhaps that would be a more appropriate way to spend time talking about some of the issues through invitees that Senator Mullen would like to appear before the committee.

Deputy Mattie McGrath: I have always respected any guests who have appeared before us and have waited until they were finished to make statements at different times. If the guest is waiting and wants to go, because I have quite a detailed contribution to make, I think we are rushing this. We are only going to give it 30 minutes.

Chairman: The Deputy has five minutes to make it and by all means-----

Deputy Mattie McGrath: Yes, but five minutes is not enough.

Chairman: Anything that cannot be said in five minutes-----

(Interruptions).

Chairman: Can we have silence in the room?

Deputy Mattie McGrath: Can I make this point again? They are waiting just to jump at us. We did not utter a syllable when others wanted to speak, which is the way it should be.

Senator Lynn Ruane: The Deputy does not need to butt in because we stick to our time.

Deputy Mattie McGrath: Look at this. Where are the manners and respect?

Senator Lynn Ruane: The reason we have to speak up is because they are eating into time-----

Deputy Mattie McGrath: This is outrageous. I thought I had the floor.

Senator Lynn Ruane: I would like another five minutes when they are finished.

Chairman: Deputy Mattie McGrath does have the floor. I ask him to say what he has to say within five minutes.

Deputy Mattie McGrath: This is continuous. It was going on last week within the cabal behind us in the Gallery. I said it was disgraceful. We are here as elected representatives. I listened to the lecture about Christianity from Senator Ned O'Sullivan. We are here to do our honest best and to represent whatever viewpoint we want.

Chairman: Will the Deputy please make the points he wishes to make-----

Deputy Mattie McGrath: I will make the point without interruption, sniping and whooping.

Chairman: We will start the Deputy's five minutes now and he can make whatever point he wishes to make.

Deputy Mattie McGrath: I am making a point in support of Senator Mullen-----

Chairman: If the Deputy wishes to finish he can-----

Deputy Mattie McGrath: ----- in that I am willing to wait until after the witness has deliberated, if it is any help.

Chairman: No, I have allowed 45 minutes, which I thought would be a fair amount for this. There is still time. I want to say something myself. I ask the Deputy to say what he has to say.

Deputy Mattie McGrath: As I said, the timeline which led to the charge of bias in the committee is critical. At the outset, the committee invited 24 pro-repeal witnesses to present before it and just three pro-life witnesses. I thank the clerk to the committee for his endurance and forbearance in co-operating with me in trying to find out the full list. Then, in a most extraordinary move, just three weeks into the 12 weeks of hearings, this committee voted not to retain the eighth amendment in full thereby demonstrating that it had no interest in hearing from all witnesses before making a decision. This move alone has destroyed the credibility of the committee and put to bed any claim that it conducted itself in an impartial way. By voting so early in the process, the committee behaved in a juvenile and contemptuous fashion towards the democratic process and our duty as elected parliamentarians to scrutinise and ask the hard questions before voting on any proposal, most particularly when it involves a life-and-death issue. This vote, which was taken just three weeks into the hearings, means that the committee gave its verdict on the eighth amendment after hearing from less than a third of the witnesses who were invited to appear before it. We voted after hearing from 14 pro-repeal witnesses and just one pro-life speaker. That is incredible. Seeking now to justify this farce by engaging in some kind of blame game is, quite frankly, embarrassing. The clear message sent to the public is that the entire thing is a stitch-up and that there is nobody to blame for this other than the members who voted for abortion in week 3 before we heard from two thirds of the witnesses we invited to appear before us.

When members reflected on what they had done, there was a scramble to extend matters late in the day in respect of pro-life speakers. Clearly, this was an attempt to gloss over the appallingly skewed line of speakers and the fact that the committee had already voted for abor-

tion. To add insult to injury, when the two additional pro-life speakers who were invited to appear declined the offer and cited the abortion vote that had taken place, pro-life groups were criticised by committee members for not accepting the invitation to speak. It is disgraceful that the three pro-life groups were invited to present not because the committee wanted to listen to their expert opinions but because the committee needed cover for the one-sided way in which it had conducted its activities. The spin emanating from this committee about pro-life individuals being invited to attend and refusing to do so needs to stop. It is highly misleading and does not put matters in context. Everyone in this room knows why they were invited late in the day. It is time that a modicum of respect was shown and people on this committee were upfront and admitted to what they know to be true, namely, that these hearings have a pre-determined outcome and have been a charade from the start. Given that the committee voted for abortion before hearing the evidence from both sides, it is perfectly reasonable and understandable that pro-life people are reluctant to take part in the process this late. The committee has already made up its mind and just wants a few more pro-life groups to attend to disguise what is a deeply flawed and one-sided process.

For the record, it is not the case that lots of pro-life groups and individuals were contacted after the initial three were invited. My understanding is that only two additional pro-life individuals and groups were contacted, bringing it to a total of five pro-life invitations against 28 or 29 on the pro-repeal side. These figures have been supplied by the secretariat. When members of the committee say they are blue in the face from looking for pro-life witnesses to come forward, there is no basis for such claims. If people here became blue in the face that easily as a result of asking just two more witnesses to attend, they should go to the doctor and have their blood pressure checked.

Chairman: Can the Deputy try to keep things non-personal?

Deputy Mattie McGrath: I just said that they said they were blue in the face.

(Interruptions).

Deputy Mattie McGrath: I do want any lectures from Deputy O'Connell.

Chairman: Deputy Mattie McGrath, without interruption.

Deputy Mattie McGrath: I do not interrupt anyone. Deputy O'Connell knows that. The Chairman said at the beginning of the process that this committee would not repeat any of the work of the Citizens' Assembly and then proceeded to invite 12 of the same witnesses who appeared before the assembly. I lay that charge with the Chairman. She made that statement on the record and then invited 12 groups that appeared before the Citizens' Assembly. The Chairman also said at the outset that only experts would be invited to the hearings and that no advocacy groups on either side would be invited. However, pro-abortion advocacy groups such as the Irish Family Planning Association, the New York-based Centre for Reproductive Rights and the largest abortion group in the UK, the British Pregnancy Advisory Service, were all invited. How does that square with the Chairman's statement?

In contrast, not a single one of the numerous families who say their owe their lives and the lives of their children to the eighth amendment were ever invited to present. That is really incredible when one thinks about it - all those stories from families who nearly aborted their children but did not do so because, as they say, the time it took to prepare to travel to England

was the time they needed to change their minds. To think that the committee has not heard a single one of these stories is inexcusable, not to mention all the other areas it has not considered from contemporary models of adoption - and we cannot discuss adoption here at all - to putting better supports in place for women experiencing unexpected pregnancies. All of the focus has been on abortion and putting the eighth amendment on trial rather than having an honest and open examination of the issue that also focuses on all that is positive about the amendment. It is impossible to argue with pro-life supporters who say this committee is irredeemably broken and has lost all credibility. I would like to state one more thing for the record. The Chairman and others claim that they asked pro-life members of this committee to submit names at the outset, and that we supposedly only came up with six or seven. The truth is that we made it very clear back at the start that we believed it to be the collective responsibility of the committee and the secretariat to actively pursue a balance in this regard.

How much time do I have left? I have more to say but the members obviously do not want to hear it. I take grave offence at Deputy Rabbitte, who has now left, and at Senator Ned O'Sullivan coming in here and reading out Fianna Fáil press releases. At its recent Ard-Fheis Fianna Fáil voted overwhelmingly to keep the eighth amendment and yet now it sends party members in here to attack us. Deputy Lisa Chambers-----

Deputy Lisa Chambers: On a point of order-----

Chairman: Only if it is a point of order.

Deputy Lisa Chambers: The Deputy's facts are incorrect. He was not present in the room at the time but I was. I ask him to check his facts before commenting on a political party of which he is not himself a member.

Deputy Mattie McGrath: The facts are there.

Deputy Lisa Chambers: The Deputy should speak about his own personal experience.

Chairman: I call on Deputy Durkan.

Deputy Bernard J. Durkan: We all do our best to be as fair as we possibly can towards the people who come before us. We can only deal with those who come before us; we cannot deal with those who do not. Nor can we presume that their cases will be made unless they come before us and we have the opportunity to ask them questions. That is fair. As the Chairman knows, I was among those who proposed not having a vote until we had finished the proceedings. I held that view very strongly. It does not make any difference how this committee votes, however, as it is the people who will decide. The suggestion that the committee has voted 'for' abortion is thus incorrect because it is the people and the people alone who can make that decision. The job of this committee is simply to stress-test the report of the Citizens' Assembly; find out how it came to its conclusions; and ask relevant questions of the members of that assembly and of others who have expertise or something to offer in these circumstances. I am only one person and I know that everybody here has tried his or her best to be as fair as possible and to ask pertinent questions, not necessarily in order to get the desired answer, but to get an answer that will in some way address the issues raised and conclusions reached by the Citizens' Assembly.

I would suggest, if it is of any help, that our colleagues Senator Mullen and Deputy McGrath might give us some names or indeed might themselves invite people they consider suitable to come before the committee. They should let us know in the next week or so if these people are

available to come before the committee and if they would be satisfied to do so. If that means that we end up with two or three new witnesses then let us facilitate that. I am all in favour of democracy. Most of the people in question, however, have already been invited by the secretariat and most have turned this offer down. I suggest, then, that our colleagues here invite directly the people who they would like to see come before this committee. As far as I am concerned and, I am sure, as far as our Chairman is concerned, I am quite certain that we will give these witnesses every opportunity to make their case and then we will ask relevant questions.

Chairman: I call Deputy Jonathan O'Brien.

Deputy Jonathan O'Brien: Accusations have been made that this committee is biased. I refute that; I do not think that it is biased. There is no doubt but that there are individual members sitting on the committee who have a bias, but as a committee we are not biased. An assertion has also been made that only three pro-life members sit on this committee, something I think certain other members here would dispute. The fact that these members have not stood outside the gates of Leinster House giving press conferences, because they have been in here carrying out their role on the committee by questioning witnesses, does not make them pro-choice. I do not consider myself pro-choice, for example, or indeed pro-life at this stage. I am a realist and I am going on the factual evidence presented to this committee.

Deputy Mattie McGrath made a particular comment that needs to be addressed. He suggested that the clerk of the committee informed him that 24 pro-repeal groups had appeared before us. I am aware that the clerk cannot speak at these meetings and it is thus unfair to quote him here when he cannot defend himself. I cannot speak for the clerk but I very much doubt that he gave Deputy McGrath that information and I find it very unfair of the Deputy to make an accusation like this in the knowledge that the clerk cannot correct him. The Deputy also claimed that the clerk had told him that four pro-life groups had appeared before us. Not only have he and Senator Mullen questioned the role of the Chairman, they are now questioning the role of the clerk to this committee, something I consider to be absolutely disgraceful. Their behaviour in this committee has been downright disgraceful.

Senator Mullen's comments today were also disgraceful when he claimed that there was no time to ask questions and that more time should have been given. Other than the first two meetings, which I had to miss due to ill health, I have attended every single meeting and listened to every single witness who presented here. I may not have asked questions of every single witness but I listened to their evidence, unlike Senator Mullen and Deputy McGrath who did not attend every session and were not present for every witness. I do not know how they now claim that they did not have sufficient opportunity to question witnesses. Witnesses appeared before this committee and gave evidence that Senator Mullen and Deputy McGrath did not even hear, never mind question, because they were too busy trying to propagate the idea that this committee is biased. I put it to Senator Mullen that the only biased person here is Senator Mullen himself. This committee is not biased.

Deputy Mattie McGrath: Can I correct the record please?

Chairman: No. There is no right of reply here. That is not directed at Deputy McGrath, that is directed at everybody.

Deputy Mattie McGrath: I never impugned the name of the good clerk. Why would I? This is typical Sinn Féin bullying.

Chairman: Sorry, I-----

Deputy Mattie McGrath: I thanked the clerk for supplying names, which he did. I made up my own mind as to who they were or what they stood for. I did not expect the clerk to do so and I would not have asked him to. Only members of a party that does not allow free speech would even think that I might have said that-----

Chairman: Sorry, Deputy-----

Deputy Mattie McGrath: I asked him for a list of names. I would never impugn this committee and I want that accusation withdrawn. This is coming from a Deputy who showed his teeth to me last week and told me that he was losing his temper. What am I supposed to do? Sit down and be frightened?

Deputy Anne Rabbitte: That is an exaggeration. Deputy McGrath has it wrong.

Deputy Mattie McGrath: It happened.

Chairman: Deputy McGrath has made his point. Does Senator Mullen want to clarify something?

Deputy Jonathan O'Brien: I ask Deputy McGrath to withdraw the comment that I engage in bully-boy tactics.

Deputy Mattie McGrath: How is the temper today?

Chairman: Is Deputy McGrath willing to withdraw that comment?

Deputy Mattie McGrath: No way in the world. I was having an exchange with the Chairman and Deputy O'Brien said that he was losing his temper. It had nothing to do with him and I was not engaging with anybody else.

Chairman: There was a lot of provocation going on.

Deputy Jonathan O'Brien: I will take this up with the relevant people.

Chairman: Yes. We can take this matter outside of this room.

Deputy Mattie McGrath: I never impugned the clerk. I thanked him for his work in supplying the names and I hope that he can accept that. This is very important.

Chairman: Excuse me-----

Deputy Mattie McGrath: I hope he can accept that. He has had a lot of engagement with my office on this and I thanked him for that. I never said that he said who these people were. We can make up our minds. Are we not allowed to think for ourselves?

Chairman: I appreciate the Deputy saying that about the clerk, who is nothing but excellent and extremely helpful to all members, not least to me.

Deputy Jonathan O'Brien: Hear, hear.

Deputy Mattie McGrath: When we leave here-----

Chairman: Deputy McGrath cannot just keep talking like this.

Deputy Mattie McGrath: I have listened to every committee member and to every guest who has come in here.

Deputy Jan O'Sullivan: This is not fair. The Deputy has no right of reply here.

Chairman: I do not know why Deputy McGrath feels that he is exceptional.

Deputy Mattie McGrath: I am the side-show here.

Chairman: Please stop talking. I call on Senator Mullen to make his point of clarification.

Senator Rónán Mullen: I have a question for the Chairman. I actually did a lot of preparation for this meeting and even when I am not present in the room I am willing to bet with my colleague across the floor that I am every bit as informed of the issues raised by witnesses as he himself is. Leaving that aside, however, I wish to ask the Chairman if she intends to return to this at a later point or whether I have an opportunity to conclude as the matter has run on.

Chairman: I do not think that that would be reasonable. The committee will decide that.

Deputy Jonathan O'Brien: I disagree with the Senator. We have to move things on.

Chairman: We have to move on because we have a witness waiting outside and I want the opportunity to say a few things in the meantime. If Senator Mullen wishes to take two minutes, however, then I will indulge him.

Deputy Jonathan O'Brien: I disagree with two minutes being given.

Chairman: The clerk has advised me to finish now. I cannot give Senator Mullen any time. It is not agreeable. I call on Deputy Fitzpatrick.

Senator Rónán Mullen: I never denied that the Chairman had a difficult job but-----

Deputy Peter Fitzpatrick: Deputy O'Brien mentioned my name and I just want to say one thing in response-----

Deputy Jonathan O'Brien: I never mentioned Deputy Fitzpatrick's name.

Chairman: A lot of names were mentioned.

Deputy Peter Fitzpatrick: Deputy O'Brien mentioned my name. He mentioned three names.

Deputy Jonathan O'Brien: I did not mention the Deputy's name.

Deputy Peter Fitzpatrick: He mentioned three names.

Chairman: I am sorry, but will the Deputies take this outside?

Deputy Jonathan O'Brien: Sorry. I did mention the Deputy.

Deputy Peter Fitzpatrick: There are other things that Deputy O'Brien-----

Chairman: Excuse me, but-----

Deputy Peter Fitzpatrick: Just one second, Chair.

Chairman: No. I am speaking.

Deputy Peter Fitzpatrick: He has admitted it.

Chairman: I am the Chair. I am not interrupting - I am speaking. Please, take those issues outside.

Deputy Peter Fitzpatrick: I just want to say one thing. In fairness, Deputy O'Brien has admitted that he said my name. I wanted to raise this because I have attended every session. I have asked most of the witnesses questions. Since joining the committee, I have not once issued a press release. Deputy O'Brien mentioned that people-----

Deputy Jonathan O'Brien: I-----

Deputy Peter Fitzpatrick: If I have to say anything, I say it in here. We are entitled to ask questions of any witness. I just want to put on the record that not once have I rushed away from this committee. I have never issued a press release. I have treated everyone, pro-life and pro-choice, fairly.

Chairman: The Deputy has done so.

Deputy Peter Fitzpatrick: Matters are getting out of hand. I want an opportunity to ask questions of the witness. I do not want her to turn around in an hour or two and say that she has not-----

Chairman: I will manage the time well. I tend to.

Deputy Jonathan O'Brien: On a point of clarification,-----

Chairman: God. Another point of clarification.

Deputy Jonathan O'Brien: In fairness to Deputy Fitzpatrick, I mentioned his name in the context of an assertion that only three members of the committee held pro-life views. In no way would I suggest that he is one of those not attending meetings.

Chairman: I took that from what Deputy O'Brien said.

Deputy Jonathan O'Brien: I named the two individuals at whom I directed those comments, namely, Senator Mullen and Deputy Mattie McGrath.

Chairman: I do not believe that anyone took Deputy O'Brien to have meant Deputy Fitzpatrick. The latter's comments are fair. I just want to conclude and-----

Senator Rónán Mullen: I want to ask a question. This is unfair. The Chairman called a meeting to discuss whether there was bias. It adds another instance of bias if we are not able to deal-----

Chairman: It does not.

Senator Rónán Mullen: I have a list of evidence. This is why we had a press conference in the first instance. One cannot tease out matters at this committee. The debate slows down the minute everyone has-----

Chairman: The Senator gets more time than anyone else to make his point. He needs to learn how to make it more quickly.

Senator Rónán Mullen: We all need as much time as we need.

Chairman: Listen-----

Senator Rónán Mullen: I do not begrudge anyone else his or her time.

Chairman: Excuse me. I want the witness to join us and I want to say what I have to say.

Deputy Mattie McGrath: Can we return to the matter?

Chairman: Not unless the committee wants to. Does the committee want to return to this matter?

Deputy Jonathan O'Brien: No.

Deputy Mattie McGrath: I propose that we do.

(Interruptions).

Deputy Hildegarde Naughton: I will only say ten words. If Senator Mullen and Deputy Mattie McGrath would like to bring in witnesses, they should please bring them in. It is the best way to deal with this.

Chairman: I thank the Deputy. I want to conclude.

(Interruptions).

Deputy Bríd Smith: I just want to make a remark to everyone. The world is looking on and three or four men are having arguments here while women and their health need to be debated. We are delaying the process. Women out there are waiting for a result to do with their reproductive health. What are we like?

Chairman: I thank the Deputy. Can we all just stop? I have a few words to say. Chairing this committee is both a privilege and a challenge. It is a privilege in that I am facilitating members who have rolled up their sleeves to examine these issues in great detail and it is a challenge in light of the fact that the issue is so emotionally divisive. Believe it or not, I do not take it personally. I cannot do so. In general, it is not intended personally and I respect what Senator Mullen had to say in that regard.

We were given a report from the Citizens' Assembly in which it recommended a change in the Constitution so as to make 13 grounds for the termination of pregnancy lawful. That is a major step. We were charged with examining whether this change is necessary and, if so, how it could be implemented. To do that, we invited a range of experts in areas such as obstetrics, human rights and international developments in the area of reproductive health care.

In the context of examining this issue by subjecting the recommendations of the assembly to full public scrutiny, the map given to us by Ms Leah Hoctor two weeks ago, which showed all of Europe, with the exception of Malta and Ireland, showed that we are an outlier. We have heard contributions to the effect that because the UK is a provider of abortion for Irish women, we can be an outlier. It was important, therefore, for the committee to understand what would be likely to happen if that ceased and the terminations performed in the UK were performed in our hospitals. That is why we wanted information on worldwide trends and what happens if

restrictive laws are removed.

Witnesses from the WHO and bodies such as the Guttmacher Institute and the Center for Reproductive Rights were asked to contribute to the committee so that we, as members, might have a strong understanding of these issues. We also sought information on the illegal importation of abortion pills. As such, our work has very much been based on what is happening on the ground.

I have listened to claims that the committee has been biased in its approach. It would have made the committee better informed if those who argue vehemently for maintaining the *status quo* gave evidence. That goes without saying. However, it did not happen. We are all aware of their views, though. In any event, those occupying polarised positions on both sides may struggle to make themselves relevant. Long may that continue because it will result in a more rational debate when the issues are put to the people.

I wish to make a few more points. The committee decided who would attend, not me. I do not know how many times I have to say it, but that is the reality. As a committee, we agreed to limit the number of advocacy groups appearing before us because of our time constraints. No vote has been taken in this room on the question of introducing abortion. I want to be very clear about that. I have said this a few times, but I will say it again because it clearly needs to be repeated - we voted to address the *status quo*. We voted on our belief that Article 40.3.3o needed to be addressed. The actual words were "not retained in full". We have agreed to address the *status quo*, but we have not decided anything further than that. Anything that has been said outside the committee other than that is incorrect and a misinterpretation, so I ask members to please be constructive with this process and try not to undermine it.

Both Lives Matter was invited to this committee and declined to attend. An advocacy group of a similar persuasion will attend this afternoon.

This is a difficult committee to sit on for all of us and it is an exceptionally difficult committee to chair. It is probably the most difficult in both respects in the history of the State. Let us all try to be reasonable and respectful to one another.

I want to suspend the meeting for two or three minutes to invite the witnesses in.

Senator Rónán Mullen: May I say something?

Chairman: No. We are inviting the witnesses in.

Senator Rónán Mullen: Is the Chair ruling that there is to be no further discussion on this? I have not been given an opportunity to put many individual concerns on the record.

Deputy Mattie McGrath: Likewise.

Chairman: By all means, the Senator can approach me about them. For now, we will invite the witnesses in.

Senator Rónán Mullen: I have approached the Chair.

Deputy Catherine Murphy: On a point of order, I would also have liked to have put a list of matters-----

Chairman: So would I.

Deputy Catherine Murphy: -----on the agenda in order to have them dealt with.

Senator Rónán Mullen: I did the work.

Deputy Catherine Murphy: I resent that. I have sat here for every hour of this committee. The Senator should tell me that he is doing the work.

Senator Rónán Mullen: The Deputy did not look for more time. I actually did the work.

Deputy Catherine Murphy: We have been told that there is a 14-1 split in the context of witnesses. I suspect that those witnesses will not be happy with Senator Mullen deciding what their position is. They are academics who have been peer reviewed and who are appearing before us to give facts, and they could challenge some of the things being said. It is unfair.

(Interruptions).

Chairman: That is it.

Sitting suspended at 2.29 p.m. and resumed at 2.30 p.m.

International Context: Dr. Patricia Lohr, British Pregnancy Advisory Service

Chairman: We will now resume in public session. I welcome members and the viewers who are watching the proceedings of the Joint Oireachtas Committee on the Eighth Amendment of the Constitution. We will be holding two separate sessions this afternoon. In the first session, we will meet a representative from the British Pregnancy Advisory Service. In the second session, we will meet a representative from One Day More, the support group for parents who have received poor pre-natal prognoses. Before I introduce our witnesses, at the request of the broadcasting and recording services, members and visitors are asked to turn off their mobile phones or switch them to aeroplane mode. On behalf of the committee, I extend a warm welcome to our first witness, Dr. Patricia Lohr, medical director of the British Pregnancy Advisory Service. I must advise Dr. Lohr on the matter of privilege before we begin our proceedings proper.

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 nor make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable.

I now invite Dr. Lohr to make her presentation.

Dr. Patricia Lohr: Thank you. I have a prepared statement and afterwards I will be happy to take any questions members may have.

