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The Protection of Life During Pregnancy Act 2013: Suicide, dignity and the Irish discourse on abortion

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Introduction

Abortion is an issue that exposes deep divisions in Irish society and this was again apparent during the recent debates leading up to the introduction of the Protection of Life During Pregnancy Act 2013.[1] This Act provides, for the first time in Ireland, a statutory framework which sets out the circumstances in which it is lawful for an abortion to be performed in Ireland. It does not extend Irish abortion law but merely gives effect to the existing position under the Constitution, as interpreted by the Supreme Court in *Attorney General v X* [1992] 2 IR 1, that an abortion is lawful in circumstances where there is a threat to the life of the woman. Abortions in circumstances where the health of the woman is at risk, where the foetus suffers from a fatal foetal abnormality incompatible with life outside the womb, or where the pregnancy results from rape all remain unlawful in Ireland following the introduction of the 2013 Act and so many women will continue to travel abroad for abortions. UK Department of Health statistics show that 3,679 women provided Irish addresses to English and Welsh clinics providing abortion services in 2013 – this includes 21 young women who were under the age of sixteen (Department of Health, 2014). Of the abortions provided in England and Wales to non-residents 67% are women from Ireland and 15% are women from Northern Ireland (Department of Health, 2014: 16). The Irish Family Planning Association suggests that between January 1980 and December 2013 at least 159,755 women travelled from Ireland to the UK for safe abortion services. It is probable that many more Irish women who obtained abortions in these UK clinics may not have provided an Irish address. These statistics are a powerful reminder that significant numbers of women who are resident in Ireland have abortions; they just do not have them in Ireland.

The 2013 Act was introduced in an effort to comply with Ireland's obligations under the European Convention on Human Rights (ECHR) following the judgment of the European Court of Human Rights (ECtHR) in *A, B and C v Ireland* [2010] ECHR 2032 (hereafter *A, B and C*) which found that Ireland had breached C's right to private and family life under Article 8 of the ECHR by failing to provide a framework for women who meet the legal test to obtain a constitutionally permitted abortion within the State. This article focuses on the centrality of suicide within the Irish discourse on abortion around the introduction of the Protection of Life During Pregnancy Act 2013 and the impact that this had on the shape of the legislation that was ultimately introduced, in particular the inclusion of a separate and more onerous process which a woman must engage with before she can obtain an abortion in Ireland where the risk to her life is from suicide. It also discusses the practical consequences of this for the small number of very vulnerable women in Ireland who will be required to engage with the new statutory process, and raises concerns about the workability of the new legislative framework.

For those observing from outside of Ireland it no doubt seems unusual that within the dominant public discourse on abortion there are very limited references to concepts such as choice,

dignity or reproductive rights, and instead the debate appears to revolve predominantly around the issue of suicidality. This can be explained, in part, by the unique history of abortion law in Ireland. Therefore Part I of this article outlines the law in Ireland prior to the introduction of the 2013 Act and provides background information illustrating how suicide came to sit at the centre of the discourse on abortion in this jurisdiction. This situation was further compounded by two more recent developments, namely, the tragic death of Savita Halappanavar in October 2012 and the judgment of the ECtHR in *A, B and C*. Part II of the article considers the impact of these factors on the debates leading to the Protection of Life During Pregnancy Act 2013 and briefly outlines the recommendations of the Expert Group and the hearings of the Joint-Oireachtas Committee. Within this context, where a risk to life from suicide was at the centre of the debate on the legislation, a number of narratives depicting women seeking abortions as untruthful or untrustworthy came to the fore. The suggestion underpinning these narratives was that legislating for abortion in circumstances where there was a risk to the life of the woman from suicide would encourage deceitful behaviour and would "open the floodgates" to "abortion on demand." Part III of the article identifies these narratives and also highlights the political objectives driving them. It also points out that there were a number of counter-narratives which emerged during the debates which were articulated by leading medical professionals in Ireland. This is note-worthy given the central gate-keeper role afforded to the medical profession under the terms of the Protection of Life During Pregnancy Act 2013.

Part IV of the article illustrates the political impact of the narratives of untrustworthiness discussed in Part III on the provisions of the 2013 Act, focusing in particular on the separate more onerous process required under section 9 where the risk to life is from suicide. It is argued that the narratives articulated by the "pro-life"[2] grouping gained traction and led to the introduction of legislation which is more than likely unworkable in so far as it applies to risk to life from suicide. It is also doubtful whether it complies with the ECHR, despite the stated intention of the Government being to bring Ireland in line with international obligations, and so the State remains open to further challenges. Part V will set out the core difficulties with the Protection of Life During Pregnancy Act 2013. Given the polarised nature of the debates surrounding the introduction of the legislation there was very little attention paid at the time to the practical operation of the statutory process, perhaps because a view a was taken by those arguing from a "pro-choice" perspective that it was strategically better to have imperfect legislation in place which could be improved by regulation or amended than getting caught up in trying to introduce a very detailed legislative framework in the face of considerable opposition. The result is significant omissions in the legislative framework which do give rise to practical concerns about whether the 2013 Act is in fact workable and these technical aspects are set out and discussed. However, in addition to these practical considerations it is also important to step back and evaluate the overall scheme of the 2013 Act and to recognise that in its terms it undermines the dignity of the women towards whom it is directed. Even those who successfully negotiate the statutory process will have lost something through their engagement with the system.

