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1 Reproductive justice in Ireland: A feminist analysis of the Neary and Halappanavar cases

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Introduction

This chapter analyses two Irish case studies concerning reproductive justice and maternal health that raise serious ethical and legal concerns. These are, firstly, unnecessary hysterectomies that were carried out at Our Lady of Lourdes Hospital, Drogheda; and secondly, the case of Savita Halappanavar whose 17 week pregnancy ended in miscarriage and her death in University College Hospital Galway (UCHG) on the 28th October 2012. Even though these cases are very different from one another in many respects, they also share important similarities. They provide evidence of a profound unease with women's reproductive capacity; the influence of Catholic norms on healthcare practice, and; the denigration of women's moral authority, agency and professional credibility (sometimes by women themselves). These are two examples among many in recent times where these kinds of factors have led to the abuse and deprecation of women in Ireland (Walsh, 2013; McAleese,2013).

My feminist reading of these different situations draws attention to the power and power differentials inherent in moral relationships at individual, organisational and societal levels and adopts Margaret Urban Walker's feminist ethics perspective which she summarises in the following way:

> We welcome all relevant scientific data but believe that the social situations of both science and morals must be kept in view, paying attention to differences of social and institutional position, perspective, and power that determine which voices and whose interests and experiences are audible and authoritative in ethics as elsewhere (Walker 2009: 5).

Key to my analysis is a desire to understand the mechanisms by which the voices and concerns of the women at the centre of these two cases were ignored, marginalised and trivialised. I address each case in turn, paying particular attention to the way in which an excess of moral authority was vested in religious leaders, religious doctrine and doctors and a correlated lack of authority was invested in women patients and midwives.

Unnecessary hysterectomies at Our Lady of Lourdes Hospital

When a small number of young and newly trained midwives in Our Lady of Lourdes Hospital Drogheda brought their concerns about the high rate of hysterectomies being carried out in their maternity unit to the attention of authorities in the hospital and the Irish Health Board in 1998, they initiated a course of events that eventually led to the suspension and deregistration of Michael Neary, the consultant responsible for the bulk of these hysterectomies. The Government-appointed inquiry, undertaken by Justice Maureen Harding Clark, subsequently determined that many of Neary's gynecological patients as well his obstetric patients were subjected to unnecessary hysterectomies and/or oophorectomies (McCarthy et al, 2008). A brief excerpt from the Report describes the

experience of one woman and draws attention to the normalization of surgical hysterectomies in the maternity unit:

> Dr Neary asked her to attend as a day patient for a D&C. She was aware of the routine involved in a diagnostic D&C procedure.... When she woke in pain she knew something had happened. She learned that she had undergone a total abdominal hysterectomy with removal of her ovaries and fallopian tubes. Dr Neary informed her that he had to carry out a hysterectomy, as he "could not stop the bleeding". Later she was told that she did "not have any cancer". This was not a possibility that had ever been discussed with her. The histology reported no disease but rather "degenerate products of conception and a collection of endometrial polyps". The operation notes and the request for histology indicate that Dr Neary believed when he carried out the hysterectomy that she had advanced uterine cancer' (Harding Clark, 2006: 159-60).

Women's bodies, fertility and well-being

Evidence from several sources: the Harding Clark Report (2006); the transcripts from the Medical Council Fitness to Practice Committee (2000) and the court cases taken against Michael Neary paint a grim picture of the maternity services that were provided to many women up to and including Neary's tenure at the hospital (1974-1998). The Report notes how habituated health professionals had become to the hysterectomies themselves - one incident is recounted where a junior anaesthesist and midwife talked about a TV

programme while a bucket with a uterus in it was carried past – '[t]he normal curiosity for reasons why unusual outcomes happened simply did not occur' (Harding Clark, 2006: 160). The Report also refers to outdated practices such as midline instead of bikini line incisions, putting birthing women into the lithotomy position and rectal rather than vaginal examinations. The Fitness to Practice Committee of the Irish Medical Council cite one witness who alleges that in his response to her query as to why he had to remove one of her ovaries, Neary responded, 'I did not like your bloody ovary anyway' (Irish Medical Council, 2000: 144). The same witness notes elsewhere that Neary compared her to a car that breaks down and told her 'that if [she were] to see the bloody mess inside [her] he had to clean up' (Irish Medical Council, 2000: 146).