My name is Patricia Lohr. I am the medical director of the British Pregnancy Advisory Service, BPAS. I trained in obstetrics and gynaecology at the Harbor-UCLA medical centre in Torrance, California. I followed this with a fellowship in family planning and contraception research and a masters degree in public health at the University of Pittsburgh. I am a fellow of the American Congress of Obstetricians and Gynecologists and of the US Society of Family Planning. I have an honorary fellowship form the UK Faculty of Sexual and Reproductive Healthcare. During my career, I have focused on the delivery of evidence based abortion care and family planning, including developing protocols, training doctors and nurses, providing services and conducting research. I am currently a member of the Royal College of Obstetricians and Gynaecologists, RCOG, abortion task force for which I am currently working on post-graduate curriculum development and a pathway for the care of women needing abortions who are medically complex. I am a founding member and the treasurer of the British Society of Abortion Care Providers which is an RCOG specialist society and currently sit on the National Institute for Health and Care Excellence, NICE, termination of pregnancy guideline committee which has been tasked with development a new evidence-based guideline for England. I was a member of the development group that wrote the last RCOG guidance on abortion care and have contributed to other national and international guidelines on contraception.

BPAS is a charity which was established in 1968 to provide not-for-profit abortion care that the National Health Service, NHS, at the time either could not or would not provide. Today, we provide contraception, pregnancy options counselling, abortion care and miscarriage management from more than 40 centres across England, Wales and Scotland. As part of our charitable remit, we also provide education on the causes and consequences of unwanted pregnancy and our nurses visit schools and colleges to provide information about contraception and fertility to young people to empower them with the knowledge to make their own reproductive decisions.

The majority of our services are provided under contract to the NHS, meaning the vast majority of women we see do not pay for their treatment. That now includes women from Northern Ireland, whose care is funded by the UK government and will be managed through a central booking service. The remainder are fee paying patients who overwhelmingly come from the Republic of Ireland. We provide care at or below cost to women from Ireland in recognition of the financial challenges they have already faced in reaching the UK and we have a policy of never turning any woman away based on her ability to pay.

While it is true that I am someone who believes strongly that abortion care is a fundamental part of women's reproductive health care, I am here today to provide this committee with factual information on the experience of Irish women who travel to the UK, how their abortion care is provided and the limitations of the current framework for providing the highest standard of care. As an organisation, we have no financial interest in Ireland changing its laws and will continue to provide not-for-profit services to Irish women if they cannot access abortion at home. In the UK, with the exception of Northern Ireland, a woman can access lawful abortion if she meets the terms of the Abortion Act 1967 and two doctors agree, in good faith, that she does so. Any abortion outside of that framework falls under the Offences Against the Person Act 1861 and carries the threat of life in prison for the woman and anyone who helps her. All abortions must be performed in NHS hospitals or at specifically licensed premises such as those run by BPAS.

The majority of abortions are performed under ground C, which stipulates that the pregnancy has not exceeded its 24th week and that 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 pregnant woman. A smaller number are performed under ground E, namely, that if the pregnancy continued the baby would be born with a serious mental or physical disability. The vast majority of abortions, 92% last year, were carried out at under 13 weeks' gestation and 81% were carried out at under ten weeks. This is in no small part due to the increasing availability of medical abortion, which can be offered at some of the earliest gestations. Medical abortion involves taking two medications, mifepristone and misoprostol, ideally 24 to 48 hours apart for maximum efficacy. Medical abortions account for more than 60% of the total number of abortions performed, although this method becomes less acceptable to women as gestational age advances.

Small numbers of abortions are performed after 20 weeks' gestation and account for approximately 1% of the total number of abortions performed. Some of these will be for reasons of foetal anomaly which are not detected until the scan at 20 weeks. Others will involve late detection of pregnancy, sometimes as a result of contraceptive use which has disturbed bleeding patterns, so that a missed period is not interpreted as a potential marker of pregnancy. While teenage pregnancies have declined dramatically over the past decade, a younger woman with an unwanted pregnancy is proportionately more likely to need a later abortion. This may be because a pregnancy was not suspected or because she has felt unable to confide in anyone about her circumstances.

In terms of the overall picture of abortion within the UK, the rate is stable at around 16 per 1,000 women. This rate is largely unchanged since the late 1990s. The age profile at which women have abortions is changing, however. The teenage pregnancy rate has decreased dramatically and more older women are requesting abortion care. At BPAS, we see more women over the age of 35 requesting abortion than women under 20. It is estimated that one in three women will need an abortion in their lifetimes and that one in five pregnancies end in abortion.

The abortion rate in England and Wales is similar to that in other socially and economically comparable countries such as France and Sweden. The UK is not an outlier in regard to its abortion rate. There is, in any event, no evidence that laws influence the numbers of abortions. The respected Guttmacher Institute has shown, for example, that the rate of abortion in countries with highly restrictive abortion laws is comparable with that in countries with more liberal frameworks.

To address specifically the issue of women from Ireland needing abortion care, last year 3,625 women were recorded in the annual abortion statistics produced by the Department of Health in England as having given an Irish address when they presented for treatment. Over the past ten years, the number of women giving Irish addresses has fallen from 4,600 in 2008. This decline may be underpinned by a number of factors, including better access to contraceptive services and emergency contraception, increased access to abortion medication and increased awareness that free treatment can be obtained with a UK address. A paper published in the *British Journal of Obstetrics and Gynaecology* in July reported that between January 2010 and December 2015, some 5,650 women from Ireland and Northern Ireland contacted one online provider alone to request medical termination of pregnancy.

BPAS has been providing abortion care to women from Ireland since 1968. There is little difference between the reasons women from Ireland present and the reasons women from the UK present; they are diverse and multifaceted. They may involve financial hardship, knowing one's family is complete, inadequate partner or family support, domestic violence or simply a woman feeling she is not in a position to care for a baby at that point in her life. While some abortions take place of pregnancies that were planned and wanted, such as those for foetal

anomaly, the majority of the women we see were trying to avoid pregnancy when they conceived. In fact, the majority of women from Ireland we treat were using some form of contraception when they conceived. We undertook an analysis of 2,703 women from Ireland who were treated at BPAS over a four-year period and found the following: 3% were using a method such as an intrauterine contraceptive, implant or sterilisation; 29% were using injections, oral contraceptives, such as the pill, a patch or a ring; and almost 50% were using condoms, diaphragms or fertility awareness-based methods. Only 20% were not using any method at all at the time they conceived. Of Irish women who receive abortion care in the UK, 70% are married or with a partner, and nearly half have already had at least one previous birth, meaning they are already mothers. All this is in keeping with information we have for women from the UK seeking abortion.

What is different for Irish women? As previously noted, medical abortion now accounts for the majority of early terminations in the UK. Many women prefer it as it is akin to a natural miscarriage, they can avoid an anaesthetic and they can be at home when the pregnancy passes. In contrast, the majority of early abortions provided for Irish women are performed surgically - 71%, compared to 28% for women resident in England and Wales. This is because for financial and practical reasons, many women travelling from Ireland often aim to fly in and out of the UK within a day and, as medical abortion involves leaving the clinic after taking the second set of medication and going home to pass the pregnancy, it is not clinically optimal for this to happen on the way to the airport or the flight home. Effectively, this means that women from Ireland are in all practical senses denied a choice of abortion method.

Irish women also have abortions at slightly later gestations than women having abortions who are resident in England and Wales. The vast majority, 81%, of residents of England and Wales present between three and nine weeks' gestation, compared to 69% of women from the Republic of Ireland. At ten to 12 weeks' gestation, 11% of residents from England and Wales and 16% from the Republic of Ireland present. At the latest gestational bracket, 20 weeks or over, 2% of women resident in England or Wales present, compared to 3.2% of women resident in the Republic of Ireland. Nearly a third of abortions, 31%, for women from the Republic of Ireland are performed at ten weeks or over, compared to 20% for women resident in England and Wales. Abortion is an extremely safe procedure, but the earlier in pregnancy it is performed the better for women's physical and mental well-being. Reasons for later presentation include the time it takes to organise travel and make logistical arrangements, particularly for those with work and child care commitments.

All women who receive NHS-funded treatment at BPAS are entitled to contraception counselling. They can choose from the full range of methods available and, if they wish, can leave with the method of their choice. Provision of contraception at the time of abortion has several advantages - the woman is known not to be pregnant, and it confers immediate protection against pregnancy and, with regard to implants and intrauterine contraception, increases the likelihood she will receive the method compared to women who must return to undergo insertion at a later date. Irish women who attend BPAS are also offered contraceptive counselling, and the overwhelming majority take it up. However, because of the costs associated with receiving their chosen method, as well as the logistics of integrating contraception care with travel, in our analysis only 31% chose to receive their preferred method from BPAS. This is compared to 85% of women we see who are funded for their contraception care. This means that an important opportunity to enable women to make a choice about contraception and receive that method is lost. It is possible women visit their general practitioner or family planning clinic on return to Ireland and receive the method they have chosen, but we have no way of

establishing this or following it up.

Regarding post-abortion care, all women undergoing an abortion at BPAS have access to a 24-hour telephone support line. While follow-up appointments are only provided to those women who want them, all women know they can contact the clinic which treated them and return for a check-up or discuss their concerns at any time. Women from the Republic of Ireland too can access the telephone support line, but if they have any concerns that need in-person care they will typically access local services, which can present its own problems in view of the stigma and secrecy that continues to surround travel for abortion.

Complications from abortion are uncommon, and serious complications are rare. In its paper, Best Practice in Comprehensive Abortion Care, the RCOG recommended that women be advised of the following risks. Failure occurs in one to two in 100 cases of either medical or surgical abortion. Fewer than two in 100 surgical abortions and approximately five in 100 medical abortions are incomplete and need some form of intervention in order to complete the procedure. The following complications may occur. Blood loss needing transfusion occurs in fewer than one in 1,000 cases in the first trimester, rising to approximately four in 1,000 at 20 weeks' gestation or more. Uterine rupture with second trimester medical abortion occurs in fewer than one in 1,000 cases. With surgical abortion there is a similar low risk of cervical trauma - fewer than one in 100 overall, but the risk is lower in the first trimester - or of uterine perforation, which occurs in approximately one to four cases per 1,000, and again the risk is lower in the first trimester. It is sometimes necessary to provide further treatment for complications such as a blood transfusion, laparoscopy, laparotomy and, very rarely, hysterectomy. An upper genital tract infection can occur after abortion, with varying degrees of severity, and is most likely associated with pre-existing infection.

Regarding the mental health impact of abortion, the risk of developing mental health problems is the same for a woman facing an unwanted pregnancy whether she has an abortion or goes on to have the baby. While most women will not require further counselling, post-abortion counselling is available to all women who have had an abortion at BPAS, either over the phone or in person. Needless to say, for women travelling from Ireland the option of in-person counselling at BPAS would be difficult, although this is available through some of the agencies in Ireland. We can advise women undergoing abortion for foetal anomaly on the transport of foetal remains for autopsy, burial or cremation. Women from Ireland must take the foetal remains home themselves and find a carrier that will accept the remains on board. If they want an autopsy or other testing for the foetal remains, this would be self-funded.

What can Ireland learn from the UK? If Ireland overhauls its abortion laws, which is certainly not for me to prejudge, it would do well to avoid some of the pitfalls and problems that the UK framework presents. The Abortion Act 1967 was passed at a time when abortion provision was almost entirely surgical and when all surgical procedures were riskier than they are today. Against this backdrop, it is unsurprising that politicians stipulated that all procedures should be carried out in an NHS hospital or in specific premises licensed by the Secretary of State for Health and that all such procedures should be performed by a doctor. Few could have imagined in 1967 that early abortion could be safely provided using medication. Our laws have prevented the provision of early medical abortion in line with guidance from the World Health Organization, which recommends that women should be able to use misoprostol at home once lawfully prescribed. This means that women can time the passing of their pregnancy and do not have to risk bleeding or miscarriage on the way home, nor do they have to attend multiple appointments.

I spoke earlier about the number of women from Ireland using online abortion services and it may surprise the committee to know that women living in areas of the UK where funded, legal abortion is available are also turning online. Over a four month period more than 500 women in England, Wales and Scotland requested help from *Women on Web*, one of the online medication abortion providers. For some women, the multiple appointments, sometimes considerable distances from where they live, were an absolute impediment to accessing lawful care.

Our laws have also prevented the full development of nurse and midwife-led services that are now the standard in other areas of care like colposcopy. Nurses are lawfully able to provide surgical and medical miscarriage management using the same techniques as an early termination but are prohibited from providing that service to women needing an abortion. With regard to premises, there is no reason why early abortion, whether by vacuum aspiration or pills, could not be safely provided from a GP surgery but again our laws make that all but impossible.

Keeping abortion within the criminal law, as opposed to regulated by health care law like all other procedures, can be hugely stigmatising. Canada and parts of Australia have opted for the decriminalisation of abortion, regulating it through health care law and professional standards. There is no evidence that abortion is more widely used or indeed more available as a result. We do not need a criminal code to impose a time limit for example, but keeping the procedure outwith the criminal law and the subject of professional guidance and health care regulation means that lawful abortion care can be provided in accordance with the highest clinical standards and best practice. Ireland has the opportunity to create a humane abortion framework that is fit for the 21st century. I hope the information that I have provided to the committee is helpful for this discussion and I am happy to take any questions that members may have.

Chairman: I thank Dr. Lohr. The four main speakers are Deputies Catherine Murphy, Bernard Durkan, Jan O'Sullivan and Lisa Chambers. Each has ten minutes.

Deputy Catherine Murphy: I will divide my time between this and the next session. Perhaps the Chairman will tell me when five minutes is up.

Chairman: Certainly.

Deputy Catherine Murphy: It is very clear. Dr. Lohr would not describe the UK system as an on-demand system given that women have to go through a rigorous regime of meeting with two medics before an abortion can take place.

Dr. Patricia Lohr: That is correct. Two doctors have to sign a form called an HSA1 form after reviewing the circumstances of the woman who is requesting the abortion, to determine whether she fits one of the five grounds of the Act.

Deputy Catherine Murphy: Dr. Lohr has spoken of how the criminalisation is done differently in this area. What information does Dr. Lohr have on the impact this has had in respect of medical care and the medical profession in the UK, given that it remains in the background?

Dr. Patricia Lohr: Knowing that abortion sits within a criminal code and that a person could potentially be prosecuted certainly has a chilling effect on doctors and nurses who might be interested in entering this field. I believe it is a barrier to individuals engaging in the field of abortion provision. Many women are not aware that abortion sits within the criminal code, but it is the case that some women are aware and they are aware that they have to meet certain criteria in order to obtain a lawful abortion. I have been made aware of cases at the British Pregnancy Advisory Service where women have concealed the reasons why they are com-

ing for the abortion because they were worried it would not meet the criteria. I will give the committee an example. A woman was experiencing extreme lower abdominal pain during her pregnancy, so much so that she felt she could not continue the pregnancy. She did not believe that this reason would meet the lawful criteria for an abortion. When she met with our doctors she told us a different reason for wanting to obtain an abortion, which did fit with the Act. It was ultimately discovered that this woman had an ectopic pregnancy and a diagnosis of ectopic pregnancy was delayed.

There are very few things now, thankfully, that lead to maternal mortality in this part of the world. Unrecognised ectopic pregnancy, however, is one of them. For some patients it has potentially devastating consequences. I have made reference to a paper that was published about women in the UK who have contacted Women on Web about obtaining abortion medications because they felt they could not leave the house, perhaps they had a controlling partner or it was a domestic violence situation, maybe they could not afford multiple visits to the clinic, etc. The framework within which those women have to obtain an abortion is a barrier.

Deputy Catherine Murphy: In her opening statement Dr. Lohr spoke about the rate of abortion in countries with highly restrictive abortion laws is comparable with that in countries with more liberal frameworks. Dr. Lohr referenced that research. Some people in Ireland argue that by virtue of the fact Ireland has the eighth amendment in the Constitution - even though there are other amendments that permit travel and information - it has saved lives when a woman has completed the pregnancy and gone on to have the baby. Would Dr. Lohr's assessment be that this contradicts that argument?

Chairman: I want to let Deputy Murphy know that if the witness responds to this query then the five minutes are up.

Deputy Catherine Murphy: Okay.

Dr. Patricia Lohr: Does the Chairman want me to respond?

Chairman: Yes. I am just managing the time.

Dr. Patricia Lohr: Ireland is fortunate that it has a country nearby where women can pay for and obtain safe abortion care. In many parts of the world where abortion is illegal or highly restricted that is not the case and women turn to unsafe means to end their pregnancies. This is associated with a very high maternal mortality rate in those countries. In Ireland's case we see that women who are able to afford to travel are able to obtain safe abortion care but I am sure there will be a number of women who cannot afford to travel who go on to continue pregnancies here that they would otherwise have terminated had abortion been available in Ireland. As we are aware, more and more women are obtaining abortion medications online here. While that is not an inherently unsafe activity these women lack the follow-up and other services they may benefit from, such as early pregnancy diagnostic services.

Deputy Catherine Murphy: I thank Dr. Lohr.

Chairman: Does Deputy Durkan want to share his time between the two sessions also?

Deputy Bernard J. Durkan: Yes.

Chairman: I will let the Deputy know when his five minutes is up.

Deputy Bernard J. Durkan: I thank Dr. Lohr for coming before the committee and giv-

ing us her views. I have a couple of questions. What is the extent of the risk associated with ordinary, conventional birth and with abortion? Has Dr. Lohr compared the figures in the UK and how do they stack up? To what extent is counselling that comes before, during or after the process of terminating a pregnancy available in the UK for women in Ireland who travel over to have a termination? Have the witnesses studied the statistics in other European countries? In some cases, there is a vastly different number of abortions per 1,000 in countries where abortion is permitted. Have the witnesses come to a conclusion as to why that might be? Switzerland and Sweden might be compared, since the rate in Sweden is approximately three times as high as Switzerland.

Dr. Patricia Lohr: The Deputy's first question was about the risk of birth compared to the risk of abortion.

Deputy Bernard J. Durkan: In the course of an abortion compared to the course of a normal birth.

Dr. Patricia Lohr: We know from maternal mortality data that are collected in the UK that the risk of continuing a pregnancy to term and delivering a baby is higher than that of having an abortion at almost any gestational age in the first and second trimester. Giving birth has got safer in the UK in the last few years and having an abortion is extremely safe. The reports on maternal mortality for the triennium of 2006 to 2008, which the Royal College of Obstetricians and Gynaecologists, RCOG, refers to in its abortion guideline, state that 107 direct deaths were associated with pregnancy out of 2.29 million maternities, giving a rate of 11.39 per 100,000 maternities. In comparison, two abortion-related deaths were reported in that triennium, of 628,342 abortions, which works out to a rate of 0.32 deaths per 100,000 maternities. I looked at some of the reports published since. Maternal mortality at the time of birth has gone down somewhat and the rate of deaths from abortion has not increased.

The Deputy's second question was about counselling for women from Ireland. I can speak for the British Pregnancy Advisory Service, BPAS. We make our telephone counselling services available to women from Ireland. They could access in-person counselling with us if they so wished but that would mean coming back to the UK. We provide women with phone-based counselling, which many women prefer. They usually only need a few discussions but can have as many as they need.

The Deputy asked about the rate of abortions across European countries. I am not an epidemiologist but looking at where the UK sits in the list of European countries, which the Deputy might have been shown a slide of in an early presentation, we are comparable. Abortion may have a higher rate in some countries than others for various reasons, as variable as the reasons women choose abortion but they are typically and commonly related to the availability of contraceptive services so where contraceptive services are widely available and funded, we tend to see a lower abortion rate. One sometimes sees cases where abortion services are well-funded, for example, in the UK, where women still avail themselves of having an abortion when they feel the need to end a pregnancy by termination.

Chairman: The Deputy's five minutes are up but he can have a point of clarification if he wishes.

Deputy Bernard J. Durkan: We were given evidence to the effect that sepsis is very rare now. I do not necessarily agree with that. Does Dr. Lohr have any evidence either for or against it in cases of abortion or natural, normal births?

Dr. Patricia Lohr: Sepsis in abortion is extremely rare. Upper genital tract infection, treated with oral antibiotics, is reported variably in the studies and often depends on the diagnostic criteria used. Where the diagnostic criteria are very strict, for example in cases of fever and evidence of increased of white blood cell count, the rates are quite low. There are higher rates where diagnostic criteria are vague, somewhere around one in 100. Those are typically treated with oral antibiotics. They are not cases of sepsis. Cases of serious sepsis are extremely uncommon.

Deputy Jan O'Sullivan: I will take the five minutes please.

Chairman: I have to be strict on time because it is bad evening and the witness will have to get a flight. I am allowing enough time.

Deputy Jan O'Sullivan: I thank Dr. Lohr for the information. She has given us many statistics, particularly about Irish women and that is useful to the committee. She says she is here to provide us with factual information about the experience of Irish women who travel to the UK. They say she has no financial interest in Ireland changing its laws. Will Dr. Lohr clarify that is the case so there is no misunderstanding?

Dr. Patricia Lohr: It is absolutely the case for me personally as well as for BPAS as an organisation.

Deputy Jan O'Sullivan: I wanted that to be clear on the record. I will ask Dr. Lohr about the experience of Irish women. She has informed us of the care pathways that BPAS provides. There is an issue for Irish women with regard to where the role of BPAS ends in the care pathways, particularly with regard to contraception counselling post-abortion. What is the effect of that? We have had previous evidence that would suggest that post-abortion contraceptive advice reduces the recurrence of further abortions. Is there any factual evidence related to that? What are Dr. Lohr's own feelings about not being able to continue the care pathway for women who have come to her services from Ireland?

Dr. Patricia Lohr: The best evidence we have for the role of contraception in reducing subsequent unintended pregnancies is receipt of the method at the time of the abortion. A number of studies have been done, looking at different models of contraceptive counselling before the abortion. None of the variations, whether specialist counselling or dedicated counselling, has been associated with the reduction in subsequent unintended pregnancies or abortion, particularly in the long term. We know that when women receive the method and start it straight away, that is associated with reduced risk. The only way that can happen is if the contraceptive counselling happens before the abortion. Every woman in our service is asked whether she wishes to use a method of family planning. If she does, we engage her in a discussion about which method of contraception would be right for her and we aim to provide it at the time of the abortion so that she is immediately and optimally protected.

Deputy Jan O'Sullivan: For women who come back to Ireland, Dr. Lohr would presumably agree that contraceptive advice she be available both before and afterwards.

Dr. Patricia Lohr: Yes.

Deputy Jan O'Sullivan: Thanks. Dr. Lohr said that 92% of terminations in the British systems happen at under 13 weeks and 81% are at under ten weeks. She also said that the majority of Irish women have surgical procedures.

Dr. Patricia Lohr: Correct.

Deputy Jan O'Sullivan: A reason she gave was the time that one needs to be there for the medical procedure. Is there also evidence from Dr. Lohr's work that there would be a delay which would be a factor for Irish women having the surgical procedure?

Dr. Patricia Lohr: As I said in my talk, women coming from the Republic of Ireland tend to present slightly later for abortion care than residents of the UK. Some women will have exceeded the gestational age for which they can have an early medical abortion procedure by the time they come into our clinic.

Deputy Jan O'Sullivan: Various people have asked about floodgates. Does Dr. Lohr have any evidence that this floodgate opened, with dramatic increases, at any time since the British Act of 1967?

Dr. Patricia Lohr: I am not an epidemiologist but I will speak about the data as well as I understand it. Illegal abortions are very difficult to count. We do know a bit about women who presented to hospital, for example, after having obtained an unsafe abortion in the UK before the Act was passed. Once the Act was passed the numbers of women having abortion did not go up dramatically. I guess that is what the Deputy refers to as floodgates. What we do know and can see in statistics is that, as abortion services became more widely available and abortion became better funded, and women became aware that those services were available and were safe, they did avail of them. Now we see that the number of women accessing abortion has been very stable for several years.

Deputy Lisa Chambers: I thank Dr. Lohr for her presentation and for coming before the committee to give evidence and answer questions.

Could Dr. Lohr please respond to the concern that there is a risk abortion will be used as a form of contraception? Could she please paint a picture of the reasons for different age groups of women obtaining abortion, for example, among women younger than 20, aged between 20 and 30 and those over 40? Are there different reasons in those age categories?