Part I: Contextual framework

Article 40.3.3 of the Irish Constitution provides 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 vindicate that right." This provision was inserted into the Constitution in 1983 as a result of fears on the part of those who opposed the

introduction of abortion in Ireland that the personal rights provisions of the Constitution could be used to read into Irish law a right to an abortion. These fears were inspired by the decision of the US Supreme Court a decade earlier in *Roe v Wade* US 113(1974) which read a right to choose into the personal rights provisions of the US Constitution. A pressure group, the "Pro-Life Amendment Campaign" (PLAC) was set up in 1981 with the aim of ensuring that constitutional protection of the right to life of the unborn would be provided. This body was primarily composed of groups drawn from a conservative Catholic background and included members of the Catholic Doctors Guild, and representatives of the Council of Social Concern. The Society for the Protection of Unborn Children (SPUC) also became involved in the campaign. It was an extremely difficult campaign "recognised as the bitterest and most divisive in recent Irish history" (McAvoy, 2008: 24). It has also been described by Hesketh (1990) as a "second partitioning" of the State. PLAC clearly drew on conservative Catholic ethos to support its campaign (for further discussion see Kingston, Whelan and Bacik, 1997). This led to divisions with the other major religious groupings in Ireland, with each of the Protestant Churches issuing statements opposing the proposal for the amendment (Fletcher, 2001: 567). Mullally (2008: 221) notes that "[t]he anti-amendment campaign argued that an absolute constitutional prohibition on abortion would deny non-Catholics equal rights to citizenship in Ireland and would perpetuate a politics of exclusion." This debate took place in the context of the early 1980's which was a period of considerable turmoil with three governments in the two years of 1981 and 1982. As McAvoy (2008: 23) observes "[i]t was not difficult to pressurise politicians who were desperate for votes and under the impression that opposition to abortion was an issue the majority of the population agreed on." Ultimately the 8th Amendment was passed by a majority of 755,423 to 324,977, although only 54.6% of the electorate went to the polls. While the "pro-life" side was successful in introducing the 8th Amendment the constitutional provision also included a provision that the right to life of the unborn is not an absolute right and must be balanced with the equal right to life of the woman.

The Supreme Court was called on to interpret Article 40.3.3, and the requirement to balance the rights of the unborn and the woman, for the first time in *Attorney General v X* [1992] 2 IR 1 (hereafter the X case). This case involved a 14 year old girl who had been raped by a friend of the family and was pregnant. Given the very traumatic circumstances both the girl and her parents wished her to have an abortion and planned to travel to the UK for that purpose. They also wished to find out would it be possible to gather DNA evidence from the aborted foetus to assist in any criminal prosecution and so contacted the Gardaí (Irish police force) about that issue. The Gardaí consulted the Director of Public Prosecution (DPP) to enquire about the evidential status of any such DNA information. The DPP subsequently informed the Attorney General of the intention of the family to travel to the UK for an abortion. At this point X and her family had already travelled to the UK and the Attorney General, acting as guardian of the Constitution, sought an interim injunction seeking the immediate return of the family to Ireland. The family returned to Ireland voluntarily, thereby negating the need for an injunction, and the case came before the High Court. Evidence was presented to the court that X had threatened to kill herself if forced to continue with the pregnancy. However, Costello J in the High Court granted an interlocutory injunction preventing the defendant, or any agent acting on her behalf, from interfering with the right to life of the unborn, from leaving the jurisdiction for nine months, and from procuring or arranging a termination of the pregnancy. This was on the basis that the risk to the life of the unborn was real and imminent whereas the risk to the life of the young girl was one of self-destruction which was a risk "of much less...magnitude that the

certainty that the life of the unborn will be terminated." (1992: 12). This decision was appealed to the Supreme Court.

It was in the context of this difficult case that the Supreme Court interpreted Article 40.3.3 to mean that there is a right to a lawful abortion in Ireland where, as a matter of probability, there is a real and substantial risk to the life of the woman, including a risk to life through suicide, and that risk to her life can only be removed through the termination of the pregnancy. According to the majority of the Supreme Court the risk to life does not have to be immediate or inevitable. On the basis that a threat of suicide constituted a risk to the life of the mother the Supreme Court lifted the injunction imposed by the High Court and X was permitted to travel to the UK to obtain an abortion. The test for accessing an abortion in Ireland therefore developed out of an unusual and highly emotive factual matrix involving as it did the rape of a child and a threat of suicide. The test creates arbitrary boundaries between life and health which are difficult to assess and to police.