This attitude towards women was not exceptional. Discomfort and unease with women's embodiment and reproductive capacity is evidenced in the broader culture of the time as well as in the practices of Neary's colleagues. For example, in the 1970s and 80s, Gerard Connolly, the senior obstetrician in Our Lady of Lourdes Hospital prior to Neary, carried out the highly painful and traumatic symphysiotomy procedure, which involved enlarging the capacity of the pelvis by cutting through the pubic bone in cases where labour was obstructed, long after medical evidence demonstrated that a caesarean section was a safer clinical alternative. One of the reasons that caesarean sections were not favoured by Catholic run hospitals was because repeated caesarean sections were considered dangerous for women. Therefore, repeated pregnancies would be dangerous and would have to be avoided, prompting the need to use artificial methods of birth control. In short, many symphysiotomies were carried out, in order to meet religious, not clinical, imperatives (Institute of Obstetricians and Gynaecologists, 2012; Morrissy, 2012; Walsh, 2014).

Moral authority as religious authority

The proliferation and continuance of such harmful practices as symphysiotomies was due, in part, to the historical and ongoing influence of Catholic doctrine and authority on Irish law, education and medical practice. In the years after Ireland succeeded in gaining independence from Britain, the legislature, dominated by members who adhered to a Roman Catholic moral code, banned divorce (1925), prevented the dissemination of literature on contraception (1929) and the import and sale of contraceptives (1935). As Oaks (1999) points out, the focus of Irish legislation in this regard has been on women's reproductive not productive lives evidenced by the marriage ban in the civil service (eventually removed in 1973). In practice, these restrictions meant that many thousands of Irish women were, effectively, forced to have large families until the (restricted) legalisation of contraception in 1980.

The Harding Clark Report indicates that the Catholic religious sisters, the Medical Missionaries of Mary (MMMs), who ran Our Lady of Lourdes hospital until 1997, regularly appealed to church laws and doctrine and consulted various clergymen on clinical issues that raised moral worries for them. On the matter of hysterectomies, they were, in fact, out of step with other Catholic hospitals in that their hospital code of ethics did not permit sterilisation – tubal ligation - even if it was indicated on medical grounds for a serious pathological condition of the uterus. Only 'indirect' sterilisation, a hysterectomy that removed the 'diseased organ' was the accepted practice (Harding Clark, 2006: 42).

In one case recounted by Michael Neary to the Harding Clark inquiry, a patient asked him to carry out a medically indicated tubal ligation at the same time as a caesarean section. The patient had herself, prior to this, sought the views of a moral theologian who had advised that, in her case, tubal ligation was permitted as the primary intention was to prevent her death or serious ill health in a future pregnancy. Neary consulted the matron on the matter, who in turn consulted the MMMs. Unhappy with the advice of the theologian the sisters sought the opinion of a cardinal and a bishop. Both men argued that the tubal ligation should be refused. According to the bishop, '[t]he Church's thinking regarding this operation is very clear. It does not depend on circumstances nor on certain thinking among some theologians. One must seek the solution outside of direct sterilisation which can only be wrong in itself .... If we had exceptions we would not maintain Catholic standards. No diversity of opinion can be permitted' (Harding Clark, 2006: 244).