I was struck by Dr. Lohr's figures, that 71% of early abortions provided for Irish women are surgical compared with 28% for women resident in England and Wales. That was because the Irish women had to travel back and forth in one day. The medical abortion, the tablet, cannot be offered to them. Do women arrive at the clinic seeking a medical abortion, thinking that is what they will have but then hear that they cannot have that service but will have to have a surgical abortion?

It appears from Dr. Lohr's presentation that there are more risks associated with surgical abortions than with medical, for example, uterine rupture, bleeding and other complications. Would it be fair to say surgical abortions are more risky and that Irish women do not have the choice when they go to the UK but have to have more surgical than medical abortions?

Dr. Patricia Lohr: I will take the last question first, about the risks of surgical and medical abortions. Proportionally, early medical abortions have a slightly higher rate of complications than surgical abortions. It is the profile of the complications that differs. With a surgical abortion a woman runs a very low but present risk of cervical or uterine injury. The most common complications of medical abortion are relatively minor, for example, some retain tissue that might need an additional intervention, although the bleeding risks are certainly higher.

In response to the question of whether women come into our clinics looking for a medical abortion and we tell them they cannot have it because they are there only for a day, we always try to meet the woman's request with regard to the method of abortion. We would never prevent a woman having a certain form of abortion but we would talk with her about the process involved. We would be honest about the regimen for early medical abortion which typically occurs over two days. Under the law in England and Wales - now Scotland is different – a woman must come into the clinic to receive both sets of medications. We would describe the process to her and assess her medical eligibility for either regimen and would leave it to her to decide. For all intents and purposes, however, from a practical point of view, most women coming from Ireland need to come and go in the same day. They have already had to gather the funds to pay for the abortion and travel so to add an overnight stay and another day away from work or home is too difficult. That is why the majority of those women choose surgical procedures.

The Deputy asked about differing reasons for abortion at different ages. We do see differences. Teenagers, those younger than 20, are often unable to care for a child, they may still be in school and it is not optimal for them to have a child. Women in their 20s and 30s are often looking to delay childbirth. We have seen the age of first time motherhood has gone up in the UK, as in many countries. Women are delaying childbirth for several years and it is important to note that most women in the UK are using contraceptive methods but all contraceptive methods have a failure rate and in typical use the failure rate for example, of the oral contraceptive pill is approximately nine in 100. If a woman is trying to prevent pregnancy for ten or 15 years it is possible, even if she is using her contraceptive method absolutely the way it is supposed to be used, that she might experience a contraceptive failure and if she is not ready to parent she will seek an abortion. Older women typically have completed their childbearing, for example, they did not expect to be able to get pregnant. They already have children and are seeking termination often for those reasons.

The last question was about contraception and I have forgotten what the Deputy asked, I am so sorry.

Deputy Lisa Chambers: I do not take this view but some of the criticisms levelled at the provision of services were that women will use abortion services as a form of contraception. I would like to hear Dr. Lohr's response to that.

Dr. Patricia Lohr: It is telling that most of the women we see were using a contraceptive method at the time that they conceived. They were not intending to become pregnant and were intending to use a method of contraception to prevent a pregnancy. On that basis I do not see evidence that women are using abortion as a method of contraception. It is a backup for when contraception fails, or in a very small number of cases, as I have described, there are foetal or sometimes even maternal indications to end the pregnancy.

Deputy Peter Fitzpatrick: I welcome Dr. Lohr from the British Pregnancy Advisory Service. The head of Dr. Lohr's organisation, Ann Furedi, recently spoke on television about how she feels that abortion should be available for sex selection, if a woman finds that she is expecting a baby girl but wanted a baby boy that should be grounds for an abortion. I think most people find it quite upsetting that anyone would think a baby's life should be ended simply because she is a girl. Does Dr. Lohr think that abortion should be allowed on grounds of gender so that a woman can abort a baby girl if she wants a boy instead? The name of the programme is "Loose Women". It is a daytime programme.

Dr. Patricia Lohr: I have not seen the programme.

Deputy Peter Fitzpatrick: Is Dr. Lohr familiar with the statement made on the programme?

Dr. Patricia Lohr: I am not familiar with the exact text of the statement. What she may have been clarifying is that abortion on gender grounds is not one of the five grounds for lawful abortion in the UK. A woman may present to us stating initially that she wants to have an abortion on the basis of foetal sex. If that were the only reason she put forward to have her abortion, we would not be able to perform that lawfully. If, however, a woman presented saying, "I know my pregnancy is - pick your foetal sex - and I am at risk of exclusion from my family, domestic violence, etc.,", there may, in fact, be lawful grounds because that might risk her physical or mental health.

Deputy Peter Fitzpatrick: My question was whether Dr. Lohr thought abortion should be allowed on the grounds of gender. What does she think? Her CEO seemed to think it should be one of the grounds. She also stated on the same programme when she was talking about sex selection that it should always be down to the woman to make the decision for herself because she will live with it.

Dr. Patricia Lohr: I absolutely do agree with the position that it is for the woman to decide when and whether she is ready to parent or have a child and put it up for adoption.

Deputy Peter Fitzpatrick: I am talking about a boy or a girl. I am talking about gender selection.

Dr. Patricia Lohr: My point is that I feel that decisions about whether to continue a pregnancy should sit with the woman herself. As a doctor and knowing the risks of continuing an unwanted pregnancy, I cannot imagine compelling a woman to have and continue a pregnancy for which she is unprepared.

Deputy Peter Fitzpatrick: On the same programme, Dr. Lohr's boss said she thinks the current time limit in England of 24 weeks, or six months, should be dropped. Most people would be horrified at this thought which suggests the life of a baby can be ended so easily. There was no question of attempts being made to save the baby's life, just that abortion should be available after six months. Currently, English law allows an abortion up to birth if a baby has a disability like Down's syndrome. The members of the committee are already familiar with the frightening statistic that 90% of babies diagnosed with Down's syndrome in the womb are aborted. How many abortions have been carried out in BPAS clinics where the reason given was that the baby had a disability? Have any of these abortions involved babies diagnosed with Down's syndrome?

Dr. Patricia Lohr: I will be honest and say that I do not have the numbers with me of women that we treated with foetal anomaly but I can certainly provide that to the committee at some later time. I can also try to get the information about the indications for those terminations in cases of anomaly.

Deputy Peter Fitzpatrick: Dr. Lohr stated earlier that abortion is an extremely safe procedure but the earlier in the pregnancy it is performed, the better it is for the woman's physical well-being. I cannot understand how an organisation with more than 40 locations in the UK has not been able to come here and provide me with the two answers I seek. I asked how many abortions had been carried out in BPAS clinics. I am not asking for any personal information. I am trying to give people here a picture of what kind of an organisation or charity Dr. Lohr is involved with. It is horrifying that the CEO of the charity is encouraging gender selection. I

said it here a few weeks ago and people were nearly laughing. That a charity in the UK is looking at the selection of genders is something I cannot understand.

I believe very strongly that we trust women. This is something I have also heard members of Dr. Lohr's organisation saying. If one trusts women, one must also trust them with full information about abortion including the fact that the baby's heart starts to beat at just 21 days in the womb and the fact that one in five pregnancies in England and Wales ends in abortion. The committee is tasked with looking at the impact of the eighth amendment in Ireland. This means undertaking to ensure that the public is fully informed of the development of a baby in the womb and how the eighth amendment is responsible for saving tens of thousands of lives in Ireland. If we are really going to trust women, does it mean we must run a nationwide education programme on all the good things the eighth amendment has done, the remarkable development of an unborn child and the fact that in England and Wales, over 190,000 babies lose their lives to abortion every year?

Dr. Patricia Lohr: It is not for me to say what sort of nationwide educational programmes there should be in this country if and when it chooses to change the law. I am not actually sure how to answer that question. I do not feel it is not in my remit, actually.

Deputy Peter Fitzpatrick: Dr. Lohr stated earlier that she goes to schools and colleges. What does she encourage these schools and colleges to do apart from gender selections and increasing legal abortion from over six months? I am just asking a few simple questions. Earlier I thanked Dr. Lohr very much for coming in today. She had a good presentation. I am just very disappointed with the answers I am getting. I am actually getting no answers.

Chairman: If there are points that need clarification by the witness or the lady to whom Deputy Fitzpatrick has referred and the information is not available today, it is perfectly fine to provide the information to the committee later and it will be put on the record at that point. Unless the Deputy wants Dr. Lohr to give information that is inaccurate------

Deputy Peter Fitzpatrick: No.

Chairman: -----the witness can have that opportunity, in fairness to her, if she wishes.

Deputy Peter Fitzpatrick: I spent a lot of time going through these questions and looking for answers. In fairness, I thank Dr. Lohr very much for coming here today but I am very disappointed. This is a charity organisation and some of the statements and the things it is doing in the UK are out of proportion. I am disappointed that a representative has come over here but cannot give me the answers.

Chairman: Is there anything Dr. Lohr would like to say in response?

Deputy Peter Fitzpatrick: If Dr. Lohr gets the opportunity, I ask her to look at the programme "Loose Women" which is a daytime programme here which a lot of people watch. Dr. Lohr's CEO has-----

Chairman: Does Dr. Lohr want to respond?

Dr. Patricia Lohr: As I said, I am sorry that the Deputy feels disappointed. Had I known that was a specific number the Deputy was interested in me having to hand on the day, I would have prepared and provided it for him. I am very happy to provide those statistics to the Deputy at a later time.

Chairman: I thank Dr. Lohr. I call Deputy Durkan. Sorry, he indicated and I have him down twice.

Deputy Bernard J. Durkan: If the Chairman loves me that much that she wants me to go again, I will.

Chairman: No. I call Deputy O'Connell. Sorry, I am obviously losing my mind.

Deputy Kate O'Connell: I apologise that I had to leave the room for something. If I repeat something that was asked already, ignore me. I can look back at the record. Deputy Durkan touched on the rate of termination in the UK. I was sourcing some documents about the rate in the Netherlands which used to be the lowest but which has risen slightly in recent years. Dr. Lohr quoted a figure of 16 per 1,000 and I think the Netherlands stands at approximately 8.6 per 1,000. Some sources attribute that to Irish people travelling there. The Netherlands, like the UK, has quite a high number of Irish women who travel there for termination. As part of the continuing development of abortion services, has the UK done anything to try to reduce its rate? In Holland, they have a non-moralistic treatment of teenagers with education and access to contraception and so on. Can Dr. Lohr outline those things?

Ground E in the 1967 Act was quoted by Dr. Lohr who said it was for the case of a baby with a serious mental or physical disability? How is "serious" defined? On occasion, people here have thrown out the term "cleft palate", but from listening to the experts it is often a combination of conditions. It is not simply the case that a child has Down's syndrome. It might be a child who has Down's syndrome coupled with kidney problems, a heart defect and so on. Perhaps the witness would elaborate on that issue. In regard to the limitations of the UK system around the abortion pill, why has nobody in the UK Parliament brought forward a measure to try to change that position? What are the barriers to it in a country that would be seen to have a liberal approach? Why has the United Kingdom as a country not done anything to date to address this issue?

Dr. Lohr referred in her opening statement to never turning anybody away. What does that mean? Does it mean that no woman is turned away when she makes contact by phone or when she lands on the doorstep? I am thinking in this regard about women who are being prevented from travel. Why in her view was the British Pregnancy Advisory Service, BPAS, set up to provide abortion services rather than this service being provided by the UK maternity hospitals under the National Health Service? The evidence suggests that reducing barriers to access to contraception tends to reduce abortion rates because of the reduction in unplanned pregnancies. As contraception is free in the UK, perhaps Dr. Lohr would elaborate on that point.

Deputy Louise O'Reilly took the Chair.

Dr. Patricia Lohr: Widespread and free availability of contraception is one of the most important contributors to reducing the risk of unintended pregnancy. As I have said, most women who present for abortions in the UK had not intended to become pregnant. Widespread availability of free contraception in family planning clinics has been important in the UK, as has been the concerted effort to reduce teenage pregnancies by ensuring that young people have available to them the full range of contraceptive methods, including national guidance which supports the use of long-acting methods of contraception in young people, which many doctors and nurses may have been reticent to provide in the past, as well as the education of young and older people about their bodies, the risks of becoming pregnant, when a woman can and cannot get pregnant and how one might prevent pregnancy. Last but not least, the availability of emer-

gency contraception in order that women can prevent a pregnancy if they have had an episode of unintended, unprotected intercourse has also been hugely important. All of these initiatives have been undertaken to try to reduce the risk of unintended pregnancy.

As discussed, no contraceptive method is perfect and in typical use, the failure rates are relatively high, even with what most people might consider to be some of the more effective methods such as the injectable or oral contraceptive pill. There is a finite degree to which one can prevent the need for abortion through access to contraception or sex and relationship education. As we know, and as already referenced today, a small number of abortions are for pregnancies which are very much wanted but because the woman has a medical condition it is unsafe for her to continue to the pregnancy or, as described, there is a foetal anomaly which is an indication for a termination.

Deputy O'Connell asked how ground E was defined. As with all of the grounds for abortion in the UK, it is up to a doctor to determine whether the woman's presentation meets the ground of the Act. There is language in the Act, and in particular ground E, that describes foetal anomaly, to which a doctor may refer but we do not, for example, have a list of foetal anomalies which meet those criteria. I agree with the Deputy that doctors look to the whole picture, particularly in cases where the pregnancy is less than 24 weeks. It may be the case that some terminations may be performed later, for example, in cases of chromosomal abnormality, but the woman would also qualify for an abortion under ground C, that is, risk to mental or physical health.

Senator Noone resumed the Chair.

Deputy Kate O'Connell: Is the decision made by one doctor in that case?

Dr. Patricia Lohr: No, two. The only time a decision is made by only one doctor is if there is a risk to the woman's life.

Deputy Kate O'Connell: In the case of a combination of serious birth defects, would the decision be made by one doctor or two doctors?

Dr. Patricia Lohr: Two doctors must agree and on the same ground. Both doctors need to be of the same opinion. If one doctor believes the anomaly is severe but the other does not then it may not be possible for the abortion to be performed under ground E.

Deputy Kate O'Connell: What recourse does the patient have? There is a purpose to my questions. I am trying to tease out where we are going as a committee, rather than being difficult. Where one doctor takes the view that a combination of conditions will be fatal and a second doctor disagrees with that, what happens? In other words, what happens when there is a difference in medical opinion?

Dr. Patricia Lohr: There is no category of fatal foetal anomaly. The Deputy will find that it is not actually a medical category. There is a consideration of the severity of the anomaly and how that might then affect the child once it is born. If it is the case that one doctor believes that the abortion could lawfully be performed under ground E and another doctor does not then the doctors may consider whether it could be lawful to perform the abortion under another ground. If the pregnancy is within the 24 weeks, that can be considered. For example, the ground of mental or physical well-being applies up to 24 weeks of gestation. If it is the case that a pregnancy is over 24 weeks' gestation, which is the limit for grounds C and D, then the woman would have to seek the opinion of, for example, another doctor.

Deputy Bríd Smith: I thank Dr. Lohr for her attendance and for her very interesting presentation. I would like to tease out with her the issue of criminality of abortion as it applies in this State and, as mentioned by Dr. Lohr in her presentation, to Northern Ireland. Three women in Northern Ireland already have been charged with attaining the abortion pill. Dr. Lohr mentioned that there has been a reduction in the number of women seeking abortions in the UK. She also said that this is probably a consequence of the availability of the abortion pill. The statistics provided by her in that regard tally with those provided by other experts who have appeared before the committee. In Ireland, attainment of the abortion pill is an offence for which a person could go to prison for 14 years. Likewise, it is an offence in Northern Ireland that carries a similar sentence.

What Dr. Lohr said fits with the testimonies to the committee from the Irish Family Planning Association and others, namely, that women mainly seek abortions for socioeconomic reasons. Therefore, they risk losing their liberty in this State because of their socioeconomic circumstances. For some women, particularly refugees or asylum seekers, travelling to the UK can often be out of reach financially. In Dr. Lohr's opinion, is a medical abortion, as opposed to a surgical abortion, the less risky option for a woman in terms of her physical health, mental health and, in the case of an Irish woman, her liberty? In other words if a woman could have a medical abortion in this country, this would be better for her than being obliged to travel to the UK for a surgical abortion because, as outlined by Dr. Lohr, having to travel to the UK often means an abortion takes place later in the pregnancy. I would welcome a response from Dr. Lohr to that point. Also, would she agree that the availability of a medical abortion is preferable and safer? Dr. Lohr mentioned in her presentation that Canada and parts of Australia have opted for decriminalisation. The UK abortion laws are almost as old as I am and without them, women in this country would not have access to abortion.

Are they a bit outdated in that they still criminalise the woman? I did not realise that there was a life sentence attached to illegal abortion in Britain but that is effectively the same here, in the North and in other countries. Will Dr. Lohr give us some insight as to why Canada and Australia opted for decriminalisation? If we get to the point where we have to frame legislation and regulation around abortion, hopefully we will, that would be a good insight for us to have.

Dr. Patricia Lohr: The Deputy's first wide-ranging question was on medical abortion. I answered an earlier question regarding the comparable rates of complications in medical and surgical abortion. It is the case that while complications with either method are extremely low, there is a slightly higher risk of complications after an early medical abortion compared with surgical but the risk profile is different. The sorts of complications that one sees after early medical abortion are relatively minor and can often be resolved with relatively minor interventions, for instance, one might use another dose of medications to remove any extra tissue that has not been passed. The processes for medical and surgical abortion are extremely different, however, and I think it is extremely important that women have access to both because they are so different. Women often prefer medical abortion because it is private, they do not need to have a surgical intervention, have an anaesthetic or go into a clinic in some places. They can pass the pregnancy at home and have their partner with them and that is important to some women. For other women, it is important to them to have their abortion done in a clinical setting, to be performed quickly since with a medical abortion there is a somewhat unpredictable time to the passage of the pregnancy, whereas with a surgical abortion it is a day-case procedure, it is timed and one knows when one will be finished. Often those process-related elements matter in some ways more to women than the absolute rate of complications because the complications are low either way and they are pretty similar. It is important women have access to both.

On medical abortion in Ireland and women availing of abortion medications online, it is entirely unsurprising because it is very expensive to travel. What one sees here is what has been seen in many other countries before abortion was legalised or liberalised, which is that women who can afford to travel for abortions or can afford to pay for them do so and women who cannot do not and go on to have unwanted pregnancies. There are consequences of having unwanted pregnancies too.

On affordability, delivering medical abortion services is a very affordable way of delivering abortion services. It can be entirely nurse-led, the medications are not very expensive and the rate of complications are low. It can be offered from a number of locations, which means that it can be less expensive for the woman as she does not have to travel as far to access services, for example. It is a very good model of care, is a highly effective mode of abortion care and is very accessible.

One issue I had not touched on regarding surgical abortion in my answer to the previous question is that women who have surgical abortions not only need to come over themselves to have the procedure but should have someone come with them and to travel back with them. If they have had a general anaesthetic or some sedation, they should have someone to take care of them afterwards and that adds to the cost. That might see women delaying the procedure further in order to gather the money.

Deputy Bríd Smith: Will Dr. Lohr comment on decriminalisation in Canada and Australia?

Dr. Patricia Lohr: I do not feel that is in my area of expertise so it would not be appropriate for me to comment.

Senator Rónán Mullen: Dr. Lohr has been invited here although her group performs abortions including late-term abortions without time limit, up to birth in some cases. She does not believe and she advocates for a scenario where unborn babies have no right to life. One thing that has not been put on the record is that BPAS received a scathing health and safety reprimand from the British Care Quality Commission after 11 serious incidents in a 15-month period involving women being transferred for emergency medical care in hospitals after undergoing abortions in BPAS clinics. Since Dr. Lohr is coming here to advise us on our laws and on what she regards as best practice, it is necessary that this serious reprimand be flagged. Is that light in which we should view Dr. Lohr's supportive attitude to the idea that abortion should be available outside hospitals and at home, as the World Health Organization pushes for?

She quotes supportively a claim by the Guttmacher Institute, which she says is respected although I believe complaints were made about it coming before the Citizens' Assembly; it does advocate for abortion. Its claim, which is strange to many, is that the rate of abortions in countries with highly restrictive abortion laws is comparable with those with more liberal frameworks. She put the rate in Britain as 16 per 1,000 women. Does that include medical abortions?

Dr. Patricia Lohr: Yes, that is the rate of abortion.

Senator Rónán Mullen: I believe it is one in five. In Ireland, taking Dr. Lohr's figures, it is approximately one in 19, so not quite four times the rate in Britain. Dr. Lohr is not the first witness to come before the committee not to note that. I do not believe she is suggesting that three times as many women from Ireland are going to the Netherlands as to Britain for abortion. Does she accept that we have a much lower abortion rate than Britain and that may be linked to the protective effect of laws that promote the life of two persons, mother and baby?

Dr. Lohr uses terms such as "abortion care" and "when the pregnancy passes", which many people would regard as euphemistic. If one believes there are two humans deserving of care, that situation does not care for the unborn child. Dr. Lohr is an obstetrician. Am I correct in presuming that she has done abortions for BPAS and other organisations?

Dr. Patricia Lohr: That is correct.

Senator Rónán Mullen: Can she give us an idea of how many over the years?

Dr. Patricia Lohr: I want to make a clarification on something that Senator Mullen said in his opening statement. He said that BPAS provides abortion up to birth, which is absolutely not the case. BPAS, as with all non-hospital based providers in the UK under regulation, may only provide abortions to 24 weeks of gestation.

Senator Rónán Mullen: I accept that clarification.

Dr. Patricia Lohr: The second comment related to the Care Quality Commission report about one of our clinics. The Senator characterised it as a reprimand. All health care organisations have opportunities to learn from mistakes. Complications happen and learning must happen afterwards. What was identified in the Care Quality Commission report, as had already been identified internally at BPAS through serious incident investigations and learning that followed, was that we did need to do better at that clinic. However, that will be found in any regulated and inspected health care environment. If anything, it supports the idea that abortion, like any other medical procedure when regulated, has the opportunity to improve and better provide services.

I believe the Senator was trying to say that the fact that we had had this report meant it should not be used as a justification that abortion may be provided safely out of hospital and at home. It is probably better to turn to published studies on the locations where abortions can be safely provided. We know from a number of publications that, for example, early medical abortion and vacuum aspiration can be safely provided from clinic-based settings. A number of studies have demonstrated that medical abortion can safely occur in the home environment.

There was a comment about an assumption of the abortion rate in Ireland and a connection was drawn between the abortion rate I cited in the UK. The Senator asked whether I thought three times as many women were travelling to the Netherlands. Have I paraphrased that correctly?

Senator Rónán Mullen: What I am really saying is that unless three times as many women are travelling to the Netherlands, our rate is vastly lower than the British rate. I am asking if the witness would acknowledge that disparity in our abortion rates.

Dr. Patricia Lohr: I do not think we know the abortion rate for Ireland. National statistics are not collected, for example, of women who obtain medication over the Internet. I am unaware of whether the Netherlands reports separately on women giving Irish addresses who are treated in that country. As I stated, we can only count in the UK the number of women who give Irish addresses. There may be a number of women coming from Ireland who do not give Irish addresses and who therefore would not be counted in national statistics.

Senator Rónán Mullen: As to the questions about Dr. Lohr's involvement with abortions and an estimate as to how many she has carried out, I also wanted to ask what would be the latest term abortion she carried out.

Chairman: That will have to be the last question.

Senator Rónán Mullen: I just want to put it on record that there are quite a few more I would like to ask but I realise there is not enough time.

Chairman: Everybody is in the same boat.

Dr. Patricia Lohr: I am trained to provide surgical abortions to 24 weeks of gestation and I have provided abortions to 24 weeks of gestation for the British Pregnancy Advisory Service, BPAS. When I worked in a hospital setting, I provided abortions at later gestation, usually in the context of obstetrical emergencies. For example, this may have involved women with pre-term premature rupture of membranes and were septic or women with severe pre-eclampsia or eclampsia.

Senator Rónán Mullen: It was not always life-saving, health-related or necessary medical treatment.