The decision in the X case, in particular the inclusion of a risk of suicide as a ground for abortion within the test, was unsurprisingly deeply unpopular with the "pro-life" movement. Campaigns to reverse the consequences of the decision were commenced and two proposals for amendments to the Constitution were put forward which sought to restrict the decision of the Supreme Court in the X case. However, in both referenda, in 1992 (proposed 12th Amendment) and in 2002 (proposed 25th Amendment) the Irish people voted to reject proposals to remove the threat of suicide from the grounds for lawful abortion. Interestingly the possibility of broadening the grounds on which abortion is lawful in Ireland has never been put to the people by way of a referendum.

The Protection of Life During Pregnancy Act 2013 gave effect to the position as set out in X and did not expand the grounds on which an abortion is lawful in Ireland. If an abortion is carried out in circumstances which do not come within the parameters of the test set down in the X case there is a risk of criminal sanction for the woman and anyone who assisted her. Prior to the introduction of the 2013 Act these sanctions were set out in sections 58 and 59 of the Offences Against the Person Act 1861. The existence of these criminal sanctions, although rarely utilised (there have been no prosecutions in living memory),[3] were described by the ECtHR in *A, B and C* as having a chilling effect on the availability of abortion in Ireland even in circumstances where a woman satisfies the test set out in the X case (para. 254). While section 5 of the 2013 Act repeals these provisions of the 1861 Act, section 22 introduces the offence of the intentional destruction of unborn human life. This was subject to criticism in the debates surrounding the introduction of the 2013 Act, with Deputy Catherine Murphy and others pointing out that it continued the "chilling effect" referred to by the ECtHR in *A, B and C*.[4] The consequence is that many women who reside in Ireland will continue to travel to the UK (primarily England and Wales) and other European countries to access abortion services, and the introduction of the 2013 Act will not significantly alter this.

Part II: Locating suicide at the centre of the contemporary debates

The discussion above highlights that the inclusion within the legal test of a risk to the life of the woman from suicide has been a contentious issue in Irish abortion law for quite some time. However, two more recent developments had the effect of placing suicide at the very centre of the contemporary debates. The first was the decision in December 2010 of the ECtHR in *A, B and*

C which stated that Ireland must give effect to the existing constitutional position in which suicide is central. In adopting a conservative position, and not recognising a broader right to access an abortion under the ECHR, the ECtHR placed no external pressure on the Government to engage in wider debate on reproductive rights in Ireland. The second was the death in October 2012 of Savita Halappanavar which appeared to undermine the "pro-life" position that pregnant women would not die in Ireland because of the terms of Article 40.3.3 of the Constitution. Both of these events warrant further discussion to contextualise the subsequent debates.

A, B and C v Ireland

The case of *A, B and C* involved three women challenging the Irish abortion laws before the ECtHR on the basis that the law violated their Article 8 rights to private life. The concept of private life in the ECHR is broadly understood and includes the right to personal autonomy and personal development, a person's physical and psychological integrity, as well as decisions to both have and not have a child.[5] All three women had become pregnant unintentionally and all three had obtained abortions in the UK. However, the circumstances of each of the women were quite different.

A and B did not come within the very narrow constitutional provisions and so they were arguing that the grounds on which abortions were available in Ireland should be extended to include those where the health and well-being of the woman was at risk. There were health, social and financial reasons underlying A and B's decisions to have an abortion. The ECtHR was quite clear in stating that there is no right to an abortion under the ECHR. A majority of the Court ruled that it was within the margin of appreciation afforded to the State the extent to which, if any, it allowed for abortions within the State. The margin of appreciation allows States to interfere with rights to the degree to which it is necessary and proportionate in a democratic society. On this basis A and B's cases failed as Ireland was not obliged to extend the limited grounds for a legal abortion within the jurisdiction.

It is worth noting, however, the strong joint partly dissenting judgment in this case in which the judges found that there had also been a violation of the Article 8 rights of A and B. The dissenting judgment highlights the strong European consensus that abortion should be permitted on broader grounds than those available in Ireland, in particular the availability of abortion in cases where the health or well-being of the woman is concerned. The existence of a consensus which touches on a human right usually operates to narrow the margin of appreciation afforded to States – this is described as part of the "harmonising function" of the Convention's case-law. The judges noted that this "is the first time that the Court has disregarded the existence of a European consensus on the basis of 'profound moral views'" (para. 9) and suggested that this marked a dangerous new departure in the jurisprudence of the ECtHR.

C was entitled to an abortion under the existing constitutional position as her life was at risk from her pregnancy – she discovered she was pregnant while undergoing treatment for cancer. Her difficulty was that because of the absence of a statutory framework in Ireland regulating the provision of abortion services it was practically impossible for her to access those services in a timely manner within the jurisdiction. The ECtHR found that the State's failure to provide a framework to give effect to constitutionally permitted abortions was a breach of C's right to

private and family life. Under Article 8, the State has a positive obligation to provide effective and accessible means of protecting the right to respect for private life. The ECtHR concluded that the uncertainty around the implementation of Article 40.3.3 had resulted in "a striking discordance between the theoretical right to a lawful abortion in Ireland on grounds of a relevant risk to a woman's life and the reality of its practical implementation" (Para. 264).