Consultant authority

While religious leaders were vested with moral authority to grant or refuse permission to clinicians to act on patient requests or their own clinical judgement, consultants too were able, within limits, to exercise their moral agency. In the situation, referred to above, Neary vehemently defended the woman's medical need for a tubal ligation. Further, in another testimony to the Fitness to Practice Committee, one of Neary's patients reports that remarking on her RC (Roman Catholic) status at the top of her chart, he admitted that 'according to Church law he should never have laid a finger on me. He had a pile of books on the desk. Slapping his hands on them he said "I did an abortion for you". He went on to say that I was ungrateful' (Inquiry by the Fitness to Practice Committee, 2000: 146). In both of

these cases, Neary appears to regard himself as acting on the basis of his moral conviction to benefit two of his patients. Moreover, one of the justifications that he offered the Inquiry for the significant number of the hysterectomies that he carried out was that they were prompted by medical concerns in relation to further pregnancies. These are described as 'indirect sterilisation' or 'compassionate hysterectomies' (Harding Clark 2006: 236, 244).

The moral authority of women patients and midwives

The question remains, what of the moral authority of the women patients[1] and of the midwives? The evidence demonstrates that the requests of the patients (some of whom, as Catholics themselves, appealed to the authority of some theologians) were ignored in favour of either church law or leaders, or, the occasional intervention by their doctor. Their questions about their 'treatment' were not answered; their concerns were trivialised; their voices were silenced (Medical Council 2000; Harding Clark, 2006).

Within such a system, the midwives were also constrained by pre-determined gender-roles/scripts that they were assigned and were expected to conform to, and by the power structures within which they operated. In contrast to the MMMs and the consultants in Our Lady of Lourdes Hospital, the midwives and nurses seemed to have little or no moral authority or space for raising moral concerns. Harding Clark notes:

> The sisters belonged to an era when nurses were efficient, ordered and respectful. They carried out orders and did not question consultants. Matron maintained a formal, distant authority over nurses. The nuns who had set the practices and

> protocols for training nurses and midwives in the hospital in the 50s thus produced suitable nurses who fitted their mould – hardworking, respectful, Catholic nurses who were well trained, knew their place, trusted the consultants and suspended their critical or questioning faculties. They were trained to certain tasks - and to those tasks only (Harding Clark, 2006: 41).

The Report notes that in reality, the Matron of the maternity unit did not have any power or authority to question the consultants. This lack of power meant that many midwives believed, rightly, that 'there was no point in complaining to her' (Harding Clark, 2006: 157).

Harding Clark describes a minority of the midwives in the unit as having no concerns about the consultants' activities and the rate of hysterectomy. They saw themselves as 'disempowered' by the consultants and in the role of 'handmaidens to the consultants'; their job was to 'anticipate the consultants' needs' (Harding Clark, 2006: 190). A second group, in the majority, were described as 'decent, hard-working caring women' who were 'deeply shocked', tearful when giving testimony, and blamed themselves for not suspecting anything. They knew and liked Neary, found him to be far more personable and approachable than others and believed that 'he never deliberately meant to harm anyone' (Harding Clark 2006: 190). A third group of mainly junior midwives, and a newly appointed part time practice development nurse and midwifery tutor were more critical according to the Report. They believed that peripartum hysterectomies were unnecessary in certain cases but they were not confident that their concerns were well founded because other senior midwives and even newly appointed doctors had made no complaint. This third group found no support among their colleagues – in fact they were admonished when they did raise concerns:

> Ann made her concerns regarding a caesarean hysterectomy carried out by Dr. Neary known to her colleagues immediately after an incident in theatre, where she questioned why she should "fetch the hysterectomy clamps". Her colleagues either did not wish to countenance such criticisms, or found reasons to disprove her perceptions (Harding Clark, 2006: 188-9).

The events at Our Lady of Lourdes Hospital raise serious questions about the lack of moral authority vested in women patients and midwives. A second case which highlights ongoing failures in relation to reproductive justice in Ireland is that of Savita Halappanavar.