Dr. Patricia Lohr: Those would have been provided beyond 24 weeks. These are cases of foetal anomaly and serious maternal indications.

Senator Rónán Mullen: What is the estimate of overall number of abortions carried out?

Dr. Patricia Lohr: I do not think I can give a number. It is hundreds or thousands, maybe. I do not keep track.

Senator Rónán Mullen: I thank the witness.

Senator Lynn Ruane: I thank Dr. Lohr for the presentation. I believe I am correct in saying that most abortions in the UK happen under the broad mental health grounds, with sign-off from two doctors. Are women ever denied an abortion on these grounds? What would the reasons be for a denial? Does the phrasing of the grounds and the verification process ever act as a barrier?

Dr. Patricia Lohr: We do not count the numbers of women who are denied so it is difficult for me to answer that question accurately. Within our service, there have been circumstances like we discussed earlier where the doctors have not always agreed on the grounds and so there has had to be more discussion about whether the woman would be eligible and under which grounds. There have been circumstances where doctors have felt a woman needs to go away and think more about the abortion or there have been cases where women have presented requesting abortions on the grounds of foetal sex. In and of itself, that does not meet the grounds for the Act and further discussion would have to happen to ascertain whether the impact of continuing the pregnancy would mean the women would qualify for an abortion under another one of the grounds.

Senator Lynn Ruane: I feel strongly about ensuring this country allows access for women on social and economic grounds. Is that catered for properly? There is a wide range of social and economic impacts but is that captured under ground C?

Dr. Patricia Lohr: Ground C can be interpreted very broadly but the ground that touches on what the Senator is discussing is ground D. This is where an abortion might be authorised on the potential impact of continuing the pregnancy on the woman's existing children. We often see it with regard to considerations of socio-economic status. For example, a woman would have children and cannot afford to have another child. Socio-economic considerations

can come into play under ground C and within the Act the doctor is given the ability to consider the woman's current position and her foreseeable future. Such wording is used within the Act.

Senator Lynn Ruane: The witness has made a strong case for decentralisation of abortion care, with mention of potential administration of abortion by GPs, nurses and midwives. How important is this in the context of reducing geographical barriers to abortion access and also in the context of the well-developed trend of anti-abortion protests in the UK outside approved clinics?

Dr. Patricia Lohr: There is potential ability to have nurse-led services in particular for medical abortions. In the UK, a doctor must always sign the prescription for the medical abortion drugs, for example, and they must always authorise the abortion. Those medications can then be delivered by a nurse and peri-abortion management can be done by a nurse in our setting. It is a more affordable model of care than utilising doctors to deliver abortion care and this has allowed us to set up a number of small units closer to women's homes around the country. That has been a strong contributory factor in the increase of early medical abortion and the knock-on effect of having the gestational age that women are able to obtain abortions come down.

Senator Lynn Ruane: My other question was on decentralisation. If a woman can access this care with her local GP or in the primary health service, it would stem the level of protest.

Dr. Patricia Lohr: I cannot speak to that in Britain because we do not have that. In the United States, when I provided abortion care, I did it during my office hours doing gynaecology. I might have seen one woman for an abortion and the next might have had abnormal uterine bleeding, for example. I might have seen the next woman because of a vaginal discharge. All of those women sat in the waiting room, anonymous to one another about why they were there. They were less likely to be a target. If one comes to an abortion clinic, one is potentially a target.

Chairman: There are six people who wish to contribute and we only have approximately 20 minutes remaining. I ask people not to be repetitive and keep the contribution to five minutes, if possible.

Deputy Clare Daly: I will have to be good. I thank Dr. Lohr for coming in. It is interesting that Senator Mullen made the point about Dr. Lohr's services being the subject of a critical review while in the Dáil Chamber they are discussing Portlaoise hospital. It is the subject of scathing reports arising from the death of babies. The solution was not to shut the maternity service but to improve it. Dr. Lohr's comments on the need for every medical procedure to be constantly improved were well made. We have an unusual position as Irish people have a constitutional right to have an abortion but we do not have the right to have it in Ireland. On behalf of the tens of thousands of Irish women who have availed of Dr. Lohr's services, I sincerely thank her for that.

Will the witness speak to the point about the irony that our abortion regime, if one likes, arises from the 1967 Act, which is the only avenue Irish women in the main have been given if they have the money to travel? In the context of the 50th anniversary of that Act and the increasing dialogue on the need to modernise the British service, what are the best lessons for us, given that we will be starting, in essence, from scratch? The witness has addressed medical abortion, but I was struck by the point that in a scenario where there is funded legal abortion services, hundreds of women in England or Wales are accessing the service from Women On

Web. Is that an illegal activity or is it a grey area? How can we learn from that?

I am confused. We have spoken before about the call by the head of the Royal College of Obstetricians and Gynaecologists asking for nurses and midwives to be allowed to administer the abortion pill on the basis of one doctor. My understanding was that that does not exist now and that it has to be two doctors, and that nurses and midwives cannot do it, or that they can when there are two doctors. Perhaps the witness could clarify that; it is potentially an important way forward.

The impact of decriminalisation and what it would mean is another area that is linked to this. It is a discussion that is happening in Britain at the moment and has been discussed in every session we have had here. What will it mean and how can we learn about it?

Dr. Patricia Lohr: The Deputy is correct to observe that Irish women currently have their abortions within the confines of the 1967 Act. There are a number of problems for women with the way the Act is written. A positive from the Act is that those definitions of the grounds for abortion are widely interpreted, and that has meant that most women who need to have an abortion are able to access that, but it is the case that there are some women who cannot. For example, the door closes when the gestation passes 24 weeks unless there is a serious foetal anomaly or a threat to life.

The question of when a woman's life becomes endangered is an important one. Where women present stating that they are suicidal, what are the mechanisms that one needs to go to in order to ensure that is the case? That puts up serious barriers and creates a situation where women and doctors are struggling to ensure that they are working within the law, while what the woman needs is to end the pregnancy which is so burdening her.

The Deputy mentioned women accessing or trying to access Women on Web because they feel that the current framework under which abortion is delivered in the UK is a barrier. It consists of having to go into a clinic and using the medications in the clinic, having to have more than one appointment and having to have a doctor sign off. In some cases, although it is not a funding requirement some of the funding bodies require that a woman goes to her GP and gets a referral into abortion care. For a woman who does not want her GP to know that she is having an abortion that is a barrier for her. Women on Web do not provide medications to women living in Britain. It would be an illegal activity if those women did obtain medications over the Internet. Women on Web will provide women with advice and guidance on how they may obtain lawful abortion care. However, we know from the requests received by Women on Web it is the case that the way that medical abortion is delivered and the restrictions on how women can obtain those medications is a barrier to them accessing services which could be provided safely and better. If we were able to provide women with truly telemedical medical abortion services, such as those that exist in some parts of the United States, they could freely and openly have a consultation, perhaps using a web chat-type module. They would have access to follow-up ultrasound scans, anti-D immunoglobulin etc., that women who obtain these medications over the Internet are not always able to access.

Are my answers too lengthy? I am trying to pick up on each of the points.

Chairman: No, the problem is that time is too tight if the witness is to get to the airport on time. The flight time is at peak traffic time, it is a bad day weather-wise, and I am conscious of that. I should not have to be thinking about these things as Chair.

Deputy Louise O'Reilly: The witness is very welcome, and her answers have been extremely informative. As Deputy Daly has pointed out, there are of course thousands of women in this State who owe a debt of gratitude for the provision of services that we simply cannot access in this State.

The witness is saying, on the issue of the provision of abortion pills, that the absolute best scenario is that treatment is delivered as close to home as possible for the woman herself. Speaking practically, the necessary pills could be provided by a nurse; there would not need to be any level of specialist skills. A GP could do it. One need not work in the area of obstetrics-gynaecology. Is that the case?

On the issue of conscientious objection, the witness referred to work that she had carried out in the United States where she provided a full range of health care. The master of one of our maternity hospitals was very clear about what a full range of health care is for women. In the facility where the witness provided that health care was there accommodation made for a person who might have a conscientious objection? The issue is often raised by people. I am sure that accommodation can be made, but I would like the benefit of the witness's experience.

Dr. Patricia Lohr: To be clear, in the UK at the moment a nurse may not prescribe abortifacient medications. She or he may give those medications under the direction of a doctor. A doctor must prescribe the medications and then the nurse or midwife may administer those medications and manage the abortion through to aftercare. It is absolutely the case that nurses, midwives and GPs can do this safely. What they need to do is understand the medications in the same way that they would understand any other medication they would provide, including the indications, the contraindications, the side effects, the potential complications and how to manage them. It may not even be the case that a GP himself or herself would have to manage all of the complications. They could work, for example, with a hospital setting. If a woman needed a surgical evacuation for incomplete medical abortion they could work with a colleague to provide that if it was not provided in their office, although as I have said it is safe to provide early vacuum aspirations from an office-based setting.

It is normal to provide for conscientious objection no matter where one is working in obstetrics and gynaecology. In fact, it is protected within the abortion Act for the treatment itself. Individuals may enact their conscientious objection to participate in abortion treatment, but that does not absolve them from participating, for example, in the management of complications of abortions. That has been the case in other places where I have worked, where I was providing the full range of women's health care.

Chairman: I appreciate the Deputy's brevity.

Senator Ned O'Sullivan: I welcome the witness and thank her for the clarity of her responses. I join with recent speakers in acknowledging the service that her agency provides to a great number of Irish citizens, women and their partners, service which for a range of reasons are not available here.

I want to clarify an area that was covered by Deputy Bríd Smith. On the matter of Irish women having surgical abortions, 71% compared to 28% for female residents in England and Wales, am I correct in assuming the 72% of English and Welsh concerned opt for the medical option for reasons of perceived safety or just for convenience? As a corollary to that, if there is a safety factor, would it be of concern to Dr. Lohr's agency that such a high percentage of Irish women are not able to avail of the medical procedure? To take it a little further, would Dr.

Lohr - it is difficult logistically for many as it is a stressful time - advise women perhaps to stay a little longer? Whereas Dr. Lohr referred to the fact they liked to fly in and out of the UK on the one day, it is a big decision for people to take. I wonder if Dr. Lohr would encourage them to stay a little longer and, therefore, be able to avail of both options.

Dr. Patricia Lohr: I will take the latter one first. We do advise that women stay because the most likely time to experience a complication is in the first several hours or 24 hours after an abortion. We talk to women about how it is preferable to stay but the reality is that most women cannot afford to stay, and it may not only be for financial reasons. They cannot afford to be away for reasons of secrecy and stigma, to be unaccounted for.

The Senator also asked why so many women in Britain choose the medical option. The reasons are very varied. Some women perceive it as being safer because it is a non-interventional method of abortion. Some women choose it because it is readily available. It is offered in a number of locations. When women have an unwanted pregnancy, they would like to be not pregnant as quickly as they can and if they can avail of a medical abortion more quickly than a surgical abortion, they may opt for that in order to achieve the abortion more quickly.

However, as I said previously, there are aspects of the process and the characteristic of the method that also matter. It is non-surgical so they do not have to have an anaesthetic. They can pass the pregnancy at home or be with their partner. They just prefer that option to having to come into a clinic and have an interventional procedure which may be associated with an anaesthetic that they also do not want to be exposed to.

Senator Ned O'Sullivan: I thank Dr. Lohr.

Deputy Anne Rabbitte: I thank Dr. Lohr for her presentation earlier. I am seeking clarification more than anything else because many of the questions have been asked.

Perhaps Dr. Lohr could explain this to me. It is possibly a lack of understanding on my behalf but when a person presents for an abortion at one of the British Pregnancy Advisory Service clinics - I am just trying to tease out the idea here - is there the opportunity for scans or anything else like that, particularly for late pregnancy presentations? The reason I ask that question is that we had various speakers in over the past number of weeks who discussed the viability of the child in the womb. I am just wondering if the service looks at that. Dr. Lohr stated earlier, in response to one of the members who asked about fatal foetal abnormalities, that the service does not really record it. Does the service record it? My questions are about viability and scanning, and the crisis pregnancy management, particularly for a late presentation.

Chairman: There is obviously some electronic device near the Deputy. I ask members to be mindful of that.

Dr. Patricia Lohr: Every woman who has an abortion at the British Pregnancy Advisory Service, BPAS, has an ultrasound to ensure the pregnancy is intrauterine and to look for viability. When I say, "viability", I mean in early pregnancy because we provide miscarriage management and if we identify a miscarriage or a miscarriage in process, we would have a different conversation with the woman than if we were counselling her about an abortion. We also scan to determine the gestational age.

BPAS does not scan for anomalies. The women we treat who have been diagnosed with a foetal anomaly will normally have been referred in to us from a foetal medicine centre and it is not in our ability to perform those sorts of ultrasounds. I hope that answers the Deputy's

question.

Deputy Anne Rabbitte: I was merely curious.

Dr. Patricia Lohr: Deputy Rabbitt's other question was about crisis pregnancy.

Deputy Anne Rabbitte: Yes, particularly for late presentations. If a person has presented at 20, 23 or 24 weeks, and this goes back to the viability, does BPAS give her the opportunity of the conversation beforehand or do women come with a definite mind that they are there to have the procedure performed?

Dr. Patricia Lohr: Every woman has the opportunity to talk about her thinking about the pregnancy. Every woman is asked, "Have you made a decision about what you want to do with this pregnancy?" Every woman is given the opportunity to speak to a counsellor if she needs to have a more full pregnancy options discussions, and if there is any degree of ambivalence if she is unsure.

Senator Paul Gavan: I thank Dr. Lohr for the presentation. I have only two quick questions. The first is obvious, or perhaps not. Does Dr. Lohr's service experience high numbers of women from countries other than Ireland coming over to avail of its services?

Dr. Patricia Lohr: We see far fewer women from countries other than Ireland. Most of the women we see who are travelling from abroad are from the Republic of Ireland, but we do see other women. Senator Gavan has not asked this question, but they come for similar reasons - abortion is restricted or perhaps the gestational age is restricted in the country from which they come.

Senator Paul Gavan: Would Dr. Lohr give examples of the sort of other countries they might come from?

Dr. Patricia Lohr: We see women from Italy and some women from Spain. We also see women - usually, they are expats - who are living in the Middle East, for example, where they may not be able to access abortion care.

Senator Paul Gavan: Can Dr. Lohr give us a flavour of how access to abortion and the BPAS are viewed in Britain from a moral or a principle's based point of view?

Dr. Patricia Lohr: I am a bit biased because I am extremely proud to work for BPAS. We are viewed as a safe pair of hands for abortion care. We are viewed as an organisation which champions the ability of women to make decisions about when and whether to parent or carry a pregnancy. We are viewed as a fiscally responsibly organisation, as a charity. We are a not-for-profit organisation and because we provide good abortion services, we are seen as being experts in providing abortion care, particularly in the second trimester and for early medical abortion.

Senator Paul Gavan: I thank Dr. Lohr.

Chairman: I thank Dr. Lohr for her presentation here today. I am conscious of the time. The traffic could be bad and we really need her to get to the airport. I thank her so much for her attendance here and for the information she provided. We are grateful to her.

Dr. Patricia Lohr: I thank the Chairman.

Chairman: The meeting will suspend for five minutes.

Sitting suspended at 4.18 p.m. and resumed at 4.31 p.m.

Termination in Cases of Foetal Abnormality: Ms Liz McDermott, One Day More

Chairman: I welcome back the viewers who may be tuning in at home. I would like to extend on behalf of the committee a welcome to our witness for our second session this afternoon, Ms Liz McDermott. She is very welcome and I thank her for attending. She represents One Day More, the support group for parents who have received a poor prenatal prognosis for their babies. Is Ms McDermott happy to have questions asked of her?

Ms Liz McDermott: Yes, I am happy to answer questions if I can.

Chairman: If there is anything that you feel uncomfortable answering, please let me know. Would you like to make a presentation?

Ms Liz McDermott: Yes, I would.

Chairman: Please go ahead.

Ms Liz McDermott: I thank the Chair, Senator Noone, and the members of the committee for inviting me here today. I am a member of a group called One Day More, a support group that came about because of the experiences of parents who received a poor prenatal diagnosis for their babies, that they would not survive either until or for very long after birth, or that their babies had significant developmental defects or anomalies that would impact them for life. When we received the poor prenatal diagnosis for our children, some of us were fortunate enough to speak to someone who had gone through a similar experience. We found this emotional and personal support to be of enormous help and in the end it is what prompted the setting up of One Day More.

The experiences of mothers like myself and families generally in maternity hospitals varies from very good indeed to very difficult and disappointing. One mother was told at her initial scan that her baby looked like a Michelin man and was asked why she was persisting with a futile pregnancy. This was followed up at each of her antenatal appointments, when she was asked to consider abortion and had to keep refusing until eventually she was advised to pick a plot to bury her daughter in. This kind of language is very insensitive, as the committee will appreciate. This little girl celebrated her third birthday last week. Another mother who refused to abort her baby who had Down's syndrome was contacted after each hospital appointment to change her mind and consider abortion. She did not change her mind and gave birth to her daughter last summer. That experience was a very negative one for her.

Couples have also contacted One Day More after they came home from England having had an abortion and told us that if they had known of One Day More, they might have considered continuing with the pregnancy had they known there were supports and perinatal hospice care such as the kind we are offering and trying to develop. All of this shows how necessary these supports and efforts are and I think it is safe to conclude that many couples would not choose abortion if perinatal hospice care was talked about more than abortion.

Some medical experts try to reassure people that abortion would only be available to women who want it, not to those who do not; they and their babies would be given every care and support throughout pregnancy and birth. However, we can see from the experiences of women

who contact One Day More that they did not receive this kind of support. They were dealt with insensitively and felt like they were almost causing problems for the hospital in not going for abortion. Some of our members' babies died before birth, and some very shortly after birth. Thankfully, some of those children are still alive and many are thriving against all predictions and expectations.

There is a very important point to make about this, which is that medical prognoses can be inaccurate, wrong, and occasionally very wrong or wide of the mark. Doctors cannot always accurately predict outcomes and parents of sick babies can be amazed at how much better things turn out for their baby than was initially thought. Hope is a vital human instinct and gives us strength and support at difficult times all through life. Challenging pregnancies are really no different. One Day More exists to offer support and hope to parents of very sick and disabled babies before, during and after birth.

As well as providing direct support to parents, One Day More raises funds for better provision of perinatal hospice care. We also provide care boxes for families awaiting the arrival of their baby with a focus on making the time they have together as precious as possible. When death is expected, the experience is bittersweet but it is incredibly uplifting to hear families describe the wonderful memories their time with their baby gave them and how much love they all felt towards each other and the baby. Even babies who do not live very long can bring with them tremendous gifts which cannot be predicted or quantified but only felt by going through the experience.

The committee may not be aware of my own personal experience. I became pregnant with my son, John, in early summer 2002. He was my second child. All was fine as far as I thought and I felt okay, though very tired, having a very active two year old daughter. I had a routine scan at 24 weeks - I could not attend the appointment at 20 weeks, which is the more typical time for this scan - in mid-December 2002 and on that occasion the nurse said she saw something amiss. She saw what she described as "shortened limbs" and could not see hands, although she said that might be positional. My husband and I had to come back the next day for an in-depth scan and the committee can imagine how we felt overnight. It was a very traumatic and difficult 24 hours

The next day, we went into the hospital and a consultant obstetrician carried out a very detailed scan which seemed to take forever, but was probably about 20 minutes. He wanted to check everything out very intensely and take measurements. I remember just looking away from the scanning machine the whole time, facing the wall. I did not want to look anywhere near this machine. I was numb and very anxious. Afterwards he said these words which I will never forget: "I'm afraid it's a very serious abnormality. The baby's limbs haven't grown, there are two very short arm buds and I can't even get a measurement on the legs." He then showed us the pictures that he had saved and described in detail what he saw. I remember looking at the baby's face on the scan and thinking he looked like my husband, especially round the eyes. The doctor told us it was a little boy. He finished by saying: "He'll never do anything but lie on a bed. I am obliged to tell you that if you want to travel to England it won't be a problem." Obviously, he was referring to the time limits that applied at that time, that there would not be a difficulty, because of the abnormality. I remember instinctively replying that, no I would not go to England. I had just seen my baby's face and even though I had no idea how I was going to cope, I felt very strongly that I had no right to interfere with this child's life in any way. I just did not have that right. This certainty was instinctive protectiveness on my part more than anything else at that time, but it does not mean I was not extremely scared. I did not relish the

prospect of how my life and my family's life would have to change.

I recall that during my pregnancy I felt jealous of women whose babies were not going to survive - their babies were destined to die in the womb or shortly afterwards - because at least their stories had a beginning, middle and end. My story was not going to end soon and the future looked extremely uncertain and scary.

I had a number of friends who were expecting babies at the time. All of them were healthy, they had no problems and their babies arrived safe and sound. I felt very sorry for myself in the midst of them and almost felt like I was living on another planet. My bump attracted comments like "Gosh, you're so neat" or "I'm sure you're all thrilled to be having another baby". I heard Claire Cullen-Delsol refer to this kind of experience during pregnancy. I can certainly identify with all of those harrowing experiences and the feelings of isolation that all mothers with difficult pregnancies go through. I agree with Claire and with others who have called for much more antenatal care to be provided to women and their families when they have received a difficult diagnosis. The fathers are also affected. They do not know how to process their emotions or how to be. The situation may not be happening to them but they feel so responsible. As a country, looking forward, we need to invest in antenatal services, carry out research and provide for care.

I was very fortunate that I had support from family and friends, but I also pushed myself to stay connected to the world I lived in rather than go completely in on myself. That is a human survival instinct. When times are tough, one digs deep and one is frequently surprised by what one can cope with. It is only afterwards, looking back, that one asks "How did I cope with that?" One does cope.

I do not say this lightly, but we did not receive much in the way of support from the hospital, with one exception, namely, the "scan doctor", as we called him, who I had to attend separately from my own doctor. All the other medical staff appeared unconcerned about us and our baby. We just went through the motions and did what we had to do. We turned up to the hospital, kept all of our appointments and I was repeatedly scanned. I hunkered down and just wanted to get the birth out of the way.

I asked my consultant what would happen when John was born. He said that nothing would happen because there was no reason to think there would be a need for medical intervention and the birth would be treated like a normal birth. On the day that John was born, I went into hospital around 10 a.m. The doctor broke my waters and I went into labour. My husband and I were in a room and there was only a student midwife with us. A neonatologist who I think was a senior registrar, came in and spoke about our baby. He took a phone call while there and said "Oh yeah, weird case - no limbs". That is a typical example of the treatment we received. I was so focused on blocking everything out and getting on with having my baby that I said nothing. I restrained my husband from objecting because he was rather upset by that comment.

John was born just after 2 p.m. that day. My consultant told me about half an hour before John was born that he had to leave the hospital to see other patients in his consulting rooms if that was okay with me. At that point, I really did not care who was there because I felt very alone. I got the feeling that the consultant was choosing not to be present at the birth. It was not as if he was not leaving to deal with an urgent matter. He did not return to the hospital that day. I recall that he came to me the next day. I do not know if he ever went to see John. I will explain why I say that. I was separated from John after he was born and I do not recall seeing him for the rest of the time I was in hospital, which was about four days.

John was delivered by a doctor who I had never met before. Right after John was born, I recall seeing other doctors. I remember seeing a whole lot of people wearing white coats standing at the foot of my bed when John had literally only been born a few minutes before. One of them announced that the baby would be taken to the special care baby unit for tests. He was not sick and I recall that his APGAR score was 9. John was physically hale, hearty and healthy other than the physical abnormality. I was heartbroken that he could not be with me as I wanted to breast-feed him. I had let the hospital know that but they were just taking him away, I felt, in a way that just suited them rather than me. At such a time one is vulnerable and tired. These people were complete strangers and they looked serious and expressionless, so I did not challenge them.

John spent his first two days in the special care baby unit while I was in a room on another floor of the hospital. I do not quite know where I was; I was not in the typical maternity wing. I can only describe this as a horrendous time because no provision was made for me and John in terms of our comfort and privacy.