The ECtHR rejected arguments by the State that there was a sufficient procedure in place by way of medical consultation or application to court. Medical consultations were considered to be inappropriate because of the chilling effect of the 1861 Act and because there is no mechanism in place through which the matter can be resolved if there is a disagreement between a woman and her doctor about whether she meets the "real and substantial risk" threshold. Applications to court were also considered to be inappropriate as they are costly, adversarial, and the courts are not best placed to make decisions of this nature.

The opportunity to expand the scope and nature of the debate around abortion in Ireland to include issues such as maternal health, reproductive choice and autonomy was not utilised in part because of the limited nature of the judgment in *A, B and C*. Complying with the judgment in *A, B and C* merely required the Irish legislature to develop a framework clarifying how the test in the X case is to be applied in practice so that women and medical professionals clearly understand the circumstances in which it is permissible to provide an abortion in Ireland and how the provision of abortion services should be regulated.

The death of Savita Halappanavar

Following the decision in the X case "pro-life" groups had argued that there was no need to legislate for abortion in Ireland, that clear medical and ethical guidelines would be sufficient (O'Regan, 2013). It was repeatedly stated that Ireland was a very safe place for a woman to give birth, women's lives were very rarely in danger as a result of pregnancy, and what was most important was that appropriate care would be provided for pregnant women who experienced complications in pregnancy (for a response to these claims see O'Toole, 2012). However, this position was called into question when the very tragic circumstances surrounding the death of Savita Halappanavar in Galway University Hospital became public. In that case an Indian woman (31 years old), who was 17 weeks pregnant, presented at a hospital with back pain. It was discovered that she was miscarrying. Savita Halappanavar requested a termination of the pregnancy as she was in significant pain but was informed that this was not possible in Ireland, due to the legal prohibition on abortion except where the life of the mother was at risk, and she would have to wait for the foetal heartbeat to stop. Savita Halappanavar subsequently died from sepsis. At the inquest into her death her husband stated that they had been informed that she could not have an abortion because Ireland was a "Catholic country." It subsequently emerged that the "Catholic country" remark was made by a midwife who stated that she was trying to convey the complexity of the position in Ireland in relation to abortion to the Halappanavars. In hindsight she agreed that it "sounded bad" and she regretted it. Arguably this midwife was trying to provide the Halappanavars with a cultural context to explain the position they found themselves in. It is clear that this encounter raises issues around race and diversity within Irish society and within medical practice (for further discussion on this issue see Enright, 2013b). The death of Savita Halappanavar provoked a wave of public outrage and garnered considerable international media attention. It seemed unbelievable that in 2012 a young woman could die in an Irish hospital from complications related to pregnancy.

At the inquest into the death of Savita Halappanavar in April 2013 evidence was provided to the coroner's court by Dr. Peter Boylan, former Master of the National Maternity Hospital at Holles Street, to the effect that during the period where a termination of the pregnancy would have saved her life, it was unlawful to perform an abortion, and that once it became lawful to provide an abortion it was too late to save her life (Holland and Cullen, 2013). Ultimately the jury returned a unanimous verdict of death by medical misadventure. A significant number of systems failures were identified in the care provided to Savita Halappanavar, including the failure to follow up on blood tests taken on the day that she was admitted which would have showed elevated white blood cells which are indicative of sepsis. However, the coroner stated that the deficiencies or failures in the care of Savita Halappanavar did not cause her death (Cullen, 2013). Following the inquest HIQA (the Health Information and Quality Authority) published a report in October 2013 on the circumstances surrounding the death and other related issues. (HIQA, 2013). Again, it identified that there were significant failures in basic care and the hospital staff treating Ms. Halappanavar had failed to notice signs of her deteriorating condition and had failed to act on them appropriately (HIQA, 2013). The Report also highlighted shortcomings in maternity services throughout Ireland, particularly in relation to the definition and recording of maternal sepsis. It also noted that there was no centralised approach to recording maternal morbidity and mortality and so it was very difficult to assess the performance and quality of maternal services nationally. This has led to calls for the introduction of a National Maternity Strategy to be implemented throughout the health services. While this indicates that the death of Savita Halappanavar may have resulted from systemic failures of the Irish health services, particularly in respect of maternity care, her death undoubtedly formed a significant part of the increased momentum towards the 2013 Act.

Moving towards legislation

In response to the judgment of the ECtHR in *A, B and C* the Irish Government established, in January 2012, an Expert Group "comprising of persons with appropriate medical, legal, regulatory and administrative expertise to advise on how to implement the judgment." (Expert Group, 2012: 5). The Expert Group was asked to provide a series of options to the Government taking into account the public policy considerations and also the need for speedy implementation.