The unnecessary death of Savita Halappanavar

Savita Halappanavar died in University College Hospital Galway (UCHG) on 28 October 2012 following on a miscarriage after a 17 week pregnancy. Ms Halappanaver self-referred to the gynaecology ward of UCHG on 21 October 2012. Initial assessment concluded that Ms Halappanavar was suffering from lower back pain and she was sent home. However, later in the day, she returned and reported 'unbearable pain' and medical records after clinical examination noted a diagnosis of 'an inevitable/impending pregnancy loss'. She was admitted to the hospital for the management of the inevitable miscarriage.

Ms Halappanavar's membranes spontaneously ruptured very early on 22 October 2012. She asked the health professionals caring for her if she could be induced in order to avoid waiting for the inevitable but she was told that nothing could be done as long as there

was a foetal heartbeat. Her condition continued to deteriorate over the next two days and she was diagnosed with sepsis on 24 October. She was then moved to the High Dependency Unit with the intention of inducing labour. However, on admission it was determined that she had already miscarried minutes before she arrived. During that night, her condition deteriorated and she was transferred to the ICU early in the morning of 25 October where she was immediately intubated and mechanically ventilated. Despite all efforts, her condition further deteriorated over the next few days and she died in the early hours of Sunday 28 October (MacLoughlin, 2013).

To date there have been three separate reports into the circumstances that lead to the tragic death of Savita Halappanavar: the postmortem inquest report of Dr. Ciaran MacLoughlin (2013); the Health Services Executive (HSE) Report carried out under the chair of Sir Sabaratnam Arulkumaran (2013a); and the Health Information and Quality Authority (HIQA) report (2013).

Gross inadequacies in basic care

All three reports point to gross inadequacies in the basic elements of Ms Halappanavar's care. The results of the post-mortem found that Ms Halappanavar's death was caused by septic shock associated with a miscarriage and chorioamnionitis and the inquest subsequently concluded that she had died as a result of 'medical misadventure' (MacLoughlin, 2013). The HSE report identified causal factors that contributed to the adverse outcome, including inadequate assessment and monitoring and non-adherence to clinical guidelines related to the prompt and effective management of sepsis. The HIQA

report concluded that there was 'general lack of provision of basic, fundamental care, for example, not following up on blood tests; a failure to recognise that Ms Halappanavar was at risk of clinical deterioration and a failure to act or escalate concerns to an appropriately qualified clinician when Ms Halappanavar was showing the signs of clinical deterioration' (HIQA, 2013: 10).

As important as it is to identify the many failures of care that Ms Halappanavar received, it is also profoundly important not to overlook the crucial fact that, as stated by the Clinical Director of the National Maternity Hospital, Dr. Peter Boylan in his report to the coroner, had Ms Halappanavar's pregnancy been terminated within the first two days of her hospitalisation 'it is highly likely, on the balance of probabilities, that she would not have died' (Boylan, 2012: 18). The fact that her membranes ruptured early on Monday 22 meant that her chances of developing sepsis increased exponentially and her continued dilation over the next two days practically ensured that that would happen.

The Coroner's Report, the HSE Report and the HIQA Report all acknowledge that the lack of intervention was of serious concern. The HSE Report concluded that one of the key causal factors that effected the adverse outcome was the failure to offer all management options to a patient experiencing inevitable miscarriage of an early second trimester pregnancy where the risk to the mother increased with time from the time that membranes were ruptured (HSE 2013a: 13). Specifically, the Report concluded that 'there was an apparent over-emphasis on the need not to intervene until the fetal heart stopped together with an under-emphasis on the need to focus appropriate attention on monitoring for and managing the risk of infection and sepsis in the mother' (HSE, 2013a: 73).

The law on abortion: the price of uncertainty

In order to understand the circumstances that lead to delays in Ms Halappanavar's treatment, one must understand the legal position in Ireland in relation to abortion. Two legal provisions are directly relevant to understanding what happened. The first is Article 40.3.3° of the Constitution (added as the 8th Amendment to the Constitution in 1983) which states that:

> The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.