I remember that the weather was warm that April. The sun shone through the window of the special care unit and I had to sit on a plastic waiting room chair. Any woman who has had a baby will know that is not a very comfortable place to be for the first few days. I felt that I was in the way because there were lots of sick and premature babies around me. John was not sick or premature but he was in an incubator. I just felt that I was in the way. There was no nurse there for us. The feeding did not go at all well and I was very distressed by the whole event. I so wanted to give my son, John, an experience of closeness because he could not use his hands or feet to move or comfort himself at all. He just did not have them and I really wanted to bond with him. After two days, John was unceremoniously, and unannounced, brought down to me. Finally, we got some privacy and I was able to breast-feed him in peace and that went very well for ten months or so.

I remember that it was very awkward going into the communal changing room for nappy changing. I tried it a few times but silence fell as soon as I came in the door. All of the chat between the new mothers just stopped. So, I just did it in my room. I just could not deal with it really. Overall, I could not wait to get out of that hospital. I did not feel anybody was particularly nice to us except the one doctor who carried out the scans and who I went back to during my third pregnancy.

So, back to a vision for future prenatal and perinatal care. One Day More, Every Life Counts and organisations like Hugh's House represent concrete examples of reaching out to women with very poor prenatal diagnoses and prognoses. These efforts are a drop in the ocean compared with what could be achieved in the way of supports if our Government would undertake research and investment in these areas. Women who have gone through this know what it is like and what would help other women. They are a tremendous resource to tap into if there is a will on the part of the Government to really look at giving women meaningful support.

It is very disappointing to see that all through this process, and that of the Citizens' Assembly, and during the past five years or so, the only serious focus of political effort has been towards introducing abortion. Looking back, I can honestly say - hand on heart - that the experience of having my son in 2003 has had a hugely positive impact on me, my family and beyond. I could not have foreseen this at the time that I was carrying him but that is the nature of life. We cannot predict the future, how things will go, how we will feel or what help we might be able to get down the line. It is a mistake to plan these things out because we risk painting for ourselves a bleaker picture than what actually happens. That is a human tendency. We always

look at the dark side or the worst-case scenario. Doctors feel duty bound to provide that in order to avoid unrealistic expectations. It is very important, therefore, to have these positive supports there for women.

I would see the introduction of abortion as something akin to deeming people like my son as unworthy of legal protection before birth - removing his right to life. I fail to see how that could become a new definition of progress. Repealing the eighth amendment would amount to that. My story is not an isolated one. Every day, new stories about women and families feeling pressure to have abortions emerge. Some people will find it hard to believe the stories I have mentioned. However, pressure from hospitals and medical staff to abort babies with special needs does happen. It is sadly what happens to people; it is their experience.

I must ask why the medical system seems to want to encourage women to opt for abortion. If we do not acknowledge this as a reality, it will keep happening and the pressure will grow more intense and direct, particularly if abortion is legalised and takes place in hospitals and clinics here. This type of pressure must logically account for the current position in England where 90% of babies diagnosed with Down's syndrome are aborted. The figures for Denmark and Iceland are even worse and would be 100%. Abortion can happen at any time up to birth at nine months. I have read that such abortions can even happen during birth, for instance, in cases where the disability or defect has not been picked up antenatally and the woman states she cannot cope.

The provision of abortion is increasingly being questioned in other countries as people see where legalisation leads. Alternatives to abortion and support for women with difficult or unplanned pregnancies are also offered in these countries. However, because they do not have anything like the eighth amendment in place and abortion is widely lawful, they face obstacles and difficulties carrying out their work. Organisations which do life sustaining work are stymied and prevented from reaching out to women in a supportive way to give them the opportunity - not a choice - to keep their baby.

We can see from other countries that abortion is a large and profitable global industry. Its practice, standards and methods are not always women centred, as is claimed, but may be more about profit. Just last month, the Care Quality Commission in Britain issued a damning report on the abortion provider, Marie Stopes. It revealed that staff were being paid bonuses to encourage women to go through with abortions. The inspectors found evidence of a policy in all 70 Marie Stopes clinics in the country directing staff to contact women who had decided not to go through with an abortion, offering them a new appointment. This is tantamount to placing pressure on women to opt for abortion and is rightly causing people to rethink their support for abortion and look at alternatives which genuinely care for women and babies. This is just one of several recent scandals involving the abortion industry in England and elsewhere.

It is extraordinary that we are discussing having a referendum to introduce abortion and no committee is examining what abortion has led to in other countries. I am not saying this to disparage or offend anyone but because I genuinely find this extraordinary. A few years ago, a conference attended by a well known abortionist, Dr. John Parsons, was held in Britain under the title, Don't Mention the 'A'-Word. Britain is a country where abortion is viewed as okay. The title of the conference betrays that nobody likes to talk about abortion and it was referred to as "the A-word" for this reason. Dr. Parsons stated the following at the conference:

> When you are doing termination procedures, especially later terminations, you are exposed to a rather gross, destructive process dealing with bits and pieces of fetuses, which are

not very nice... That is why we are not keen on people observing abortions. I was recently asked if I would have a journalist join me at work, who wanted to write for *The Daily Telegraph.*

Deputy Lisa Chambers: I am sorry to interrupt but do I have an incorrect copy of Ms McDermott's presentation?

Ms Liz McDermott: This is additional material I have put together. I can read it into the record.

Chairman: That is fine.

Ms Liz McDermott: I can also make it available to members.

Chairman: That is absolutely fine. Please continue.

Senator Rónán Mullen: The Deputy's intervention was completely unnecessary given the experience of the committee thus far.

Chairman: As was Senator Mullen's intervention.

Senator Rónán Mullen: No, it was not. The intervention was a discourtesy to the speaker.

Chairman: I am chairing the meeting. I have asked the witness to continue and I am happy for her to do so. I do not want any interruptions, including from the Senator.

Ms Liz McDermott: Dr. Parsons continued: "After discussing with other people, we decided this was probably not a terribly good idea because it does not really help women who have got to make this decision to hear how unpleasant it is." These are not the words of a pro-life activist but someone who performed abortions as part of his career. When I first read Dr. Parsons's words, I could not help thinking about the abortion movement's repeated claim that women must be trusted to decide about abortion. If the movement really believes women can be trusted with this decision, which ends their baby's life, the abortion debate would and should be more open about telling women what happens to their baby during abortion and how the procedure is carried out. I reiterate that I am not raising these issues out of any disrespect for the committee but because I respect democracy and want complete fairness and openness in the debate.

Since 2012, there has been a working group on abortion established by the Government, two sets of exhaustive Oireachtas hearings and legislation in 2013. We had five Private Members' Bills introduced in the Dáil, a Citizens' Assembly and now another Oireachtas committee examining the issue, all of which have focused on broadening the grounds for abortion. None of these committees or debates focus on alternatives to abortion. Earlier today, the committee heard from the British Pregnancy Advisory Service, England's largest abortion provider. The Citizens' Assembly also heard from this organisation. Why has no space been provided to explore positive alternatives to abortion and hear from the many life care groups and service providers here and in other countries? What about wonderful projects such as Hugh's House, which provides a home from home for families of babies who are in hospital with potentially life-limiting conditions, or A Perfect Gift, a group of dedicated mums who prepare and deliver welcome baskets to families of all newborn babies with Down's syndrome, or Anew, an organisation which works hard to address the scandal and alleviate the problem of up to 20 homeless pregnant women living on our streets on any given night, which is scandalous? These are just

some of the initiatives already taking place to offer support to women and families experiencing challenging pregnancy related circumstances. They are initiatives that work to unite rather than divide society and they should be front and centre of any debate on the eighth amendment.

Speaking from personal experience, I agree with those who say abortion is an outdated procedure, which is being increasingly undermined by scientific knowledge about life in the womb and the humanity of pre-born babies. In the 50 years since abortion was legalised in England, nearly 9 million babies have lost their lives in a brutal and sudden way. This has caused a deep, hidden pain for countless women who were convinced by the sloganeering about choice that denies abortion has any adverse after-effects on women. The experience of many women who have experienced pain and regret for long periods, some of whom eventually seek and receive counselling and help to recover from their trauma, shows that the claim that abortion has no repercussions for women is untrue.

The eighth amendment on the other hand acknowledges the right to life. It does not claim to be its author - it protects it. Those campaigning for repeal of the eighth amendment do not seem to regard the right to life as inalienable and innate to every human being. Instead, they seem to wish to treat it as something granted or limited by the State based on a majority consensus on who falls within the categories of persons who are entitled to have their lives protected against all comers. If this is true, the State can also remove the right to life, which leaves all of us vulnerable at some stage of life to falling within a category of persons whom the State does not protect.

We must learn again what human rights are and that no one has the authority to grant or remove them from any human being. On World Prematurity Day last week, members may have heard a consultant paediatric cardiologist, Dr. Paul Oslizlok, explain on RTÉ the reasons there are more cases of complicated heart problems in babies in Ireland than in England, Scotland and Wales. His response to a question as to why Ireland's rate of operations is so high was revealing. He stated we do not have termination of pregnancy on the island of Ireland, whereas in England, Scotland and Wales these pregnancies would probably have been terminated. We can see, therefore, that our doctors have gained world class experience of paediatric heart surgery precisely because of the presence of the eighth amendment and we do not resort to aborting these babies. This expertise would most definitely be lost if the position were to change.

We have two paths ahead of us. If the eighth amendment is repealed or amended, we will deny certain unborn babies the legal protection to life. If we vote to keep the eighth amendment, we can and must commit to making Ireland a society worthy of the most vulnerable and defenceless members of the human family by fully resourcing the provision of high quality support and care for pregnant women during and after pregnancy in order that they will have the opportunity and confidence to keep going and know they will continue to be cared for and helped, irrespective of the challenges they may face. That is the end of my submission. I thank the committee.

Chairman: Thank you very much, Ms McDermott, for telling us your personal story. We appreciate that it is difficult for you to do so and we are grateful that you attended because many who would be of a similar viewpoint to you chose not to attend. We are indebted to you for attending.

Ms Liz McDermott: I was in two minds myself I have to say. I nevertheless chose to give a voice to this story.

Chairman: I think you did your side of the argument a service. We are grateful to you for attending here today.

Deputy Bernard J. Durkan: I thank Ms McDermott for attending and telling her story, which is a heart-rending one. Our hearts go out to anybody in that kind of situation. On the degree to which non-directive counselling was available to the witness, this is something we have raised in this committee on numerous occasions. The witness attended an Irish hospital and she referred to directive counselling towards abortion rather than non-directive counselling which sought to help her out in the circumstances in which she found herself. We note and accept the points the witness makes about that. How many such instances does the witness know of? Ms McDermott referred to the fact that there have been countless similar cases with abortion as the solution. Does she recognise that there may be some women in cases of fatal foetal abnormality, for want of a description, who may not be able to deal with the eventual outcome and trauma? Some people have the gift of being able to stand up to a situation, as the witness did, even alone, as it were. Some may not. How does Ms McDermott see that and how does she feel about the fact that some women who are pregnant and maybe isolated and alone and who might not have any counselling except of a directive nature might fear the outcome? What advice would Ms McDermott give them?

Ms Liz McDermott: I do not think we got counselling of any sort at the time. That was 2002. I would not describe it as counselling in the sense that there was nobody who stepped in and heard our side of things. On the day it happened I remember we asked if there was anyone we could talk to and the doctors and the staff looked around generally and eventually somebody went and got a chaplain because there just was not anybody. The doctor just said there would not be a problem going and he said he was obliged to give me certain information. He was performing that. It was not directive or non-directive. He was just complying with his legal obligations. When the Deputy talks about fatal foetal abnormalities, again that is a term that does not have a medical meaning and I think it is very important. It keeps being trotted out but it is medically meaningless.

Deputy Bernard J. Durkan: For the purpose of this exercise.

Ms Liz McDermott: Very sick babies or babies with a substantial abnormality are nevertheless babies, they have a life to live, and they are alive when they are being talked about. In so far as abortion being a solution to a life that is like that, again I have tried to say that not being able to deal with the eventual outcome is not something that can be predicted, and any woman in any kind of crisis pregnancy will feel frightened and will feel that she cannot cope. That is how I felt. I am not painting myself as any particularly strong member of society. I felt I could not cope. I often crumbled and was found in a puddle of tears in the corner of a room. My daughter was probably largely abandoned during that time.

That is why I think the answer to that dilemma is the provision of proper supports. At the time a diagnosis is given, right there and then there should be a pathway of care that is immediately activated for women and their families to support them and which does not describe their babies as anomalies or fatally ill. They are their babies, they have been pregnant, they have carried their babies, they have a bond and a relationship with them already and then suddenly all this information is coming at them kind of to turn away from that. I can understand why women feel that way and that abortion is the only way out and the only way that they are going to cope. However, that is the challenge for us as a country and I think it is one that people increasingly are coming to recognise, that we have to provide proper, meaningful and sustained antenatal support which women should not have to go looking for. That is how I would deal with that. It

cannot be predicted in advance that women are going to be able to cope with it or not.

Deputy Bernard J. Durkan: In the witness's case, she had the fortitude and strength to believe and her maternal instincts rose to the occasion. How does Ms McDermott see that other group of women who may not be able to stand up to the potential trauma, who may be frightened, and who may have no counselling of any description either? What do they do? How does she think we should treat them?

Ms Liz McDermott: I think we should be supportive of them. However, the reality is they are pregnant with a very sick baby. They have to be supported in some way. Even if they have an abortion, that is going to be a hugely traumatic experience for them. They will likely be quite far on in their pregnancies and abortion is an invasive procedure and can be quite a violent procedure for any woman to endure. She can feel very isolated in any event. That is the reality. We cannot take this away, we cannot itemise one experience, and I am particularly strong and I have a strong way of coping with things. It is instinctive for women to nurture and we do it physiologically. Our bodies nurture the babies when we are pregnant. They do not distinguish between the fact that they are sick or they are not going to live for very long. A woman's body does what it needs to do and a woman lives out of that place, very much on a physiological level, during pregnancy. That is why abortion is a very destructive and invasive procedure that interrupts entirely what the body and the mind want to do. Women must be dealt with very compassionately. I do not judge or criticise. I fully understand the fear that creeps in. That is the word that was used and was exactly what I felt at the time: huge fear. The challenge for the rest of society is to support, in a real and meaningful way, the woman who is feeling that. Her baby should also be supported in order that the baby's rights are upheld in all of this, and in order that she does not have to walk this walk alone, be it to an abortion clinic or through a natural labour at some point. Either way that baby is going to have to be delivered. There is a compassionate and humane way to do it, which I would say is the natural way, with all the supports. Sometimes that is a physical propping up of women and it should be constantly there for them rather than sending them on the lonely journey to an abortion procedure.

Chairman: I do not ever mean to rush the witness, and I am not, because I am very conscious that she is talking about personal circumstances, so I will try not to interrupt. However, I still have a time situation to manage, just to let her know that.

Deputy Jan O'Sullivan: I thank Ms McDermott very much for attending the committee meeting. It is really important that she has come and she has told us her personal story. We were all probably horrified at the cold way in which she and her family were treated in the hospital. That would certainly be a cause of concern to all of us here. I refer also to the experiences that she described in the beginning of her presentation around women being asked at each appointment to consider abortion and women being contacted after their hospital appointment to change their minds. Everyone present would view that as wrong and inappropriate. As Deputy Durkan stated, all counselling should be non-directive. There should be no attempt to make a woman make a decision that is not the one that is right for her.

My question is on this issue. Ms McDermott described that experience as well as her own, but that practice seems to have been at variance with medical guidelines. One Day More provided examples, although I only got them shortly before I arrived. They include the examples of Anna Kate, Grace and Laura. In each case, there seemed to be a more positive experience of the hospital's treatment. To what extent does Ms McDermott's group have information on the various ways in which people are treated in Irish maternity hospitals?

My next question is on perinatal care. We received a presentation in which that type of care at a particular maternity hospital was described. Everyone would be supportive of that as well as the case that Ms McDermott makes for high-quality support and pathways of care for pregnant women. In the experience of Ms McDermott's group, is there much difference in how women are treated by various hospitals? If so, what recommendations should our committee make in that regard?

Ms Liz McDermott: One Day More only hears the experiences that women relay to it. We are not in a position, and do not have the resources, to conduct meaningful research in hospitals. The Deputy is right, in that some people thankfully have a positive experience. They are given support and are not put under pressure. Increasingly, however, other people feel like they are being put under pressure. We do not have answers as to why. We can only report that it is happening based on what people tell us. On occasion, people even change hospitals because they cannot withstand the pressure.

The Deputy is right about this not being in line with medical guidelines. It is anecdotal evidence as reported to us, but we have no reason to doubt it. It should not happen. No hospital should treat in that way a woman who has stated her intention to continue with her pregnancy. That should be fully supported. Perhaps the problem is that there is an additional cost in the provision of perinatal hospice care within the antenatal setting. Hospitals must manage budgets and so on. I cannot say, but it is for the Government to inquire as to why women are going through this kind of experience. I am glad to be able to report that it is what they are going through. It should not happen. Where women have declared their intention to proceed, they and their families should be fully supported and their babies' lives, no matter how deformed or short lived, should be honoured and respected fully.

Deputy Jan O'Sullivan: I thank Ms McDermott.

Deputy Lisa Chambers: I thank Ms McDermott for attending. To join with Deputy O'Sullivan, I am disgusted to hear that Ms McDermott was treated that way in a hospital. It is not okay. There should be proper care, counselling and support for every family in that situation. I hope that it is not a regular occurrence. It is good that we got to hear that side of things.

Could Ms McDermott tell us more about One Day More? When did she get involved in the organisation and how many others are involved? How many parents does it represent?

Ms Liz McDermott: It was a coming together in a conversational way after discussing the issue of abortion and women's experiences. When people have a story like this one, they tend to meet eventually. It came about so as to determine what could be done to reach out to women in pregnancy. The One Day More name came from one of our members. She knew that her baby was not going to live for very long and she wanted to have one day more with him.

There are approximately 25 members. It is small - there is no head office or resources. We operate locally. We have managed to reach out to approximately 20 families. There are leaflets in hospitals as well as an online presence, so people can make contact that way or by phone. Much of our support is provided over the phone, given the geographical limitations.

We provide care boxes to hospitals containing blankets, hats and memory-making things, for example, footprint and handprint kits, as well as photo frames and baby books to read to a baby. There is a particular book called *A Gift of Time: Continuing Your Pregnancy When Your Baby's Life Is Expected to Be Brief*, which is available in a perinatal hospice care setting in

America and answers questions that people in this situation have. People tell us that the care boxes are valuable to them because they have heard a great deal of negative information from doctors and hospitals about the worst case scenario, what will happen and dire predictions. They love getting something that is a positive, a box that says, "Your baby is your baby", there is another way to perceive the situation and they can have time with their babies.

That is what we try to do. It is a grassroots, low-key group, but with will, resources and investment, it could become tremendous. It tries to feed into Hugh's House and other organisations like Anew to provide care. Some people who make contact after having abortions might need counselling. We put them on that road. We cannot provide it ourselves, but we try to support them at that point in their journey.

Deputy Lisa Chambers: I thank Ms McDermott. That was informative. It sounds like One Day More is doing fantastic work.

A lady presented to us a number of weeks ago. She was from a group that was searching for services in cases of fatal foetal abnormality. I realise that Ms McDermott does not accept that as a medical term but, like her, the lady told her story. I was moved by it and found her story upsetting. There were some similarities. She spoke about how she found people asking when the baby was due and their personal commentary on her bump, her and her baby extremely distressing. She had all of the guidance and support from her doctors and her family and everyone knew that the baby was not going to survive. She did not have the means to travel and, even if she had, travel was not an option because she had a young child. She said that she suffered from post-traumatic stress disorder following that experience. This is an individual who was not pressured and knew all of the facts. She is saying that the absence of choice has had a severe impact on her mental health. Does Ms McDermott see people's difficulty when dealing with such a situation? What would she say to a woman like that?

Ms Liz McDermott: I agree that Ms Claire Cullen-Delsol's story was extremely difficult to hear. We share that common ground. We had the bumps that people commented on and we did not have answers to give. It was traumatic. She had supports, but not of the professional kind. When I talk about support, I mean support in dealing with that kind of experience.

The Deputy is right about it being harrowing. When one has a difficult pregnancy, there is no easy way out. It is traumatic and painful and there is a great deal of emotion. However, in my experience, while after John was born I had moments of extreme sadness when I looked at him and thought of all the things he could not do, I had the consolation of knowing I was doing my best for him. This was his life and this was how it had to go for him. I do not like the idea of any woman suffering post-traumatic stress disorder, PTSD, and I think that is avoidable if she is supported properly and fully in the way she endures and suffers that. Part of this would be just going through one's pregnancy and facing the world and facing people.

I will tell the committee an awful story. My baby was nine days old, and I remember going around Superquinn, as it was at the time. I had him in a flat pram with a blanket, so all that could be seen was the head, and he was asleep. A woman - I did not know who she was; she was one of those ladies in supermarkets who loves coming up to new babies - came up to me, literally pulled the blanket back and just stood there in shock and said nothing. I felt so invaded. My privacy was invaded and I just ran away. That is people. We all have these stories and experiences. I think people like this kind of experience of people coming together to support one another. There is a kind of emotional propping up of one another that needs to happen, and women who have gone through these kinds of pregnancies can do that. I do not think abortion

takes any of that away, and the trauma and invasiveness of abortion can almost contribute to a worse mental outcome, perhaps. I do not have medical data to back that up, but sometimes people say they felt stronger because they did the right thing, did right by their baby and kept going with it. There is a strength to be derived from doing that, and that support is still the answer.

Deputy Lisa Chambers: I have taken up all my time. This is a very personal experience for each and every woman as an individual. I thank Ms McDermott.

Deputy Peter Fitzpatrick: I welcome Ms McDermott and thank her for her presentation and for sharing her thoughts with us. Many people remark to me that there is a real lack of support for parents who find themselves in unplanned and difficult situations in Ireland, and Ms McDermott's experience has proven this to be true. She spoke about the contrast between the two visions, as she sees it, for these parents. Will she talk to us about whether she feels we can provide the right support while introducing abortion as well?

Ms Liz McDermott: No, I do not think we can. I do not think those two care paths sit well together. The experience in England is that when abortion is an option, it becomes the default option, the expected option, and women can lose their choice and their freedom and can feel almost that people want them to have an abortion because it seems the easiest thing for everyone else and all round. If abortion is legalised in this country, there will not be the will to invest in anything that will conflict with it. People will go one direction for the abortion clinic in a hospital and another direction for all the perinatal hospice care. Those two things seem to me to be mutually exclusive, and it would be very difficult in a concrete, real way for the two to sit together.

Deputy Peter Fitzpatrick: Ms McDermott mentioned perinatal hospice care. She believes unnecessary abortions happen because people do not know about perinatal hospice care. That is a real tragedy for women and their families. How many people does Ms McDermott think are affected by this every year?

Ms Liz McDermott: It is hard to say because perinatal hospice care is patchily provided. In America they have recently developed this into a whole separate path of care, which is something the committee and the Government generally could look at.

Chairman: To be fair to the witness-----

Ms Liz McDermott: I am not at all an expert in this-----

Chairman: -----she has had an experience but she is not a medical expert.

Ms Liz McDermott: -----but I think the Deputy is right in saying many people do not know about perinatal hospice care. It really needs to be developed and advertised.

Deputy Peter Fitzpatrick: This is my last question. Ms McDermott says the eighth amendment acknowledges the right to life and that it does not claim to be its author, merely its protector. Will she elaborate on that?

Ms Liz McDermott: I meant that in the sense that the eighth amendment declares what this country stands for, that we uphold the right to life of all our citizens, all our human beings, unborn and born. There are circumstances in which medical intervention is required to save a woman's life, and we understand that. We understand that a woman may die in the event of her baby being ill or of her getting sick during pregnancy, but the eighth amendment is a posi-

tive, life-saving measure because it says we as a country stand for the rights of all our citizens. However, we cannot just have the eighth amendment and then leave women without the supports, and this is where we need to go forward. The eighth amendment has given some women a little time to come to terms with crisis or unintended pregnancies. It is a valuable tool for us to build on for the future to create a new vision for difficult pregnancies. Abortion is old. It is an old procedure and process and has created a lot of wreckage. We can do better, and the eighth amendment is a good starting point, but we need to provide proper supports.