The Report of the Expert Group was published in November 2012, very shortly after the death of Savita Halappanavar, and it set out a number of options for Government on how to proceed. These included the issuing of Professional Guidelines, the introduction of secondary legislation in the form of Regulations, the introduction of Legislation alone, and Legislation supported by Regulations (Expert Group, 2012: 44). The Report did not explicitly recommend one course of action to the Government, however, it did describe the introduction of legislation complemented by regulations as being "constitutionally, legally, and procedurally sound" because it offered a suitable mix of clear statutory guidance and sufficient flexibility to allow for developments in medical knowledge and changes in best clinical practice (Expert Group, 2012: 49). In respect of the procedures to be introduced the Expert Group stated "…it was generally considered that two doctors with the relevant training and expertise appropriate to the case would be sufficient for making a clinical decision as to the risk to the life of the woman, whether the risk arose because of a physical or mental health condition" (Expert Group, 2012: 32). More doctors could be involved by way of informal consultation or multi-disciplinary assessment if necessary. The Expert Group suggested that the decision on whether the legal test was satisfied

would have to be made in a timely manner and formally communicated to the women (Expert Group, 2012: 31). There are legitimate questions to be raised about developing a system of regulating abortion that defers very significantly to the medical profession and places them as gate-keepers (for further discussion see Sheldon, 1997; Lee, 2003). This issue will be discussed further below in the context of the emerging medical contribution to narrative and counter-narratives. These concerns must be balanced against the potential harms caused by an over-reliance on law in relation to what is a very intimate decision for any woman. However, this was not a focus of the debate around the proposed legislative framework in Ireland - the main point of contention in the public and political debates was the inclusion of suicide as a risk to the life of the woman (in accordance with the decision in the X case) within the legislation.

The Government committed to introducing legislation accompanied by regulations, although not without some internal conflict. The current Government is a coalition between the majority Fine Gael party – who are a centre-right Christian-democratic party (Fine Gael MEPs sit with the European Peoples Party in the European Parliament) – and the social-democratic Labour party. The Labour Party had included a specific commitment to introduce legislation for the X case within its election manifesto. In contrast Fine Gael was quite divided on the issue of abortion. Within the coalition there were Members of Parliament (known as TDs – the term stands for Teachtaí Dála), primarily from Fine Gael, who opposed the introduction of any form of legislation on abortion and in particular did not wish the threat of suicide to be included in the statutory framework. Ultimately a number of Fine Gael TDs and Senators were expelled from the Parliamentary Party because they did not vote for the Protection of Life During Pregnancy Act 2013 during its passage through the Oireachtas (the Irish Parliament).

Following the Report of the Expert Group the Joint Oireachtas Committee on Health and Children held a number of public hearings on the issue of legislating for abortion in Ireland. Members of the legal profession, the major religions, the medical profession, and civil society groups were invited to address the committee. This proved to be an informative and useful exercise. At the Joint Oireachtas Committee hearings the issue of when a risk to health becomes a risk to life was described by medical professionals as a clinical decision that medical professionals are used to assessing. The testimony from the medical practitioners was that they required a clear statutory framework that allowed them to care for their patients without the threat of criminal prosecution hanging over them.

During the discussions on these developments once again abortion highlighted divisions within Irish society, with politicians, medical professionals, and religious groupings disagreeing very publicly on the matter, both within their own ranks and with each other. For the reasons outlined above, the debate revolved around the issue of suicide, both its inclusion and whether the assessment process should be more rigorous than for threats to life from a physical condition. A significant aspect of the debate was the emergence of a series of narratives which characterised women seeking an abortion on grounds of suicide as unreliable. The next part of the article outlines these narratives and sets out the impact that they had on the shape of the legislation which was subsequently enacted.

Part III: Identifying the narratives within the discourse on abortion

Cover states that narrative – the familiar/background cultural stories we tell and rely on – provides the nomos, or normative universe, within which law operates (Cover, 1983-1984: 4). He also argues that every law must be located within a discourse "to be supplied with history and destiny, beginning and end, explanation and purpose." (Cover, 1983-1984: 5). The comment of the midwife in the Savita Halappanaver case that abortion was not possible in those circumstances because Ireland is a "Catholic country" illustrates the role of narrative in locating legal rules within a cultural context and providing a story which seeks to explain the "why" of the law and how the law interacts with other controlling forces in society, such as religion and morality. Focusing on narrative allows us to consider the beliefs and influences that underpin the debate around legal reforms, beliefs that are sometimes stated clearly and at other times are implied. The implied narratives can be particularly powerful when they draw on unspoken and deeply rooted collective understandings. Narrative also provides the context within which legal rules, including the new rules for abortion in Ireland, operate.