This constitutional provision was interpreted by the Supreme Court in *Attorney General v X & Others* [1992] 1 IR 1 (the 'X Case'). The case concerned a 14 year old girl who had become pregnant as result of rape. The Attorney General applied to the High Court for an injunction preventing the girl from travelling to England for an abortion. In the High Court, a psychologist testified that the girl might commit suicide if she was refused an abortion. The High Court granted the injunction but its decision was overturned on appeal by a majority of the Supreme Court. Finlay CJ laid down the test to be applied in such cases as follows:

> I, therefore, conclude that the proper test to be applied is that if it is established as a matter of probability that there is a real and substantial risk to the life, as distinct

> from the health, of the mother, which can only be avoided by the termination of her pregnancy, such termination is permissible, having regard to the true interpretation of Article 40, s. 3, sub-s. 3 of the Constitution.

In brief, the Supreme Court found that abortion is legal in limited cases where there is a real and substantial risk to the life, as distinct from the health, of the pregnant woman, which can only be avoided by the termination of her pregnancy. The critical question for health professionals is how to determine what comprises 'a real and substantial risk'. In the 20 years since, up until and including the death of Ms Halappanavar, successive governments failed to bring forward legislation to give effect to the Supreme Court ruling.

The patient's voice

Ms Halappanavar, with the support of her husband, asked for a termination of her non-viable pregnancy on a number of occasions. When and how often she made this request is in dispute. The evidence of the inquest, the HSE Report and interviews with her husband, friends and some of the staff, suggests that she first asked for a termination on Monday 22 October and repeated the request on each of the following two days. The HSE Report states that Dr. Katherine Astbury acknowledged that, on October 23 Ms Halappanavar's husband had enquired about the possibility of inducing labour in order to avoid a protracted waiting time for an inevitable miscarriage. She also reported that she had advised him that this was not possible under Irish law. She indicated to the HSE investigation that the law was such that '[i]If there is a threat to the mother's life you can terminate. If there is a potential major

hazard to the mother's life the law is not clear .... [t]here are no guidelines for inevitable miscarriages' (HSE, 2013a: 72). Dr. Astbury's claim that the law was unclear was also supported by Dr. Peter Boylan, who told the inquest, '[t]ermination of pregnancy at that time [on 22 or 23 October] was not a practical proposition because of the law' (Boylan, 2013: 18). The HSE Report concluded that the law as it stands needed clarification as to what constitutes sufficient risk to warrant a termination:

> There is difficulty in interpretation of law in relation to "what constitutes a potential major hazard or threat to mother's life". This needs clarification. The consultant clearly thought that the risk to the mother had not crossed the point where termination was allowable in Irish law on the morning ward round on the 24th (HSE, 2013a: 72).

Moreover, the Report concluded that the investigation team 'were satisfied that concern about the law, whether clear or not, impacted on the exercise of clinical professional judgement' (HSE, 2013a: 76).

Moral authority: The rights of pregnant women and the rights of everyone else

In recent years, Irish healthcare providers and health professionals have become more sensitive to the values and preferences of patients and service users. This is reflected in government policy documents, professional codes of conduct as well as (draft) legislation on

capacity, advance directives and case law. Specifically, where there is any medical uncertainty in relation to the possible outcomes of interventions, the obligation on doctors is to acknowledge this uncertainty and to seek the views of the patients whose lives are at risk. The HSE National Consent Policy, for example, obliges doctors in situations where they are unsure of the outcome of resuscitation measures to seek the views of patients as to whether or not they want the intervention:

> In some cases, the health professional may be uncertain whether the potential benefits of CPR outweigh the risks. In these situations, the preferences and values of the individual are of paramount importance, and the health professional should acknowledge the uncertainty, outline the benefits and risks of each option, and assist the individual in coming to a decision (HSE, 2013b: para. 6.2).