Deputy Louise O'Reilly: I thank Ms McDermott for attending the committee meeting and sharing her very personal story with us. I know everyone very much appreciates it, and not one of us thinks it was in any way easy for her to attend here and do this. We are very grateful for the perspective she has given us.

It is true to say, and Ms McDermott echoes this herself, that every pregnancy has its own uniqueness and that every woman who is pregnant is deserving of support. It is fairly obvious from the picture Ms McDermott paints that that support just is not there. The word "patchy" probably does a service to access to perinatal hospice services in this country. It is a very generous description because such services are practically non-existent. To be able to provide women with a full range of care, such services should be in place.

I would like to try to build a picture in my head. Ms McDermott provided for us stories of people who are members of her organisation. Grace and - I will probably mispronounce this - Maite were born in Galway and the Coombe, respectively, but the papers do not say where Anna Kate, John Paul, Laura, Lily or Luke were born. Were they born in Ireland, as in, the Twenty-six Counties?

Ms Liz McDermott: Yes.

Deputy Louise O'Reilly: There is no uniformity to this. It happens throughout the country.

Ms Liz McDermott: Yes, absolutely.

Deputy Louise O'Reilly: Is Ms McDermott's organisation a 26-county or a 32-county organisation, or is it international?

Ms Liz McDermott: It is a 26-county organisation. It is very much local. We are typically based in Dublin. As I said, we are women who met and had this common experience. However, we would love to grow the organisation. We can contact people in the Twenty-six Counties.

Deputy Louise O'Reilly: The reason I ask is that some, though not all, of the stories, including Ms McDermott's, refer to very directive counselling, or whatever word one wants to call it. I have just two questions for her. First, will she bring us up to date on the experience her members have had in reporting this and how it was dealt with? That level of directive counselling is not provided for within the law. These are very serious matters. Ms McDermott talks about conversations that have happened within her earshot and she refers to women who felt, or were, compelled to abort babies. That kind of directive instruction should never happen and is not allowable. I imagine it made those women feel extremely angry and upset.

Would Ms McDermott not agree that any woman who chooses not to go down that road also has the right to feel angry and upset if she is prevented from making the choice that she feels she should? If a woman in this jurisdiction who simply cannot continue with a pregnancy is compelled to go through with it, would Ms McDermott not accept that those women also have

the right to feel angry and upset that they have been forced into that situation? Two wrongs do not make a right. It is not right to compel a woman to terminate a pregnancy, but a woman has a right to feel angry if she is compelled to continue with a pregnancy. We have heard descriptions and personal evidence from women here and from one woman in particular, Claire Cullen-Delsol, and the post traumatic stress disorder, PTSD, experienced, a very serious medical condition that can occur as a direct result of being compelled to continue with a pregnancy. Would Ms McDermott not agree that those women have the right to feel angry and upset just as other women do who feel they were compelled in any way?

Ms Liz McDermott: How they feel is how they feel. It is not for me to say if they have the right to feel that. I am no doctor but it has been reported that PTSD can be a consequence of having an abortion. It is difficult-----

Deputy Louise O'Reilly: I am specifically referring to evidence given to us about a woman who was suffering from PTSD.

Ms Liz McDermott: Fair enough. As I understood from Claire's experience, the whole pregnancy was very difficult for her. Perhaps the PTSD might not have happened if she had been better supported. Identifying the root cause of the PTSD as being her inability to access abortion conveniently and locally for her-----

Deputy Louise O'Reilly: I do not think convenience came into it, and I do not think that is-----

Ms Liz McDermott: She could not travel. I am not saying it was about convenience but that she said it was not possible for her to travel, as I recall. That meant she had to continue with her pregnancy. I think that is the point the Deputy is making. That awful experience that she had during her pregnancy gave rise or contributed to the PTSD.

Deputy Louise O'Reilly: She was being forced to continue with it.

Chairman: In fairness, the lady in question is not present and we have heard from her already. It is not a road to go down in that sense.

Deputy Louise O'Reilly: Will Ms McDermott reply to my first question, if that is all right?

Ms Liz McDermott: We are a small organisation and we do not have resources to say how abortion will or will not affect people and what people experience. I cannot point to research that has been carried out.

Deputy Louise O'Reilly: Ms McDermott might have misunderstood my question. She is in touch with these people as part of her organisation's work. Will she relate to us their experiences when they reported the directive counselling, which is clearly outside of the legal framework within this jurisdiction? It was clear, when I read the stories, that people were telling Ms McDermott and the organisation that they were in receipt of this directive counselling, which is not legal. What was the experience when that was reported and how that was treated?

Ms Liz McDermott: We do not keep a dossier. We do not take this information to construct a dossier to use against hospitals. If the Deputy is curious to know and investigate the fact that people hear this counselling, that would have to be done as an investigative process. People make contact with us either online or after they get a leaflet or a care box from the hospital. They tell us their stories and in the course of their stories, they say what they were told, what

they went through and that they do not know what to do. We are not there to start castigating hospitals. It is a point we make but we are there to support people going through this traumatic journey. We are not there to file a dossier but people's experiences suggest that medical guidelines and protocol are not being followed. While we are told that all supports will be given to pregnant women should they wish to continue with their pregnancy, that is not what women seem to experience, to our understanding, but we are not collecting data on this as such.

Deputy Louise O'Reilly: So they are not telling One Day More that they are reporting it?

Ms Liz McDermott: They are not reporting it. They are just saying at that time-----

Deputy Louise O'Reilly: They are not reporting it. I am conscious of the time. I thank Ms McDermott.

Ms Liz McDermott: We would advise medics please not to do this in hospitals. I hope the committee would take that into account.

Deputy Catherine Murphy: I welcome Ms McDermott. I had to step out to speak in the Dáil but I was here when she making her opening statement. Like others, I know it is difficult to come here and talk about a very personal story. From the word go, in order that Ms McDermott knows where I am coming from, I believe in the right to choose, including the right to choose to continue with a pregnancy and be supported with that pregnancy. I have to say that the language and sensitivity Ms McDermott talked about and her experience and the experience of others within the maternity services should be of concern to us all. It is interesting that when we had people in from the group Terminations for Medical Reasons, they made the point that one cannot change a diagnosis but one can change how people are treated. They would make different arguments from Ms McDermott but we need to say something with regard to how the experience in maternity hospitals has to change in order that people feel supported in the decisions they make. It would be very useful for us to hear what those changes would be. Our report will be intended to respond to a range of different things. I see this as an issue that should be very much something that is provided within our health system. What does Ms McDermott have to say about changes she would specifically seek in maternal services? I take the point about perinatal care. Most of that is funded by charity rather than the health service.

Ms Liz McDermott: That is a big question. Changes I would like to see include having a whole system put in place at the point of delivery of bad news to a pregnant woman so as to deal with it and provide support. That would require a big investment and considerable research. Consultation with families who have gone through this would be really useful, as would reaching out with an open mind and open views to everybody to contribute truthfully and honestly. I have tried to outline the negative experiences people have reported to groups like One Day More. My own experience was that when one is in the medical process and dealing with feelings about one's baby, one is also interacting with doctors. A person is just another patient number to them, part of a clinical process. It is not quite a conveyor belt but there is a slight element of that. One feels like one is in the way and causing trouble. All of that requires psychological and emotional support and another care pathway in order that one does not sit in waiting rooms with all the healthy pregnant women. There should be another system that would kick in. Considering the American model would be a good starting point for the committee. It would be great if that could be recommended to the Government and perinatal hospice care highlighted as an urgent requirement in order that women find out at the beginning what is going to happen and what the path ahead for them will look like. If that does not happen, women do not know what the road ahead will be for them but are looking down a very uncertain and scary path that

they have to walk on their own. Going for an abortion can seem not like a choice but, rather, the only option one can take at that point, which is the point of decision. If the perinatal hospice and antenatal support care package was put in place, it would hopefully render redundant the situation of having to abort one's baby. My desire is for women to have an option not to have to abort their babies because the country provides a world-class, very progressive modern and supportive system of care for them.

Deputy Clare Daly: I thank Ms McDermott for coming in. It is much appreciated by all members and I know how difficult it must be for her.

There has been much discussion of crisis pregnancies at the committee but there is no doubt that a diagnosis in the latter part of a wanted pregnancy that reveals a condition that will limit the life of the baby is utterly devastating. Ms McDermott presented very well that in those circumstances help and support are absolutely critical and there is no doubt that the State has failed people in that regard. People who have had such a diagnosis and chosen to continue with the pregnancy, as Ms McDermott did, may have received great solace from that and felt it was the right decision for them. All members have met such people and it is very useful that they give their testimony. We have met others who chose a different ending and felt the best solution for them, factoring in all considerations, was to terminate the pregnancy. Many of them told of getting solace from the experiences they had in Liverpool Women's Hospital or whatever place it may have been. There is no right answer to the issue but there is a right answer for each individual pregnancy. Is it not the case that the only way of respecting that is by allowing people to make the latter choice in Ireland, surrounded by supports and family? A change in the constitutional position will not affect the decision making of those who decide to continue with the pregnancy and will only alter the position for those who decide to end it.

Ms Liz McDermott: There is no right answer. To say that people want to make the right decision for themselves is to completely ignore the baby in all of this. It is a separate human life and it is very difficult to airbrush that life out of the narrative. Nobody can say with any real certainty what way things will go for a baby who is sick or results from a crisis pregnancy or whose mother feels very unsupported or cannot face having a baby at that time. Our legal system cannot provide for every eventuality and individualise our laws for that but it is incumbent upon us to support every woman. If we affirm the right to life of children in the womb, the pre-born, we are also supporting their mothers, fathers and families and it is incumbent on us to invest in that in a meaningful way. Ending a pregnancy is ending a life and that is an uncomfortable reality we try to skirt around. We do not like coming up against it but it is a reality. Sometimes I think about what would have happened if I had chosen to have an abortion, gone down that road and listened to the advice around me. A woman at a baptism party asked me had I not had a scan, by which she meant to ask why on earth I had the baby. A dehumanising language is applied to disabled people. We uphold equality and welcome disable people and support the Paralympics and Special Olympics but we do not support women who are facing into a lifetime of caring for those children. I sometimes think about what it would have meant if I had chosen to have an abortion and get rid of John. I would not have had to move house or look for a special car and it would have made life far easier in many ways but I would have missed out on him rolling over at four months and smiling at me and his getting up at nearly two years of age and starting to walk across the floor, which I never expected. It was a complete surprise to me that he could do that. It is not just my family and I who would have missed out but also the wider community. I have brought with me a poem John's sixth class teacher wrote for him when he was leaving. It is called "Ode to John". The teacher is not a man who usually writes poetry. It is an astonishing testament to the life of John McDermott. He is not mine to

do anything with and I cannot get past that. Many people in this country think the same way.

Deputy Clare Daly: Nobody would seek to delegitimise the decision Ms McDermott made and the person who implied that to her was completely wrong. Does Ms McDermott not recognise the very tragic testimony of people who made a different decision and felt it was the best decision for them? Many of the points she is making are about women feeling pressure to abort. I have been involved in this issue for a long time and have never met anybody who felt pressurised into having an abortion but I have met plenty of people who decided to have an abortion, most of whom were satisfied it was the best decision for them. Some have regrets. I have met people who put their children up for adoption and had regrets about that but it was their decision. The only way of respecting everybody's decision and supporting them is to change the legislative position.

Ms Liz McDermott: I understand why some women opt for abortion and why it would seem the best thing for them to do at the time. I am trying to say that one cannot make that call at that time. I could not have known how John would impact on me, my family and many others in many ways. It is not possible to say it was the best thing because one cannot know that. One has bracketed out any other outcome. Having a baby is a good and positive thing. Women have possibly become a bit afraid of it because it interferes with our careers and there are issues in terms of a lack of supports for women going back to work. All those things can come crowding into one's mind when one is pregnant. We have to face up to the fact that people decide to have abortions and there is such a thing as abortion regret and some people have experienced serious amounts of emotional trauma that they did not expect after an abortion.

Deputy Clare Daly: The clinical evidence that has been presented to the committee does not support that view. In most instances, women are satisfied it was the right decision for them. The committee has heard evidence of that from Professor-----

Ms Liz McDermott: I do not disagree but there is other evidence out there. Perhaps the studies that have been done are slightly slanted.

Deputy Clare Daly: All present would agree that the lack of perinatal care and the problems in our maternity services are issues that come up quite a lot. However, the shortcomings Ms McDermott has highlighted exist in Ireland now in the context of the eighth amendment being part of the Constitution. The situation is bad now, when we do not provide for abortion in Ireland. Why does the witness think that if we provided for abortion things would get worse or that there is any link between the two things at all?

The reality is that 170,000 Irish women travelled for abortions, mainly to Britain, since the eighth amendment became law. If we acknowledge that that reality exists, and those people do not have a right to determine their own pregnancy, what is the solution? Should we compel them to continue with the pregnancy? How do we deal with that when many of them say that it was the right decision for them? If we recognise that that was genuinely their decision, do we say they should be compelled to continue the pregnancy? I would like to grapple with that question. I sincerely thank Ms McDermott.

Chairman: I can understand why you ask the question, but it is a difficult one for the witness to answer.

Ms Liz McDermott: We come at the problem from different perspectives, philosophically. Deputy Daly, in principle, supports abortion as a procedure and a solution to a crisis pregnancy

or problem pregnancy. I do not see it as a solution to anything, because when someone is pregnant, she is pregnant. One cannot turn the clock back. It does not make her un-pregnant, and it is certainly a harrowing event for her baby, who is still her baby. I know that there can be all sorts of circumstances and I am not trying to judge anybody in this.

However, I would say that abortion becomes an industry. There are people who have vested interests in making abortion available. There is profit in all of this too, and that can lead to a certain amount of pressure on women. I do not want to get into an ideological debate with members on this, because I am not qualified to answer all of these questions. We either uphold the right to life and apply it to all our citizens, regardless of whether they are at the beginning of life, at the end of life or sick during life, or we start to qualify it. We bracket out certain cohorts, or we say that it is not for us to say who has the right to life. I say this with all sensitivity. I understand the difficulties women in particular are in.

Deputy Clare Daly: I wish to clarify that I do not expect Ms McDermott to have the evidence. I know she is not medically or legally qualified, and that is not undermining her. However, we do have to take evidence into account. Ms McDermott said that abortion was a violent procedure, that it was a harrowing experience for the baby and that if people knew what it was they would not choose that option. We must be careful. The evidence would contradict that view. The medical evidence is that a foetus does not feel pain until after 24 weeks. We heard testimony of many instances of fatal foetal diagnosis where people who went to Liverpool had the baby delivered and were able to hold it, and they got solace from that. Of course, in the early stages, an abortion is just like a heavy period. That is uncomfortable, but it is not violent.

Chairman: I thank the Deputy. We will leave it there, because we have heard a lot of that evidence in the committee and the witness is not here as a medical expert.

Deputy Bríd Smith: I thank Ms McDermott for her evidence, and I would like to thank the parents in the seven moving case histories that were presented to us. I would like to move straight from the personal onto wider questions about Ms McDermott's charity. One Day More is a charity properly registered with the Charities Regulator, is it not? Does the group engage in fundraising?

Ms Liz McDermott: Yes.

Deputy Bríd Smith: I am astounded that in her testimony Ms McDermott spoke about some of the parents being told that their pregnancy was futile, that the foetus was like the Michelin man, or that in the case of a baby who had Down's syndrome, the parents were constantly contacted after each hospital appointment, to try to make them change their mind and have an abortion. Has Ms McDermott never dealt with a parent who would make a complaint to the Irish Medical Organisation, the management of the hospital or the Garda about this sort of harassment? If she has not, does she think that encouraging these people to complain, so that this type of treatment is dealt with, would be a good role for her charity? Everybody would find it quite shocking that any parent would be treated in this manner. That is one question.

Moreover, Ms McDermott spoke about the abortion industry, and how its for-profit nature puts another pressure on people to have an abortion. I know she does not want to get into a big philosophical discussion about it, but would that logic not tell her that abortion should therefore be free, safe and legal, so that there is no profit attached to it? The corollary of what Ms McDermott is arguing is that abortion should become a maternity or reproductive service that women can avail of.

I would like Ms McDermott to comment on the fact that her group is angry about the way hospitals have treated these parents, and the discussion about how badly they were treated is what brought them together, yet they do not seem to complain about it.

I would also imagine that Ms McDermott is very angry that this Government and other Governments have not signed up to the United Nations Convention for the Rights of Persons with Disabilities, that they continue to cut special needs services for children in schools, and that we have over 3,000 homeless children. I wonder if her charity is engaged in fighting those kinds of things, and in trying to improve those aspects of society for the children that are actually born. I am really interested as to why they do not complain about the treatment that is meted out to them as parents.

Ms Liz McDermott: We are there to support parents in their pregnancy. Lots of people asked why I did not write a letter to complain about the hospital and the treatment and tell the whole story. I have to say, whenever it happens to a woman, she just wants to be away from it. She just does not want to go back there. One is too upset at the time to even say the words. This happened to me in 2002 and 2003, and I am finally able to talk about it without getting upset. That is a real reason people would not want to jump up and down and make an official complaint about it. They are very vulnerable. However, it is important for there to be somewhere for people to go with that experience. I agree that if it can be collated into some kind of submission to hospitals to clean up their act and desist from this kind of pressure, that would be important. However, on the Deputy's point that we should make abortion safe, legal and free, it will be very expensive. In the UK, where abortion is supplied on the National Health Service, over £750 million of taxpayers' money has been paid to private sector abortion clinics since abortion was legalised. The boss of Marie Stopes received £420,000 as a salary in one recent year alone. That is four times the UK Prime Minister's salary.

Deputy Bríd Smith: I am sorry for interrupting the witness, but they are private clinics. When I say free, safe and legal-----

Ms Liz McDermott: This is taxpayers' money being used to-----

Deputy Bríd Smith: Ms McDermott is missing my point. When I say free, safe and legal, I mean provided for, the way it is under the NHS.

Ms Liz McDermott: Ireland is not as rich a country as the UK, and if the UK is not fully funding free abortions to women, I do not see how Ireland is going to be able to provide-----

Deputy Bríd Smith: They are fully funding it. The problem is that they use private operators, but that is not my point. What I am actually asking Ms McDermott is this. She complains about the abortion industry because it is for-profit. Would the logic of that complaint not mean that it should not be for-profit, that abortion should be provided as a service?

Ms Liz McDermott: The Deputy mentions a not-for-profit basis, but very lucrative salaries are paid to the people who work in the sector. We are not going to be able to provide it for free. When I say profit, I mean that it is very profitable, and it is incentivised. Marie Stopes was criticised for looking for employees to be paid bonuses. That inevitably brings pressure to bear on women.

Deputy Bríd Smith: Ms McDermott is making my point for me.

Ms Liz McDermott: The answer is not therefore to make it free to everyone because there

is no possibility of making anything free. Everything has a cost.

Deputy Bríd Smith: No - to the woman who is looking for the abortion, it is free. My-----

Ms Liz McDermott: It still has to be taxpayer funded.

Deputy Bríd Smith: Absolutely. But so-----

Ms Liz McDermott: If it is taxpayer funded and the salaries are hefty, then it is going to be a big burden on the taxpayer, is it not?

Deputy Bríd Smith: That does not make sense because the consultant who saw Ms McDermott when she was pregnant would also be paid a hefty salary.

Ms Liz McDermott: Yes, and he was paid by me as well, not to attend the birth.

Deputy Bríd Smith: And paid by Ms McDermott as well. And he treated her so badly he should be complained about to the medical organisations that look after these things. My point is, given that One Day More is set up with charitable status, I assume it is registered with the Charities Regulator.

Ms Liz McDermott: But to support women - we are not out to get doctors or attack hospitals. What we are there to do is to provide emotional support to women who are going through a pregnancy and who need to get through the system. We do not-----

Deputy Bríd Smith: I absolutely get that but what-----

Ms Liz McDermott: I am not going to be quizzed on "why don't you do this or that". That is for other people to take up. We do what we can and we fit it in around our own lives.

Deputy Bríd Smith: I absolutely get that but I just really would like Ms McDermott to address the question. Would it not be a big help to the women she comes across if consultants who behave in this manner were reported for doing so? Would that not be a big help?

Ms Liz McDermott: Yes. All we can do is suggest that they might do so; what I was saying is that when it is happening to you, you just want to be - you cannot deal with that kind of thing. It is just impossible.

Senator Rónán Mullen: I welcome Ms Liz McDermott. We are two thirds into the process of the committee and today is the first time somebody who is in favour of the eighth amendment had a platform alone, so to speak, with a session devoted to them. What she has had to say is just so radically different from everything that has gone before. It is so noteworthy.

To correct one thing, Deputy Daly was picking Ms McDermott up on issues around pain and the question of whether abortion is violence. Actually, we have had very scant discussion about the question of foetal pain and I think no discussion about the question of the different types of procedures used. We have certainly had nothing diagrammatic or that would allow us to quiz for ourselves how violent or not abortion is at different stages. That is one of the many things that this committee has turned a blind eye to so far. Perhaps before the end there will be some discussion.

The reason I picked up the fact that Ms McDermott was interrupted - and I think that was also a first - is that while it may not have distracted the witness, I find that type of thing extremely disruptive and I lost what she was saying about Dr. John Parsons. I would be grateful

if she would repeat for us what he had to say.

While Ms McDermott is looking for that, I might also ask her another question. There has been some talk about directive counselling and whether people in One Day More should report it. I am not so clear, to be honest, about what is illegal in these situations. For example, a doctor might say, "I feel obliged to tell you that it would be legal if you were to have an abortion in England." I understand Ms McDermott is a lawyer. I am not sure there is such a legal obligation but that would be interesting if there was. We have a Constitution that actually protects the unborn.

Ms Liz McDermott: I think it was the provision of information, back then, about the availability of abortion.

Senator Rónán Mullen: Everybody here seems to agree that it would be wrong to suggest a decision to go to Britain. I think Deputy O'Sullivan talked about "necessary non-directive". Even that is very undefined. I did not succeed in getting the HSE crisis pregnancy programme representatives last week to define directive counselling. We have a Constitution that protects the unborn. Ms McDermott has been very eloquent about how she could not have foreseen how she could cope. That is one big plank of her argument about why abortion should not be provided. I think I am not misrepresenting her when I say she also believes that John, in her case, had rights irrespective of how she felt. Is that correct?

Ms Liz McDermott: Very much so, yes.

Senator Rónán Mullen: If that is the case, then, that there is another human being who has rights in this situation, does Ms McDermott think that the whole area of directive counselling needs to be re-imagined? If we have a Constitution that protects the unborn, ought doctors not to be encouraging people, instead of leaving a cold choice and saying, "It is up to you; we are going to wash our hands of that particular decision."? That is not the way doctors act in other areas. They act to try and protect people's health and promote their wellbeing. I do not want to lead the witness. She must tell me if this is not her view. Is it her view that doctors ought to be suggesting or at least encouraging people to go with the life of the baby, even in very difficult situations?

Ms Liz McDermott: I think there is certainly an experience of dehumanising which can happen. Phrases like "anomaly" and "fatal foetal abnormality" - to describe human beings in that way is insulting. I think what the Senator is asking is if there genuinely can be non-directive counselling if we are putting abortion on the table and if we have a Constitution that forbids abortion and upholds the right to life of the unborn, should our counselling therefore be directed towards that. Yes, I would agree. I think doctors are in a difficult position. The provision for the availability of information about abortion is a fine line for them to walk, perhaps. They would know experientially that women do travel to England and they do not want to appear to be judgmental or, in other words, to tell a woman what to do. That is the dilemma we are in.