Narratives of the untrustworthy, manipulative and hysterical woman

There are multiple expressions of the theme of the unreliable and hysterical woman woven into the fabric of the discourse on abortion in Ireland and these emerge primarily in media and political debates. The first narrative is of the untrustworthy woman who will lie about having suicidal thoughts in order to obtain an abortion. The second is of the manipulative woman who will persuade doctors to conspire with her to provide an abortion in circumstances which do not fall within the legal framework. The third is of the hysterical pregnant woman who is at the mercy of her hormones and so cannot make rational and competent decisions on important matters during that period. In the first two expressions of the narrative the agency of the woman is understood as being utilised to undermine the rules that are in place to protect the unborn. In the third expression of the narrative the agency of the woman is denied – she must be protected from herself in circumstances where the pregnancy impacts on her ability to make rational decisions. This part of the article does not purport to provide a detailed account of the many examples of these narratives within the current debate. The quotations that are offered are intended to provide a flavour of the discourse and the articulation of the core narratives. Any perusal of the Irish parliamentary debates, newspapers, and broadcast media coverage of the issue will provide many more examples of each of these narratives.

Within the debate on abortion in Ireland narratives relating to women who will fabricate suicidal ideation to obtain an abortion outside of the narrow legal provisions are clearly evident. Hunt (2012) wrote in the Sunday Independent:

> "But we know, don't we, though few are yet prepared to say it, that because of the nature of mental illness, it can be hard to spot. We will have to depend on the word of doctors and of course the word of the woman herself. And if we are living in a country where the only reason that an abortion, even at an early stage of pregnancy, is allowed is if there is a risk to the life of the mother, well then... need I spell it out? Will we see a rise in suicidal Irish women that corresponds to a drop in the numbers who traditionally travel to English clinics?"

The use of the phrase "don't we" here is a good example of the power of narrative. It implies that the knowledge is deeply ingrained and clear to all, to such an extent that it is not necessary to

set out the information in detail because everyone involved is already familiar with it. As Benjamin (2010: 788) notes narratives may be characterised by their "pervasiveness and the confidence with which they are asserted." In this way the narrative easily and unobtrusively provides the context for the discussion on legislating for abortion. This particular narrative is not new, nor is it exclusive to Ireland. Narratives of the unreliable woman in Irish discourse reflect similar narratives that were evident in discussions around the availability of abortion in the US pre *Roe v Wade* when therapeutic abortions were only available where the life of the woman was at risk and where psychiatrists who recommended legal abortions were sometimes characterised as unwitting accomplices or "pawns of importuning women" (Solinger, 1993: 247). Physicians were also warned of the "clever, scheming women, simply trying to hoodwink the psychiatrist and obstetrician" in order to obtain an abortion (Eastman, 1954: xx). In relation to the specific threat of suicide one US physician noted that "a mere threat of suicide or even an abortive attempt at suicide is not in itself regarded as medical indication for therapeutic abortion; it may be nothing more than an effort to blackmail the surgeon into performing the operation"(Israel, 1963: 619). The language in the current Irish narrative on the hysterical and unreliable woman has been toned down somewhat but the central character remains unchanged. The purpose of these narratives is to create a situation in which it is generally acceptable to question the genuine nature of any threat to the life of the pregnant woman in circumstances where she wishes to obtain an abortion because of suicidal ideation.

The second narrative focuses on women who manage to convince/pressure the doctor to participate in what is characterised as their fraudulent attempt to obtain an abortion. This will result, we are told, in an opening of the floodgates and the introduction of abortion "on demand" into Ireland. The suggestion that doctors would be manipulated by women was apparent in submissions before the Joint Oireachtas Committee hearings on abortion. Professor Patricia Casey, psychiatrist in the Mater Misericordiae University Hospital, Dublin and the Department of Adult Psychiatry in University College Dublin, (and also Patron of the Iona Institute, a socially conservative lobby group which "promotes the place of marriage and religion in society")[6] stated:

> "In Ireland we have a history of introducing social change in reproductive and sexual matters by first making the agenda medical. It seems likely that mental health or psychological medicine will be used to widen access to abortion in Ireland as 'an Irish solution to an Irish problem.'...[W]hen a woman insists she is suicidal and the doctors disagree, they may nevertheless acquiesce in granting an abortion so as to err on the side of caution. Only the naive could believe that the government's decision to legislate will lead to the introduction of an 'exceptionally low level' of abortion in Ireland.... Once the service is available it will be used."

A further variation on this narrative is directed towards a concern that some medical practitioners will be of the opinion that the legal grounds for an abortion are too narrow and will stretch these to allow for abortions in circumstances where the health of the woman is in danger. Once more this narrative is neither new nor exclusive to Ireland. One of the reasons abortion boards or committees were established in US hospitals in the mid-1950s was to limit the numbers of abortions that were carried out by what were perceived by some members of the medical profession as liberal obstetricians (Solinger, 1993: 249). These committees therefore operated as a control tool to protect against the "floodgates." This was also indicative of the politicisation of the medical profession and led to a split, with some practitioners

emphasising the importance of limiting the numbers of abortions provided to women and other doctors considering the provision of abortion services as part of the care provided to women (Solinger, 1993; Joffe, 1991). Again this highlights some of the concerns around placing medical practitioners as the gate-keepers of access to abortion when the grounds are both very strict and so subjective – the outcome for the woman may be influenced by the composition of the board or the time of the year or month (this may be relevant if a considerable number of abortions were already approved that month). This introduces a lottery element into the ability of a woman to access a fundamental right.