Not so with pregnant women whose lives are at risk because of their continuing pregnancy. Even when there is a great deal of uncertainty, as in Ms Halappanavar's case, and the risk is very grave; pregnant womens' assessment of the uncertainty and their view of how much of a risk they are willing or able to take counts for nothing as against, supposedly, objective statistical probabilities and clinical judgement.

The lack of authority vested in pregnant women prompts an important ethical and legal question: what is the morally significant difference (if any) between pregnant women and other people that would justify treating them differently? The obvious difference is that a pregnant woman carries a human foetus in her womb and it could be argued that this

relationship places a particular kind of moral duty on her which would justify treating her differently. The warrant for treating her differently however, would hinge on determining the scope of this 'moral duty'. Laura Purdy puts it thus:

> The question before us is a special case of the most general moral question: what do we owe others? …. Several different levels of obligation are recognized, depending on the nature of the relationship between the individuals in question. Various types of agreements (marriage, for instance), as well as biological relationships (such as parenthood) raise our expectations of what is morally owed; the law tends to reflect this understanding (Purdy, 1990: 278).

Purdy suggests that the closest analogy to the relationship between a woman and a foetus is that between relatives. However, she points to several cases where the law has asked less of relatives and parents of born children than it does of pregnant women, including the case of *McFall v Shimp*, 10 Pa. D & C3d. [C.P. 1978] where a court refused to order involuntary bone marrow surgery on Shimp in order to increase the probability of his leukemic cousin McFall's survival. In a similar vein, Annas points out, 'No mother has ever been legally required to undergo surgery or general anesthesia (e.g., bone marrow or kidney transplant) to save the life of her dying child. It would be ironic, to say the least, if she could be forced to submit to more invasive surgical procedures for the sake of her f[o]etus than for her child' (Annas, 1982: 17).

In short, even if one were to grant the foetus the same moral status as a born child, a pregnant woman's obligations towards her foetus should be no more demanding than a parent's duty towards her child. And, if one holds, as many people do, that foetuses are not yet persons, then *a fortiori*, the demands on pregnant women should be significantly less than the duties we expect of parents of born children. Refusing Ms Halappanavar her request for a termination and forcing her to continue her pregnancy is an extreme example of the differential treatment of pregnant women. It is a particularly tragic one given that her foetus was not viable and it posed a serious threat to her health and, ultimately, her life.

New legislation: old ambiguities

Savita Halappanavar's death and the argument made by the health professionals charged with her care - that they were bound by the legal position set out in Article 40.3.3° and the X case – caused a national and international outcry and put pressure on Irish legislators to clarify the precise scope of the law in circumstances such as Ms Halappanavar's. Ironically, in the same week that Ms Halappanavar was in the Galway hospital, an expert group appointed by the Government was finalising its recommendations in response to a European Court of Human Rights judgment in *A, B, & C v Ireland* (2011) 53 EHRR 13 that required the state to clarify by law and/or regulation when it would be permissible for a woman whose life was at risk to avail of an abortion in Ireland. The publication of the Report of the Expert Group, combined with the general public's repugnance at what had befallen Ms Halappanavar, assured the introduction of legislation that specified more clearly the implications of Article 40.3.3° and the X case in determining access to abortion in certain

circumstances. In brief, the Protection of Life During Pregnancy Act 2013 provides that in cases where a woman's life is at risk, it is lawful for health professionals:

> [T]o carry out a medical procedure in respect of a pregnant woman … in the course of which, or as a result of which, an unborn human life is ended where … there is a real and substantial risk of loss of the woman's life from a physical illness, and in their reasonable opinion (being an opinion formed in good faith which has regard to the need to preserve unborn human life as far as practicable) that risk can only be averted by carrying out the medical procedure' (section 7(1)).