I heard it said that we have an abortion service and we outsource it to the UK. We do not provide abortions other than on the very limited grounds of the 2013 Act. I would love for more women not to feel they need to make that choice. Deputy Daly said that most women are happy to make that choice. I have to say I have encountered women, and groups that I have worked with have encountered women who say: "I do not want to do this but I have no choice." That might be because they have no practical supports, they have nothing ahead of them, the boyfriend is not interested or whatever. There can be myriad things. In terms of directive coun-

selling I think doctors should be encouraged and they need to be almost given permission to be more definite in the encouragement that they give.

It meant a lot to me to have the scan doctor actually come back from Arklow - I think he was doing a clinic there - to see me in the hospital. He said he had just been up in the baby unit and had seen John and that John was lovely. It was a humanising and compassionate interaction and it meant so much to me. He was the only one in the whole structure of that hospital. It was like the rest of them just felt they just could not go near this. I think there is an awkwardness that exists.

Senator Rónán Mullen: Supposing Ms McDermott's vision and mine, as it happens, does not prevail, and the State withdraws legal and social support for these very sick babies in these situations, would that lead to more people having abortions or terminating the pregnancy? Does Ms McDermott think it would impact on the culture? Does she foresee any other consequences?

Ms Liz McDermott: Very definitely. The data would show that when abortion is legalised it is very difficult. The committee has heard the medical experts saying that they want really rather flexible legislation because it is very hard to put women within certain categories if the State legalises abortion in situations A, B and C-----

Senator Rónán Mullen: Is Ms McDermott talking about anomalies?

Ms Liz McDermott: Well, anomalies or rape and incest, these kinds of things. If we introduce a flexible or wide-ranging abortion service, in other countries where that is the case I think the abortion rate settles at something like one in five, generally. That is not just in the UK but in most other countries. We have about one in 20 currently. It does not take a mathematical genius to see that one in five is an awful lot more than one in 20. I think it is inevitable that there would be more abortions and that certainly women would, perhaps as a knee-jerk reaction - I can understand why they make that decision - but they would opt for abortion because the supports are not there to continue on. It is not just during pregnancy but throughout life. If a woman has a child with a disability, there must be a proper level of support and care provided. However, that is costly. There must be buy-in from the whole country. It is not a vote winner. It is not a politically attractive thing to do.

Senator Rónán Mullen: Will Ms McDermott read out Dr. Parsons's comment for us?

Ms Liz McDermott: Yes. The Senator asked me for that. The discussion is titled, "Don't mention the "A"-Word". This is what Dr. Parsons said. I think I was halfway through when I was interrupted.

> When you are doing termination procedures... you are exposed to a rather gross, destructive process dealing with bits and pieces of fetuses, which are not very nice... This is why we are not keen on people observing abortions. I was recently asked if I would have a journalist join me at work, who wanted to write [about this] for the Daily Telegraph. After discussing with other people we decided this was probably not a terribly good idea because it does not really help women who have got to make this decision to hear how unpleasant it is.

My point is that we are keeping the truth from women.

Chairman: I am very sorry to interrupt, but there is a vote in the Dáil so we will have to suspend the meeting. I hope members will come back. I do not think there is any point in starting another contribution now.

Sitting suspended at 6.11 p.m. and resumed at 6.30 p.m.

Business of Joint Committee

Chairman: I wish to read into the record a letter from Dr. Abigail Aiken dated 21 November 2017 in response to a number of statements that were made in this committee:

Dear Senator Noone,

Thank you again for the opportunity to present the findings of my research to the Oireachtas Committee on the Eighth Amendment. I have followed the work of the Committee since my appearance on October 11th and wish to thank the members for their continued thoughtful consideration of the issues at hand.

A particular result from my research on early medication abortions obtained in Ireland using online telemedicine was discussed again at the Committee meeting on November 8th. I believe that there was some confusion about how to interpret the results of the bar chart showing the feelings women reported after completing their abortions. It is very important for your further discussions and deliberations on the mental health implications of abortion and the need for counseling that this chart be interpreted correctly. I would like to provide some brief further clarification for the Committee.

The most important thing to understand is that the chart reflects the number of times each feeling was reported (expressed as a percentage), and not the number of women who reported each feeling in isolation. It is not accurate to say that "46% of women expressed negative feelings". If you were to read the chart that way, then you would also have to say that 174% of women expressed positive feelings, which clearly makes no numerical sense. The reason you cannot interpret the chart as though these feelings were expressed in isolation is because most people reported more than one feeling, and thus the percentages sum to well over 100%.

To help the Committee make these statements accurately, I have re-run the analyses to express the results as the percentage of women reporting three broad categories of feeling: 1) negative feelings only; 2) positive feelings only; 3) a mix of positive and negative feelings. The results show that: 7% of women reported only negative feelings, 66% of women reported only positive feelings, 27% of women reported a mix of both positive and negative feelings.

It is critical to recognize that negative feelings occurred much less commonly that [sic] positive feelings, and also that the vast majority of negative feelings were accompanied by positive ones, most commonly relief and satisfaction. I think it would be considered very normal for a woman who feels relieved or satisfied about her abortion to also feel some sadness. But such feelings cannot be equated with serious mental health concerns, nor can we claim that these women necessarily need counseling.

It is also important to understand that we cannot necessarily attribute any of these feelings solely to the abortion itself because for these women, the circumstances under which they obtained and conducted their abortion were often very stressful. For example, a woman who reports feeling disappointed may be disappointed by the abortion, but equally, she may be disappointed in the way she had to go about obtaining the abortion under Ireland's

current laws.

Finally, it is also worth considering the feelings of these women prior to their abortions. Given that 100% of them voluntarily sought early medication abortion, it seems reasonable to conclude that their feelings regarding their unwanted pregnancies were overwhelmingly negative.

I thank the Committee for their attention to this matter and hope these additional data provide useful clarification.

Sincerely,

Abigail R.A. Aiken, MD, MPH, PhD

Sitting suspended at 6.34 p.m and resumed at 6.37 p.m.

Termination in Cases of Foetal Abnormality: One Day More (Resumed)

Chairman: I welcome our witness back to the committee.

Deputy Kate O'Connell: I thank Ms McDermott very much for coming here today. I know how hard it is for her to tell her own story. I completely understand that it is only now - after 2002 - she is able to come here to do so. I am sure that at times it is very difficult. How is John now? I believe that no one has asked this of Ms McDermott today. In the last session Ms McDermott gave us the poem from the sixth class about John, but I am assuming he is with us still.

Ms Liz McDermott: He has moved on and he is 14 years old now.

Deputy Kate O'Connell: He is 14. Is Ms McDermott caring for him at home?

Ms Liz McDermott: Yes. In fact I left him on his own doing his homework when I came in here.

Deputy Kate O'Connell: I just thought it might be important that we acknowledge that John exists.

Ms Liz McDermott: I thank the Deputy. He does.

Deputy Kate O'Connell: I would also like to point to the issues that Ms McDermott dealt with at the time of his birth and some of the lessons that can be learned from that. There are aspects that have been brought up at the Oireachtas Joint Committee on Health in respect of the national maternity strategy and the ten-year Sláintecare report about the provision of maternity services in Ireland. The witness may not be aware that new HSE national standards for bereavement care to ensure clinical counselling services are being rolled out to support all women, even in the cases of a miscarriage, an intended termination of a pregnancy or a late-term miscarriage. This is in the pipeline and there is recognition, on behalf of the Minister for Health, that this is an area we have not looked at before. I just wanted the witness to know this as a positive out of all this.

Ms Liz McDermott: I am glad to hear that.

Deputy Kate O'Connell: I also take on board some of Ms McDermott's points about anomaly scanning and getting that letter to book. I remember getting my own letter for the anomaly scan and genuinely not really knowing what that meant. When I had a not-great experience at that scan, I learned very quickly what it meant. My experience is at odds with Ms McDermott's experience. When I had a diagnosis for my first child of complex physical birth defects - not of a fatal foetal abnormality - which was my second pregnancy, no one pressurised me into anything. Like Ms McDermott telling her story, I distinctly remember such details of that day; I remember what I was wearing, I remember what the doctor was wearing, I remember the weather, I remember the heat, I remember the face of builder I met when I was going out.

Ms Liz McDermott: It is because it is such a significant day.

Deputy Kate O'Connell: Yes. It was a significant day and I will never forget it. I remember asking the consultant a very straight and direct question. I am prone to asking direct questions. When I asked if this was grounds for a termination - I had not discussed this with my husband who was sitting beside me - she said "No" but when I asked if I could have an amniocentesis so I might know what I was dealing with her answer was that that was no problem. My experience was completely different. At no point of my journey did anyone suggest to me that I would be better off starting again and so on. That never was the case. I did not have a fatal foetal diagnosis, rather I had a complex physical defect, possibly combined with genetic defects, that would have lead to a fatal foetal diagnosis. I am not trying to diminish Ms McDermott's situation. My situation turned out to be very positive in that my child had no genetic defect and is now alive and seven years old. Throughout that process, I was assisted by doctors in one of our leading maternity hospitals in keeping my son alive in the best *in utero* conditions possible. For example, I ensured I had the best possible healthy lifestyle and that I took adequate rest because as we all know the longer the child remains *in utero* the better the outcome.

Ms McDermott mentioned Dr. Oslizlok, the paediatric heart surgeon in Our Lady's Children's Hospital. In my experience as a pharmacist - as my pharmacy is open late and located near a maternity hospital I tend to have more experience in this area than other pharmacies - the diagnosis of cardiac conditions pre-natal are used to the benefit of the survival of the child. I am not a cardiologist. In the case of a diagnosis at 22 weeks of a chamber not forming correctly that information is used by cardiologists to monitor the pregnancy, by scanning every couple of weeks, to see if the situation improves. Often such problems rectify themselves. Also, it is possible to treat *in utero*. It is often argued that scanning and diagnosis leads to children with abnormalities being discarded. I would argue that scanning and diagnosis helps children survive because it allows all involved, including parents, to know what they are dealing with.

Ms McDermott mentioned to Deputy Chambers that they are 25 people in her group. Is that correct?

Ms Liz McDermott: Yes.

Deputy Kate O'Connell: Ms McDermott also said that she has no evidence that anybody has referred these people for counselling. To my mind, that is in breach of the law of this land. If there is repeated pressure being put on people, I have a problem with that. We heard at length from psychiatrists of how women can be vulnerable owing to hormonal changes that occur in pregnancy. What Ms McDermott stated is to my mind to take advantage of people. Perhaps when she next meets the group she would suggest to them that they retrospectively complain. As a Member of Dáil Éireann I am uncomfortable that people in vulnerable situations are being directed in a particular way by our hospitals.

Chairman: Deputy O'Connell has been speaking now for almost six minutes and she has not yet put a question to the witness.

Deputy Kate O'Connell: I believe in choice. I understand where Ms McDermott is coming from in that she made her choice and continued with her pregnancy and now has her son, John, who brings her great joy. I continued on my journey. Does Ms McDermott believe we should be compassionate to the people who might not be in as fortunate a situation as she and I were? Where a woman of 52 years of age finds herself pregnant with her fifth child and her husband has a problem with alcohol and her youngest child is in university, the situation is completely different. Would Ms McDermott agree that there is a spectrum of situations such that what might suit her or me would not suit everybody?

Ms Liz McDermott: There is a spectrum of situations. We cannot legislate for all situations. In legislating for abortion we are making a statement about life, namely, that life is contingent upon what particular people can deal with. That is a very dangerous line to cross. I have repeatedly made the point that women need support so that they do not feel that abortion is the only thing they can do to get themselves out of this reality. We cannot, unfortunately, make women unpregnant but we can put in place measures that will support and help them. I acknowledge that for a woman who is advanced in years, has put having children behind her and has moved on with her life, the road ahead in terms of pregnancy is not an easy one but it is not impossible either. That has been my experience and I want to share that with everybody. We also have to be mindful-----

Deputy Kate O'Connell: I understand. Does Ms McDermott believe there is any ground for abortion in this country? A "Yes" or "No" answer will suffice.

Ms Liz McDermott: No, I do not consider abortion solves-----

Chairman: The witness has been asked to a give a "Yes" or "No" response.

Ms Liz McDermott: I do not see children as a problem or a thing that needs to be managed or dealt with in that type of life-ending way. There are always more compassionate responses. I take the Deputy's point about needing to be compassionate to women. I am not seeking to target women. It is for society to put in place the supports which take women out of that choice situation. Sometimes, it is not that they do not have a choice. Deputy O'Connell and I were fortunate. We had opportunities that others do not have. We need to rectify that.

Deputy Kate O'Connell: Does Ms McDermott believe the enactment of the Protection of Life During Pregnancy Act 2013 was a good idea given she does not agree with abortion, ever?

Ms Liz McDermott: No, I do not think it was a good idea.

Chairman: The Deputy's time has expired.

Deputy Kate O'Connell: I would like to comment on a couple of points made. I am definitely not over Senator Mullen timewise.

Senator Rónán Mullen: People take a long time to get over me, generally.

Deputy Kate O'Connell: Reference was made earlier to nervous system development. It is stated in a medical research paper that I read - this information was also provided to the committee by experts in this area - that there is no nervous system development until 24 weeks and, arguably, 30 weeks. I just wanted to clarify that point.

Chairman: Thank you, Deputy O'Connell. The next speaker is Deputy Naughton.

Deputy Hildegarde Naughton: My question follows on from previous questions. I thank the witness for being here. She has spoken very articulately and it is important that the committee hears her viewpoint.

Ms McDermott made the point that women need support. We are all agreed that we need to do more in this country to improve our pathways to care for women when dealing with a crisis pregnancy, be it fatal foetal abnormalities and so on. In this regard, we need to ensure that they have proper supports, including counselling. Am I correct that in the case of a woman who obtains a diagnosis of fatal foetal abnormality, who receives all the counselling that is appropriate and required in that regard, and having discussed the matter with her partner, opts to not continue the pregnancy, bearing in mind that she planned the pregnancy and wants the baby, Ms McDermott does not believe that she should have that choice?

Ms Liz McDermott: I do not know that that has ever been the case. I do not know that that level of support is given and so it is impossible to judge-----

Deputy Hildegarde Naughton: I am being hypothetical. In that scenario, would Ms McDermott-----

Ms Liz McDermott: I am not going to get into that hypothetical situation. To reiterate a point I made earlier, there are two lives involved. As a country we have to balance, acknowledge and uphold rights and declare what those rights are. The eighth amendment refers to the equal right to life of mother and child. As for us having that view and acting upon it, I appreciate that many countries do not do that. They have a different perspective on it and make the rights of the child contingent on a range of other circumstances and people's say-so. If we support women and say their babies are important to us as a country and not just to them but that we are in this as a collective - there is a tendency to individualise and thereby isolate people, put them into little cells where one person says one thing and I say something else - how do we legislate or adjudicate the rights and wrongs in that? This is a collective and the common good must always be legislated for. When women are in extremely challenging circumstances, as happens, the supports need to be there. It is how one views abortion as a solution. Is it a solution? It is not really a solution for a baby. I come back to the point of the trauma of it being carried out, particularly if it is a late-term abortion, in the sense that women want these babies. We want our babies, think our babies are healthy and perfect and then find out they are not. They are very sick, will not survive or will be very disabled. We must form a new relationship with that baby. We cannot just say "well, this is a wanted child" because what is that child now? Our understanding of what that child is has changed because we now know that child is different from the one we had in our minds.

Deputy Hildegarde Naughton: This is where counselling may come in.

Ms Liz McDermott: Yes. Counselling can really bring someone to a point of saying this is the reality of who their child is. My child and the children of lots of other people with disabled children have revealed to them aspects of their personality and contributed to their lives in a way we cannot foresee.

Deputy Hildegarde Naughton: I agree with that but my question relates to the case where a woman felt she had gone through everything, discussed it, received all the counselling and supports that were there for her and felt that at the end of the day, she could not continue in the

case of a fatal foetal abnormality. Ms McDermott has expressed her point. I do not want to delay it. I think I have got the answer.

Ms Liz McDermott: That mother has to give birth in some shape or form. Is she giving birth to a baby in the natural course of its life or do we intervene and bring that baby's life to an end and then deliver a dead baby?

Deputy Mattie McGrath: Again, I thank Ms McDermott for coming in today. We were complaining earlier about people not coming in. That is their right but Ms McDermott has certainly brought the other side to the committee today and I am delighted to learn things about Hugh's House and A Perfect Gift. I was not aware of those organisations and supports. Some people say it is cruel to ask a woman to go through with a pregnancy if she really believes she cannot face it. Is that ever true in Ms McDermott's opinion? Does she think that is cruel?

Ms Liz McDermott: I think it is cruel to put pressure in any shape or form from whatever direction on a woman to abandon her baby. Babies are there and we are carriers of them. It is in our nature as women and we need to come back to that. I felt, as perhaps did others, that when your baby looks different to everybody else's baby or has lots of things wrong with him or her, you feel a bit judged and that you are somehow the parents of a child who is not ideal. That in itself puts pressure on parents. As for women who are on their own or who are older, I have heard older mothers say they felt like they were the grandmother in the antenatal class. There are all sorts of subtle pressures that women must endure during pregnancy. I do not like to talk about it in terms of it being cruel to force, and I do not even like the word "force", women to continue a pregnancy. When you are pregnant, you are pregnant and there is a baby there. As for the idea of forcing that to continue to its natural process, it is not a forcing question. It is about supporting the woman who has found out something new or has particular challenges to deal with. It is not about forcing or locking them up and telling them "you are not allowed to leave this room". It is about being compassionate and humane to both parties - both patients - and encouraging the woman to bond and believe in herself. Sometimes women say that they just need someone to tell them they can do this. Lots of people have abortions because nobody really said they would be there for them if they had the child. Lots of people told them that if they had the abortion, they would be there for them but they did not say that if they had the child, they would be there for them so there is a big burden on women to opt for abortion that is just subliminally in the air we breathe because it is a case of "well, why wouldn't you?". I am trying to change that perspective, attitude and approach to pregnancy and unborn babies. I do not think it is cruel. I do not see it in that paradigm but I think we need to support women.

Deputy Mattie McGrath: I did not use the word "force". I said "ask". Perhaps Ms McDermott can speak a bit about the harm that occurs when we continue to describe very sick unborn babies as having fatal foetal or life-limiting conditions or conditions incompatible with life. She knows that after a group travelled to Geneva and lobbied, and I introduced a Private Members' Bill, the HSE changed the language it used around this area. I was surprised that Ms Justice Laffoy allowed the use of the term at the Citizens' Assembly despite the HSE having issued guidelines. Could Ms McDermott elaborate on that?

Ms Liz McDermott: The language around children who have something wrong with them - language such as fatal foetal abnormality - cannot but dehumanise the baby and is disrespectful. It is also disrespectful to the parents of that baby because he or she is their baby. When I read about the 50 years during which the Abortion Act has been in place in the UK, I discovered that somebody wrote that the kind of language used in the House of Lords debates involved described disabled people as mongols, spastics and monstrous. Terms like "fatal foetal abnormal-

ity", anomaly or "incompatible with life" seem to be a slightly more subtle way of describing those children. As it is the 21st century version of that dehumanising language, that should not be allowed in any case. We have to call things by what they are and according to their nature. Terms like "baby with a lot of health problems", "baby who is not going to live for very long" or "poor survival" constitute the proper language that respects the mother of that child who is hearing it because it is hurtful. She is already stressed enough dealing with her pregnancy and its challenges. She does not need other people to hear her baby being described in a belittling and dehumanising way.

Deputy Mattie McGrath: Would Ms McDermott agree with a previous-----

Chairman: It is a point of clarification if that is okay, because the time is up.

Deputy Mattie McGrath: No, it is another question. We were told by an expert here some weeks ago that she felt the eighth amendment was damaging the mental health of every person in this State - man, woman and child. How is Ms McDermott's son doing now? Is he in secondary school? Ms McDermott might be allowed to read a poem if that is possible. I would like to hear it - later or any at stage.

Ms Liz McDermott: What was the Deputy's first point?

Deputy Mattie McGrath: An expert stated here that the eighth amendment was damaging the mental health of every person in this State - man, woman and child.

Ms Liz McDermott: Obviously, I do not agree with that statement and I do not see how one could medically verify it other than by interviewing every person in the State. We hear the other side - that people are alive because of the eighth amendment - so our mental health is not that bad.

Deputy Mattie McGrath: I asked about the little boy, who must be a big boy now.

Ms Liz McDermott: Yes, he is 14 now and in second year in school. He is very bright and popular and has a very full life. He is probably the most outgoing of all of my children. He faces his challenges. It is hard for me to talk about him because he is my son, but the poem his teacher gave me when he finished primary school taught me what other people, and not just me, get from him. He would probably cringe now if he knew I was reading this poem out. It will not win any prizes but it says a lot. The teacher writes:

John McDermott, what a guy,

Never afraid, not all that shy,

He inspires all around him from day to day,

Blue Steel surrounds him, come what may.

Modesty and brilliance wears well on his shoulders,

His friends will testify that he's strong as a boulder,

He is friends to all, both young and old,

Never a bad word to say, no matter how bold.

His work speaks for itself from year to year,

No challenge too big, the solution always clear,

His wit and humour delight his peers

Always there for his friends over the years.

John was born to discover and create

To feel inspired, never to imitate.

So please John, allow us to thank your eight years,

It goes without saying your leaving St. Mary's brings us all to tears.

Blue Steel is something from a cartoon, I think. I do not know about the members of the committee but I have never had a poem written for me. That is what John meant to this school and to other people.

Senator Rónán Mullen: On a point of clarification: I think Blue Steel is the intellectual property of Mr. Zoolander. The teacher obviously did not know enough-----

Chairman: I thank Senator Mullen for that very important clarification. I call on Senator Ned O'Sullivan.

Senator Ned O'Sullivan: I welcome Ms McDermott. I am very thankful that she came before us and she has certainly given us much to think about. I hope that her presence here and the reception that she has received from all of the committee members will encourage other witnesses who have declined our invitation to perhaps reconsider and come before us so that we get the broadest possible range of views presented to us. I am very glad to hear that John is doing so well. Ms McDermott's story has been both eye-opening and somewhat horrendous to me with regard to the degree of both direct and indirect pressure brought to bear upon her to terminate the pregnancy. The same would seem to apply to the other families' stories she also circulated here today. I am somewhat surprised that the One More Day group does not primarily focus on addressing this particular issue because, as previous speakers here have said, it would seem that some of the medical professionals in question were actually in breach of the law. One More Day has the knowledge and wherewithal to pursue this matter and bring it to the public. It is a sensitive matter for the mothers involved but I believe that such a move would do the State a great service. I would in no way, shape or form condone any attempt to coerce a woman into having an abortion; in fact I would condemn it outright. The only parallel I can think of in our society are the cases where women who wish to terminate in this country, in the case of fatal foetal abnormality for example, are forced to go full term. I wonder if Ms McDermott might consider that there is quite a strong connection between the pressure that she was put under and the pressure that a great many of women in this country have been put under down through the years and right up to the present.

Moving on to more general matters, I am not sure where Ms McDermott made the leap to reach her conclusion on the eighth amendment. I am at something of a disadvantage here because she did not include much detail on this leap in the document that was circulated to us. I tried to see the Blacks of the transcript during the interval but I just did not have time to do so. I thought that I had perhaps missed a page, which in turn meant that I was not able to really concentrate.

Ms McDermott's main message to us today concerns the eighth amendment. I can very clearly understand that she made a very strong choice. I am sure that it was a difficult choice but from what she has said, there was no hesitation there and I do not that think that the word "abortion" featured in her lexicon at all. She had a choice; she made her choice; it was the right thing for her to do and I support her 100% in that choice. Does she not think, however, that the same compassion should be shown to women who might make a different choice in equally difficult situations?

Is it fair of me to ask if the circumstances of John's birth informed Ms McDermott's views on abortion in general or did she have strong convictions about this beforehand? Has she always been pro-life by conviction or did this result from the unfortunate circumstances of John's birth? Has she been lobbying for the pro-life movement for the entire interim period? A previous speaker asked where One More Day stood on the Protection of Life During Pregnancy Act 2013. I am not sure whether the group adopted a position on that Act and campaigned on it. I am just trying to see where that particular leap came from so perhaps Ms McDermott might address this.