The third narrative is one which characterises pregnant women as inherently emotionally unstable and therefore incapable of making an informed choice in relation to abortion in circumstances of crisis. This narrative was evident in an article in the Irish Times by Enda Hayden, barrister and consultant psychiatrist, who stated:

> "What is the legal capacity of a pregnant mother to provide informed consent to an abortion in situations where she is emotionally overwhelmed to the extent that her judgment is impaired, and how is this addressed and over what time period? This is not a theoretical question but a common clinical reality for psychiatrists treating patients with a diagnosis of emotionally unstable personality disorder, a diagnosis particularly associated with risk of crises during pregnancy." (Hayden, 2013).

This narrative is very similar to that which underpins the decisions in a series of English cases involving women refusing consent for caesarean sections. A fundamental principle of medical law is that a competent individual can refuse consent to treatment even where such refusal may result in the death of the person. In England and Wales this principle applies equally to refusal of a caesarean section as the foetus does not have any distinct rights – this was confirmed in the cases of *Re MB (An Adult: Medical Treatment)* [1997] 2 FLR 426 and *St George's Healthcare NHS Trust v S* [1998] 3 All ER 673. The situation would clearly be different in an Irish context in light of Article 40.3.3 but to date the Irish courts have not been required to give a decision on this issue (for further discussion of this see Wade, 2013). However, in the English and Welsh cases where women have refused consent to a caesarean section they have been found to lack capacity to make that decision. While this finding was not contested in a number of these cases,[7] there were other cases where there was an argument that there was insufficient evidence to support the finding of lack of capacity.[8] There is a body of commentary on these cases highlighting the extent to which the very fact that the woman is pregnant is deemed to be an indication of her reduced mental capacity (Francis, 1997-1998; Jackson, 2007; Widdett and Thomson, 1997; Morris, 1999; Wells, 1998).

In determining where the narrative of the mad/hysterical woman came from it is worth referring to traditional feminist critiques of the mental health system which highlighted the fact that women who deviated from societal norms, for example those women who rejected the traditional role of wife and mother, or those who did not conform to sexual expectations, were at greater risk of being labelled as "mad" (see further Chesler, 1974; Showalter, 1985; Ussher, 1991). Solinger (1993: 256) highlights the operation of this narrative in the context of abortion in the US where "there was a broad consensus among many essayists in the medical journals and elsewhere that unwillingness to provide a safe environment for the fetus revealed a deeply rooted history of mental illness." Feminist critiques of the traditional mental health system argued that this process of labelling allowed the mental health system to operate as a tool of

social control and to sanction those women who stepped outside stereotypical gender roles. The link between rejecting the maternal role through seeking an abortion and the requirement to thereafter be controlled (and punished) is illustrated by Solinger (1993: 261) when she discusses the high incidence of simultaneous abortion and sterilisation in US hospitals in the 1950s. Unsurprisingly this practice meant that some women opted for illegal abortions rather than risk sterilisation as a result of exercising reproductive choice. It is possible to detect traces of the narrative of the unreliable woman who rejects the maternal role and therefore must be controlled underpinning the current abortion debate in Ireland, particularly in the context of the discussion on suicide.

The articulation of counter-narratives

While the multi-faceted narratives set out above are well established within the Irish discourse on abortion it was also possible in the recent debates to identify emerging counter-narratives. For the most part these counter-narratives attempted to articulate another image of the suicidal pregnant woman seeking an abortion as someone who needs to be believed and respected. The National Women's Council of Ireland, the Abortion Rights Campaign, other civil society groups, politicians and media commentators were among those voicing these narratives. However, what was most notable were the contributions from senior medical professionals responding to the dominant narratives. As observed above the new legislation on abortion in Ireland adopts a medical model which positions doctors as the gate-keepers and those charged with determining when the test set out in the X case is met. It is therefore worth interrogating the counter-narratives that were being driven by, or supported by, psychiatrists and obstetricians.

One of the first examples of the counter-narratives was evident in the testimony of Dr. Anthony McCarthy, then President of the College of Psychiatry, when he addressed the Joint Oireachtas Committee, and noted that the discourse in relation to suicidal pregnant women was markedly different from that in relation to suicidal ideation among other groups in society. He queried why it was acceptable to view pregnant women experiencing suicidal thoughts with suspicion while others in such a difficult position are treated with compassion and concern? The written submission to the Joint Oireachtas Committee from the College of Psychiatry (2013: 4) states "much of the public debate about the issue of suicide and its risk in pregnancy has, in our view, been simplistic, sometimes harsh and judgemental, frequently uninformed or misinformed, and contrasts markedly with the way suicide and its risk is usually discussed in other circumstances."