While this legislation represents a long awaited gesture towards recognising the obligation of the state to protect the lives of pregnant women, many argue that it does not go far enough. It fails to include circumstances where the foetus is not viable or where the woman has become pregnant through rape or incest. The legislation also patently fails to acknowledge pregnant women's rights to bodily integrity and autonomy and requires significantly more of them than other people. However, even if one were satisfied with the narrow scope of the legislation, it is extremely doubtful that it will succeed in addressing concerns about women's safety. As a number of obstetricians have already pointed out, how a 'real and substantial risk' is quantified remains problematic and very few seem willing to acknowledge that the pregnant woman should be key to that determination (Joint Committee on Health and Children, 2013: 160-1, 515). Finally, it is possible that any ambiguity in the legislation may be availed of by some healthcare practitioners for

ideological reasons to justify withholding a legally permissible abortion and that it will paralyse others from acting and/or prompt 'wait and see' care plans such as that which prevailed in UCHG. [2]

That health professionals can be very sensitized to the association between abortion legislation and Catholic ideology was made clear in another dimension to Ms Halappanavar's story that is considered in the final section – the 'Catholic country' remark.

The 'Catholic country' remark

In his account of events given to the Gardai and, subsequently, to the inquest, Ms Halappanavar's husband, Praveen Halappanavar, mentioned that a number of the health professionals (at least one doctor and one midwife) had justified the refusal of a termination on the grounds that Ireland was a Catholic country (Holland, 2013b). Global interest in the case included shock and outrage at the thought that religious ideology, not evidence based medicine, had influenced clinical decisions. However, none of the health professionals who had either said this, or witnessed it being said, had come forward until the coroner's inquest. At the inquest, Ms Halappanavar's consultant confirmed that she had referred to Irish law but denied any reference to Catholicism. However, a senior midwife, Ann Maria Burke, admitted that she had suggested that the rationale for why the hospital could not provide Ms Halappanavar with an abortion was because Ireland was a 'Catholic country' (Holland, 2013b).

When Ms Burke told the inquest that she had made the comment to Ms Halappanavar, the coroner told her that her remarks had 'gone around the world', that the

abortion had been refused on legal, not religious, grounds, and that neither religious dogma nor tenet influenced clinical practice in Irish public hospitals (Cullen, 2013). However, while on the one hand, the coroner is clearly correct: the law and the consultant's interpretation of it led to the refusal of a termination, it could also be argued that the law itself is religiously based. The history of the origins of Article 40.3.3, some thirty years ago, demonstrates that the law on abortion in Ireland is firmly embedded in Catholic ideology. In a statement issued in November 2012, the Irish Catholic Bishops' Conference distinguish between 'abortion' or the '*direct* and *intentional* destruction of an unborn baby', which they claim is always immoral, and 'medical treatments which *do not directly and intentionally* seek to end the life of the unborn baby'. This distinction appeals to what is known as the 'doctrine of double effect', a Catholic theory that has long been strongly debated and contested in the philosophical literature (Foot, 1967; Kamm, 1991; Clarke, 2013). Whatever its merits or demerits, this kind of thinking would explain why health professionals might be concerned about the timing and appropriateness of medical interventions where a foetal heartbeat was present and also provide a rationale for clinical care pathways that in Ms Halappanavar's case involved 'wait and see what happen[s] naturally' (HSE Report, 2013a: 73). It is beyond the scope of this chapter to discuss this at length, but at the very least, it indicates that Ms Burke may have been explaining the 'logic' behind the law as she understood it to Ms Halappanavar and her husband (O'Toole 2013). In Ms Burke's testimony to the inquest, she expressed regret and stated that the remark had been made in a particular context and 'had not been meant in a hurtful way' (Holland, 2013b).