Ms Liz McDermott: I will respond to the question on my pro-life convictions, or otherwise. Like most people, I never thought about abortion very much because I did not need to think about it. I did not like the idea of it but I was certainly not in any way actively involved in pro-life politics or campaigning. When I had John and was confronted by abortion as a real option, I realised that I felt very strongly that babies are not choices for anybody else to make. Babies are separate human beings to whom we owe duties and responsibilities. We have, not rights over them, but rather duties towards them. At the time I reacted instinctively as a mother to want to protect my baby, who seemed more vulnerable than other children and perhaps more in need of mothering. That is why I was upset when he was unexpectedly taken away from me after birth. No care plan had been put in place for me that was sensitive to my needs and my desire to bond with my child. I would say then that my conviction that abortion is neither a solution nor a good path to follow stems from my experience of having gone through that journey.

The Senator asked if compassion should be shown to women who make another choice. I do not see babies as choices for us to make once they exist and once they are living and growing inside us. The choice over whether they are there or not and whether they live or not is not for us to make. We have to fall back on the question of what are human rights and who is entitled to them. We did not know much about life in the womb back when abortion was legalised in the United Kingdom, our nearest neighbours. We know much more now about the action and development in the womb in the very early stages, right down to the first 24 hours after conception. Science is catching up with the pro-life conviction when it now says that the human life starts at the beginning and is on a continuum. Does it have the right to life or does it not? I do not see that it is up to us to legislate for and qualify that. I do not have the authority to do this and nor does anybody else. We have human rights because we are human. That is it and that, as far as I am concerned, is the qualifier. I do not like the fact that women feel they have to make that choice. I would love to see a more compassionate system in place that says to them, "We value you and your baby too much. We love you too much to do that and we love your baby too much to do that, and we want to support you."

Senator Ned O'Sullivan: Does Ms McDermott not see the corollary between someone trying to force her to do something that was totally against her wishes in relation to John and the person who has no choice at present in this country about taking another decision?

Ms Liz McDermott: My experience was not that I was being forced to have an abortion.

There was a kind of a lack of care, a lack of concern, a lack of provision for me which is all I was asking for. I did not need to be supported. I had already made that decision. My husband probably had not at that stage but I took the lead on it, I suppose.

There is not really a corollary. When one is talking about choosing to honour the life of a child and choosing to take it away, I do not see that one can put those two on the weighing scales and say that the two are really the same argument in reverse because I cannot bring myself to look at any child, any baby, as anything other than human potential and a member of our society who needs to be protected. That is where I stand with it.

Chairman: I thank Ms McDermott. I have to move on to Deputy Rabbitte.

Deputy Anne Rabbitte: I thank Ms McDermott for her presentation earlier on. I am one for direct questions as well. Ms McDermott stated earlier on that she believed the child has equal rights to those of the mother. Is that correct?

Ms Liz McDermott: That is what the eighth amendment states. I would agree with that, yes.

Deputy Anne Rabbitte: Where the life of the mother is at risk, what does she believe along those lines?

Ms Liz McDermott: Risk is a wide-----

Deputy Anne Rabbitte: She could lose her life.

Ms Liz McDermott: With life at risk, if there is an emergency, there is cancer or there is something like that, of course, treatment must be provided to a mother so that she-----

Deputy Anne Rabbitte: Is there a choice to be made between-----

Ms Liz McDermott: It is not a choice. No, there is not a choice in that case because the treatment that the mother needs may or may not bring about ending the life of the baby. If she needs it, if there is some sort of rupture or a placenta praevia, or something like that of a dramatic nature, there has never been any question. It is not considered as abortion. It is life-saving treatment that a woman needs in that moment and there is no problem with that. I do not consider that as abortion.

Deputy Anne Rabbitte: All right. No, no, I just needed-----

Ms Liz McDermott: On risk, one can be asked to define risk. When it comes to mental health, it is too vague a thing. Professor Veronica O'Keane said it is very difficult for us to diagnose or assess or quantify the risk. What is the risk? How do we deal in percentages? I had the one-in-a-million child and then I went on to have a child who got leukaemia at the age of two and almost died. Percentages, risks and statistics are kind of meaningless and that is why I think-----

Deputy Anne Rabbitte: To me, they are not, to be honest with Ms McDermott. When I talk about risk to the mother, I think about the mother whose life is at risk and who could have three other children at home. That is the life of the mother. That is why I sit on this committee. I have sat here for the past number of weeks to welcome the people here to inform me. This is the one part I battle with. I battle with the life of the mother whose life is at risk because there are other children or family dependent on her. That is my biggest battle in trying to figure out

where this whole debate will go. Is Ms McDermott saying to me she agrees then that the life of the mother supersedes where the life of the mother is at risk?

Ms Liz McDermott: If it is directly at risk, if she is likely to die unless she receives medical intervention-----

Deputy Anne Rabbitte: Intervention, yes.

Ms Liz McDermott: -----it is a medical assessment. I am not in that position so I cannot say. My problem is that once one starts legislating for particular categories of risk and assessment, one just gets into very grey areas. In the grey areas, one can reach a situation which we have in the UK where the legislation still calls for there to be a substantial risk to the life or health of the mother but that is not what happens in practice because nobody can really quantify that. If a woman comes in and says, "my health is at risk", "my life is at risk", or "my mental health is at risk", no doctor will say, "well, I am not sure that it is."

Deputy Anne Rabbitte: No doctor will say that it is at present because, under the legislation, we have his or her hands tied. Legally, they are tied because there is a 14 year sentence for them to make a decision.

Ms Liz McDermott: I cannot comment. I do not know that many obstetricians have been prosecuted for the judgments that they make, and quite rightly so. It is a serious issue. Everybody and the legal system would be sensitive to the circumstances, but it is still important to have. If there is a flagrant breach of the legal requirements and medical best practice, I suppose the legislation is there for that kind of extreme situation that might kick in. To answer the Deputy's point, I am not a doctor and I do not have a problem with doctors making the call when they have to take action.

Deputy Anne Rabbitte: All right.

Ms Liz McDermott: I do not think that has ever been a problem.

Deputy Anne Rabbitte: I will ask another question, if Ms McDermott does not mind. When Ms McDermott gave birth to her beautiful son, John, did she give birth in Northern Ireland or southern Ireland?

Ms Liz McDermott: Southern Ireland.

Deputy Anne Rabbitte: That is okay. I thank Ms McDermott.

Deputy Jonathan O'Brien: I would echo everyone else's comments in relation to how Ms McDermott was treated. It is appalling that anyone would be treated in such a manner.

I also am one for direct questions. If it comes across as confrontational, it is not intended to be. I will say that upfront.

I question some of what Ms McDermott has put on the record of the committee here today. First, on Ms McDermott's comments in relation to Down's syndrome, Ms McDermott stated that 90% of such pregnancies in the UK are terminated. She went on to state that in Denmark the corresponding figure is 100%. Ms McDermott also went on to say that some such abortions happen during birth itself. I was just wondering if Ms McDermott has any evidence of that and, if she has, what evidence she is relying on in terms of the figure of 100% of pregnancies of children who are diagnosed with Down's syndrome being terminated.

Ms Liz McDermott: In Denmark, it is stated government policy to eradicate Down's syndrome by 2030.

Deputy Jonathan O'Brien: Ms McDermott said that 100% of children who were diagnosed with Down's syndrome are terminated in Denmark. I am just wondering what medical evidence she has. Where is the research that Ms McDermott came up with in that regard?

Ms Liz McDermott: In the statistics that come out, I think it is 100%. In Iceland, there has not been a baby with Down's syndrome born in five years.

Deputy Jonathan O'Brien: In Denmark.

Ms Liz McDermott: Apologies, I meant to say Iceland. In Denmark, their government strategy is to eradicate Down's syndrome by abortion by 2030. If that does not put pressure on women who have a Down's syndrome baby to abort-----

Deputy Jonathan O'Brien: Okay. Ms McDermott is willing to correct the record that it is not 100% in Denmark?

Ms Liz McDermott: I will correct the record, yes.

Deputy Jonathan O'Brien: Could Ms McDermott give me the-----

Ms Liz McDermott: I would like it read into the record that in Denmark there is a government policy to eradicate Down's syndrome by 2030.

Deputy Jonathan O'Brien: Could Ms McDermott give me the evidence where some abortions happened during birth itself?

Ms Liz McDermott: I have read that. I have come across that.

Deputy Jonathan O'Brien: Where has Ms McDermott read it?

Ms Liz McDermott: I have read it in various literature.

Deputy Jonathan O'Brien: Can Ms McDermott name one of those pieces of literature?

Ms Liz McDermott: I was just reading about David Alton talking about it. In the UK, he is a pro-life government Minister. I have not got medical evidence. I can get that for Deputy O'Brien, if he really wants me to.

Deputy Jonathan O'Brien: Would Ms McDermott be willing to pass it on to the committee?

Ms Liz McDermott: I would be perfectly willing to, yes.

Deputy Jonathan O'Brien: I want to get through as many questions as possible. Ms McDermott also stated that the abortion rates in countries where the setting has been liberal are much higher than those countries where it is restrictive. All of the evidence that we have heard before this committee, including evidence from the Guttmacher Institute, states that abortions rates, whether in a restrictive setting or a liberal setting, are comparable. I am just wondering where Ms McDermott got that research from.

Ms Liz McDermott: I was comparing this country, which has a rate of one in 20, with countries where abortion is lawful or where there is a liberal abortion regime, where the rate is

one in five. That includes the UK, America, Canada and various countries like that.

Deputy Jonathan O'Brien: We had a session at which we discussed abortion rates worldwide. The highest abortion rate, according to our evidence, occurs in Sweden, where it is 18 in every 1,000. The lowest is in Switzerland, where the rate is five in every 1,000. I do not know how that tallies with the 20% figure, or one in every five.

Ms Liz McDermott: These statistics are provided by governments. It is not from surveys or a slanted view. I do not have the data here.

Deputy Jonathan O'Brien: Will Ms McDermott pass on the data?

Ms Liz McDermott: Sure.

Senator Rónán Mullen: I can offer clarification at the end of the meeting. Those figures do not necessarily contradict themselves as like is not being compared with like.

Deputy Jonathan O'Brien: That is fair enough. Ms McDermott said she has experience of working with other groups, saying that some of the women she worked with in partnership with other groups had stated they did not want to do it but they felt they had no option but to obtain an abortion. What other groups has Ms McDermott worked with?

Ms Liz McDermott: I have worked with a counselling charity called Gianna Care. We tried to reach out to girls who think they want to have abortions and try to offer them supports.

Deputy Jonathan O'Brien: What about the Every Life Counts group? Has Ms McDermott worked with it?

Ms Liz McDermott: No.

Deputy Jonathan O'Brien: Okay. Does she know anybody who has done any work with it?

Ms Liz McDermott: No.

Deputy Jonathan O'Brien: Okay.

Ms Liz McDermott: I am not involved with every pro-life organisation out there.

Deputy Jonathan O'Brien: I was just wondering.

Ms Liz McDermott: I do what I can. I am primarily a mother raising my family.

Deputy Jonathan O'Brien: I understand that.

Ms Liz McDermott: I try to do what I can to support things in which I believe. I am here to share my story but I prefer to be on the ground, trying to give people constructive and practical help.

Deputy Jonathan O'Brien: I appreciate that. Ms McDermott stated that she is opposed to the Protection of Life During Pregnancy Act.

Ms Liz McDermott: Yes.

Deputy Jonathan O'Brien: The Act allows terminations where there is substantial risk to

the life of the mother. Is Ms McDermott opposed to terminations in those circumstances?

Ms Liz McDermott: The Deputy asks about where there is substantial risk to the life of the mother but in the mental health arena, this can be vague and nondescript. I do not want the Deputy to trap me into saying something. That is the way I am feeling, to be honest. I feel I am being entrapped into making a statement. I do not agree, in the mental health arena, that abortion is helpful to women in general.

Deputy Jonathan O'Brien: What about where there is a risk to the life of the mother?

Ms Liz McDermott: If there is a risk to the physical health and it is presented by a serious complication within pregnancy, an abortion, a termination or a treatment must be given that targets it. That is instead of deliberately targeting the life of the child.

Deputy Jonathan O'Brien: What about the risk to the life of a mother through suicide?

Ms Liz McDermott: I would have to say there is evidence that suicidal ideation is not solved by providing abortion and there are other ways to support women.

Deputy Jonathan O'Brien: My final questions relate to the right to travel, which is the 13th amendment to the Constitution, and the right to information, which is the 14th amendment. Does Ms McDermott agree with them?

Ms Liz McDermott: People have the right to travel to do anything. I am not in favour of curtailing the borders and preventing people from travelling. We are talking about what we have in place with our laws in Ireland. We cannot control what other people do and we cannot prevent people travelling to do whatever they want abroad.

Deputy Jonathan O'Brien: Are we not preventing people from doing what they want by forcing them to get on a boat and go abroad to get a termination?

Ms Liz McDermott: Nobody is forcing anybody to get on a boat or a plane to have an abortion. That is a choice made by women.

Deputy Jonathan O'Brien: It is a choice they do not have here.

Ms Liz McDermott: That is because we do not believe it is a good choice for anybody to make because it interferes with the life of the unborn, which is protected by our eighth amendment. I think it is a good thing.

Deputy Jonathan O'Brien: Ms McDermott says "we do not believe". I am sure that is the case for her but every expert medical opinion that has been presented before the committee would disagree with that analysis.

Ms Liz McDermott: Perhaps the committee just needs to hear from other medical people. If the committee has heard one side of the story, it needs to hear the other. That should happen.

Deputy Jonathan O'Brien: I am sure Ms McDermott has no regrets about the decision she made and had support from her partner or husband and family at the time. Will she try to put herself in the position of a very vulnerable young woman who may have had the same or similar diagnosis? Could Ms McDermott understand if that woman made a different decision and accessed a termination? One of the questions that has been asked of Ms McDermott by several members but which she has not yet answered relates to compassion. Does Ms McDermott have

any compassion for a woman who decides she just cannot go through with a pregnancy?

Ms Liz McDermott: Of course I have compassion for people like that. That is why organisations offer post-abortion counselling to people who struggle with their feelings.

Deputy Jonathan O'Brien: Those would be abortions they are not allowed to have in this State.

Ms Liz McDermott: If women have abortions, it does not matter where they have them-----

Deputy Jonathan O'Brien: It does.

Ms Liz McDermott: -----if they suffer afterwards.

Deputy Jonathan O'Brien: It does if a woman does not have the money and has to go to a moneylender or get into the height of debt. There may be shame and stigma and family members may not know. It makes a difference to those women.

Ms Liz McDermott: It does. I regret that this is the way it is and women feel such shame and stigma in Ireland. They also see a lack of support and poverty, and they may have to resort to moneylenders to do anything. It is incumbent on the State to avoid that.

Deputy Jonathan O'Brien: I put it to Ms McDermott that the shame and stigma arises because of how the State treats women through its health care.

Ms Liz McDermott: I disagree with that.

Deputy Louise O'Reilly: Ms McDermott referenced Gianna Care. Is that the same group that operates from No. 46 Dorset Street? Those groups were highlighted in an article in *The Times* and Ms McDermott might use the word counselling for what they provided. I do not think I would.

Senator Ned O'Sullivan: It was directive counselling.

Deputy Louise O'Reilly: Yes. They advised women there was a link between abortion and breast cancer. Is that the same group?

Senator Rónán Mullen: To clarify, that is an organisation called Ask Majella.

Deputy Louise O'Reilly: I am addressing-----

Senator Rónán Mullen: That is an attempt to trap-----

Deputy Jonathan O'Brien: It is not. It is an attempt to clarify a matter.

Deputy Louise O'Reilly: It was in No. 46 Dorset Street. I am asking if it is the same organisation.

Ms Liz McDermott: That is its office.

Deputy Louise O'Reilly: That is grand. It is all I need to know. I thank Ms McDermott

Ms Liz McDermott: I take issue with the Deputy's attempt to cast a slur-----

Deputy Louise O'Reilly: I am not trying to cast a slur on anybody. I was seeking clarifica-

tion that it was the same outfit highlighted in the newspaper.

Chairman: The Deputy got that.

Senator Rónán Mullen: It is an organisation.

Deputy Louise O'Reilly: Apparently it is.

Senator Paul Gavan: I thank Ms McDermott for coming today. We have all been very impressed by her story and it is great to hear John is doing so well. In particular, there are some very important messages for the committee to take on board with regard to the level of care and support that should be there for women who choose to continue with their pregnancy in challenging circumstances. Like my colleague, Deputy O'Brien, I am conscious of the time so I will offer a couple of direct questions to Ms McDermott. She should know it is not about in any way being confrontational. I was struck by a comment made by Ms McDermott just a moment ago. She said nobody is forcing anybody on a boat or a plane. As we speak, we know that at least 12 women are travelling to Britain for abortions. Why does Ms McDermott think they are travelling?

Ms Liz McDermott: They are doing so for myriad reasons, I suppose. Many of them would not be able to see a way of having their child. There could be a whole host of reasons why they would travel. I suppose for them to feel forced to travel means they feel forced to have an abortion. I think it is just getting into the whole issue of pressure and how we view people in difficult pregnancy situations.

Senator Paul Gavan: Surely, the reason they are on that boat or plane is that the State is saying it will not facilitate terminations.

Ms Liz McDermott: We are saying that we do not consider that terminations are appropriate medical care or health care for women and babies.

Senator Paul Gavan: So if they want a termination, is it not true to say they have no choice but to travel?

Ms Liz McDermott: If they want a termination, they are free to travel.

Senator Paul Gavan: That is one way of putting it but my point, coming back to Ms McDermott's original line that no-one is forced, is that she has conceded herself that they have no choice but to travel if their mind is set on a termination. That is true, is it not?

Ms Liz McDermott: Yes but we are talking about our legal system and we are talking about mothers and babies.

Senator Paul Gavan: It is more than that.

Ms Liz McDermott: If the Senator is ideologically disposed to saying abortion is a good thing, then let us just open it up and have open season and just strip unborn children of their rights altogether. Women have abortions for all kinds of reasons and a lot of those women and girls who travel do not have supports. That is why they travel. It would not be any different if they were having the abortion here. They would still be in that predicament. Whether she travels down the road or across the sea, it is the act itself, what is being done. Focusing on the geography of where that happens is missing the point.

Senator Paul Gavan: To take up the point that Senator O'Sullivan and indeed Deputy O'Brien made, Ms McDermott rightly spoke about compassion. She should have been shown an awful lot more compassion and support in her situation. However, there are women who desperately need compassion here at home, who passionately feel that they have to have a termination. We have had medical evidence, not from cheerleaders for the pro-choice side but from the Master of Holles Street and the Master of the Rotunda. These are people who look after our mothers and babies and feel just as passionately as Ms McDermott does and more so. The evidence they have given us is that they honestly believe from their experience that we need to allow for terminations in Ireland.

That does not square with Ms McDermott's point of view, and I get that. However, this committee has to make its judgments based on evidence. The evidence has been consistent. When we hear somebody like Professor Anthony McCarthy from the National Maternity Hospital describe a woman literally beating herself, beating her womb because she is so desperate to have a termination, I cannot understand the lack of compassion in that circumstance. To me, in that circumstance, I can fully understand why Professor McCarthy is so frustrated at having to say she has to go elsewhere, to England, and that he cannot even direct her to a hospital.

Ms Liz McDermott: I am not a medical practitioner, obviously, and I do not claim to talk for the medical profession and the situations they encounter. Do we legislate for terminations for babies just based on a woman saying "I do not want this baby"? That is a cultural shift in this country that I think is massive and we have to acknowledge that. I do not see it as compassionate treatment for the baby or for the woman, either. I see it as a violent act that harms a baby and harms the mother. She cannot know when she is pregnant. Sometimes - I do not want to diminish - I am not saying that women are not capable of making a proper decision - but our hormones are all over the place. We are extremely vulnerable to all kinds of things and our feelings can fluctuate from high to low to being all over the shop throughout pregnancy. I come back to women saying "I had the abortion and I came home and felt awful. I felt stripped of my child. I woke up and they were not there". It is only at that point sometimes that they feel the loss and they regret what they have done. What does the Senator recommend I do or any of us does to that woman? Do we say "well, actually, tough, you made your choice"?

Senator Paul Gavan: I am glad Ms McDermott raised that because I think it is the fundamental point. I do not think I am in a position to say to any woman what decision she should make in respect of her body and her health.

Ms Liz McDermott: It is not her body. It is not just her body.

Senator Paul Gavan: Can I please finish? By all means, Ms McDermott can then answer. This comes to the crux of it. Does Ms McDermott not believe that we should trust women on this issue?

Ms Liz McDermott: Trusting women to do something bad to their babies-----

Senator Paul Gavan: So you do not think we should trust women.

Ms Liz McDermott: If abortion was not harmful to women there would be no such thing as abortion regret. There would be no such thing as women turning to drink. Even in the case of well-known people, somebody like Stevie Nicks has said she had an abortion because the father did not care whether she kept the baby. Women are very vulnerable.

Senator Paul Gavan: I am a big fan of Fleetwood Mac but we are dealing with evidence

here and the evidence we have seen tells us that, actually, most women are fine after an abortion. I understand that is not Ms McDermott's perspective. My last question has, in fairness, been answered. Ms McDermott does not believe we should trust women on this issue, does she?

Ms Liz McDermott: It is not a question of trusting women or not trusting women.

Senator Paul Gavan: I think it is.

Ms Liz McDermott: I think that is skewing the thing. Women are being----- we take in messages from the environment around us that say "you are not going to be able to mind this child or cope with this". It is a kind of undermining of women and women feel very ill-equipped. All they can see as a solution to the predicament is abortion. They think, "at least it is done, it is over, there is a certain outcome to that, I will be relieved of all responsibility".

Senator Paul Gavan: With respect, that is the witness's own personal perspective and we get that.

Ms Liz McDermott: It is a factual thing.

Senator Paul Gavan: I do not think she could then extend it to say that is every woman's perspective. It clearly is not.

Ms Liz McDermott: Obviously people have different opinions.

Chairman: We are getting into the realm of speculation here. In fairness to the witness, she is not a medical practitioner. We are very grateful to her for attending here today. I really feel that she has done a service to the point of view she represents by turning up. I thank her for her presentation and for attentively answering all of the questions that have been put to her by the members. We really appreciate her attendance.

Ms Liz McDermott: I have tried. Could I just make a point of clarification?

Chairman: Sure.

Ms Liz McDermott: Deputy Bríd Smith was asking about the charitable status of One Day More. There is a new process. We are practically at the point of getting the charitable status applied but it is just a process that is ongoing. It has been applied for and is in the system.

Deputy Bríd Smith: Five years after it was set up?

Ms Liz McDermott: Yes. We have only applied for charitable status because it has become-----

Deputy Bríd Smith: I am just wondering if the process takes five years. That is all.

Ms Liz McDermott: No, we did not apply-----

Senator Rónán Mullen: The Deputy should bring in the Charities Regulator. She is badgering the witness.

Deputy Bríd Smith: I asked the question about it earlier on and the witness has made a point of clarification.

Ms Liz McDermott: We were not seeking charitable status initially. We were just there as a sort of an outreach, doing this. Then it became more firmed up and we got involved with other

things, and sought charitable status.

Deputy Bríd Smith: I thank the witness.

Chairman: Thank you for that clarification. Is there any other business?

Senator Rónán Mullen: I have a question. It has nothing to do with today's proceedings. I want to draw the attention of the committee to one issue that has been coming up, the question of directive counselling. I did not get satisfactory answers last week from the crisis pregnancy programme about where it is defined. Could we get our legal advisers to give us some help on this? What is the law in this country around directive counselling and where is it defined? Is it a crime? For example if, as Ms McDermott described, somebody is suggesting that a woman could go to England, is that illegal?

Chairman: I think that is a good idea, Senator.

Senator Rónán Mullen: I would really welcome some clarification on those issues.

Chairman: Perhaps we could seek written evidence on that and then address it with the committee's legal adviser when we meet her closer to the decision-making process. It is a good suggestion.

The joint committee adjourned at 7.40 p.m. until 2 p.m. on Thursday, 23 November 2017.