To conclude, instead of being castigated, it could be argued that Ms Burke should be praised, not just for her testimony to the inquest, but also for her sensitive response to Ms

Halappanavar's puzzlement. On the other hand, the fact that none of Ms Halappanavar's requests for a termination, nor any of the conversations that Dr. Astbury and Ms Burke acknowledge having had with her about an abortion, were documented in the medical or midwifery notes indicates an uneasiness about discussions involving abortion and a lack of respect and inability to respond appropriately to a woman's request for an abortion. It also raises a more general worry about how health professionals view their role and ethical and legal obligations in relation to women who seek legally permitted abortion. The evidence of witnesses to the Hearings of the Joint Committee on Health and Children (2013) suggest a wide range of views on abortion among Irish health professionals. However, it is unclear what impact these views have on decision-making in maternity units around the country and independent empirical research on the impact of religious and cultural beliefs on clinical practices in Ireland is long overdue. Moreover, Dr. Peter Boylan raises the worry that some midwives may, on occasion, neglect their duty of care to pregnant women and delay an emergency (and therefore legal) termination because of their objection to abortion. Boylan remarked, in his report to the inquest of Savita Halappanavar, that her transfer and termination was in part, 'dependent on the midwives in the delivery unit accepting care of Ms Halappannavar when it was known the foetal heartbeat was still present' (Boylan, 2013: 15). He later reported to Holland that the previous year, a colleague of his, in similar circumstances in another hospital in Dublin, had been told by a senior midwife on the labour ward, 'You're not doing a termination in this hospital.' According to Boylan, his colleague 'had to pull rank and say, "Then I'm getting agency nurses in," and it was only when a non-national nurse came forward [that the termination could proceed]' (Holland, 2013a: 223).

Conclusion

The cases discussed in this chapter are examples of the way in which women's bodies in the Irish state have become the site of various battles waged in relation to sexuality, reproduction and moral and religious authority. The first part of the chapter drew attention to the cultural unease with women's embodiment and reproductive capacity that permeated Irish society and culture until at least the final decades of the 20th century. It also outlined the unnecessary suffering visited on many hundreds of pregnant women in Our Lady of Lourdes Hospital which derived from the Catholic ethos of the hospital and the adherence of a significant number of the medical, nursing and midwifery professionals there to Catholic authority and doctrine. It observed that the unequal distribution of moral authority was also keenly felt by many female patients and midwives whose concerns were trivialised and whose voices were, for the most part, silenced. Finally, it indicated the ways in which some midwives used what authority they had to control dissenting voices and maintain the status quo while others raised their voices in resistance.

The second part of the chapter highlighted how clinical decision-making in relation to women's reproductive choices can be infused by Catholic ideology – this time through the ambiguity and interpretation of Irish laws on the permissibility of abortion. It also pointed to the marginalisation of the views, values and preferences of pregnant women in decisions that impact on their lives and the excessive obligations that pregnant women in Ireland are legally required to meet compared with other people.

While it is clear that the Catholic church continues to cast a long shadow on Irish laws and medical practice, it is also clear that many health professionals, legislators and the general public are increasingly anxious to see a genuine separation between the church and

the functions and services of the state. The insights, conclusions and recommendations of the various reports on the tragedies discussed in this chapter send a strong signal to health professionals, allied professionals and health care organisations that they must set their moral compass to reflect the norms of a civil, egalitarian and pluralist society. They must focus, proactively, on fostering a maternity environment that consults with and encourages pregnant women to voice their experiences, concerns and preferences; one that is more open about the level of clinical, moral and legal uncertainty inherent in the practice of medicine and the need for that uncertainty to be made more explicit. It remains to be seen how much time, and what personal toll individual women, and those who love them, will have to pay before that cultural and ideological transformation is to take place.

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Endnotes

[1] It could be argued that the failure to recognize the moral authority of patients (male and female) was (and is) a more general issue; one that current HSE documents and policies as well as professional codes (Irish Medical Council 2009 and National Nursing and Midwifery Board 2014) are attempting to address.

[2] It is evident from the HSE Report (2013: 73) that a 'wait and see' approach was adopted from Sunday 21 October 14.20 'wait and see what happened naturally'; Monday 22 October 08.20am 'await events'; Tuesday 23 October before 6.00am 'await events'.