Another example of this counter-narrative was articulated by Dr. Rhona Mahony, Master of the National Maternity Hospital, before the Joint Oireachtas Committee hearings. She also addressed and challenged the dominant narratives relating to manipulative and dishonest women:

> "As a woman, I am offended by some of the pejorative and judgmental views to the effect that women will manipulate doctors to obtain termination of the pregnancy on the basis of fabricated ideas of suicide ideation or intent. There also appears to be an assumption that psychiatrists are unable to assess the issue of suicide ideation, which is something they do every day in their clinical practice."[9]

The second part of this statement by Dr. Mahony provides an insight into one of the more complex motivations behind the emergence of the counter-narratives. There was a concern

among medical professionals, particularly psychiatrists, that the Government would legislate in a manner that would interfere with their professional autonomy. Throughout the Joint Oireachtas Committee hearings medical practitioners reiterated that they required legislation to clarify the legal position, but that they also required flexibility to enable them to exercise their clinical judgement. Many of the medical professionals making submissions at the hearings characterised the decision as to when the life of a woman was at risk as a medical one and not a legal one. In relation to what was the core issue of suicide, psychiatrists clearly wished to preserve their professional status and independence. This is perhaps unsurprising in the face of narratives which suggested that psychiatrists would collude with women to ensure that they could access abortions when they do not come within the legal test or that women can manipulate psychiatrists with untruths. The influence of these dominant narratives on the political debate, which ultimately resulted in provisions in the legislation for the involvement of multiple medical practitioners of different specialties in making a decision which is routinely made by one psychiatrist, was seen by psychiatrists as a slight on their professional competence. The result was one of the most forceful counter-narratives to emerge in this debate.

Dr. Anthony McCarthy, one of only three perinatal psychiatrists in Ireland, declared on national radio (Morning Ireland on 22nd April 2013) that a leaked proposal that a panel of six medical practitioners, two obstetricians and four psychiatrists (one a perinatal psychiatrist) would be required to assess a suicidal woman would be an "abuse of women". He stated that it was "idiotic" and that it sounded like "some kind of a sick joke." He described the therapeutic damage that would be done to a distressed woman by requiring her to appear before an "inquisition." This was supported by Dr. Veronica O'Keane, also a clinical psychiatrist with perinatal experience, who described the proposal as "obstructive, unworkable and an insult to women" (Crosbie, 2013b). Subsequently the College of Psychiatry issued a very powerful statement to the affect that they would not participate in any compulsory assessment of pregnant women with suicidal ideation seeking an abortion as this was abusive. Then President of the College, Dr. McCarthy, stated that psychiatrists would not act as the country's "social police" (O'Regan, 2013a). While this position was no doubt motivated by a desire to protect women and the integrity of the profession, it also set down a marker that attempts to undermine professional autonomy by the Government would be met with resistance. This has in fact proven to be the case with ongoing objections from psychiatrists in relation to the 2013 Act and difficulties in establishing the mechanisms set out therein. The next part of the article will tease out the detail of the 2013 Act which places particular obligations on medical practitioners including psychiatrists.

Part IV: The impact of the dominant narratives – a separate process for suicide in the Protection of Life During Pregnancy Act 2013

In order to fully understand the difficulties with the relevant provisions on suicide it is necessary to locate these within the broader statutory framework and to contrast it with the provisions dealing with risk to the life of the woman from physical threats. The Act provides a definition of "unborn" as follows: "in relation to a human life, is a reference to such a life during the period of time commencing after implantation in the womb of a woman and ending on the complete emergence of the life from the body of the woman." The Act contains separate

procedures depending on whether the risk to the life of the woman arises from a physical illness or from suicidal ideation. Section 7 relates to physical illness and provides that it is lawful to 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 two medical practitioners have examined the woman and have jointly certified in good faith that there is a real and substantial risk of loss of life and in their reasonable opinion that risk can only be averted by carrying out the medical procedure. One medical practitioner must be an obstetrician who practises at an appropriate institution and the other is described as "a medical practitioner of a relevant speciality."[10] The reasonable opinion must be "an opinion formed in good faith which has regard to the need to preserve unborn human life as far as practicable." This is intended to ensure that the right to life of the unborn is factored into every decision made under the Act. The suggestion is that where the foetus is viable and the pregnancy can be terminated through early delivery thus removing the risk to the life of the woman and preserving the right to life of the unborn then this is what should occur (de Londras and Graham, 2013: 62; DOH, 2014: 31).[11] The medical procedure must be carried out by an obstetrician at an appropriate institution. Where practicable at least one of the medical practitioners should consult with the woman's general practitioner, with her consent, for the purposes of obtaining information in respect of the woman which may assist the medical practitioners in their decision to certify under section 7. Section 8 refers to risk of loss of life in emergency situations and in these circumstances it is permissible for one medical practitioner to determine that there is an immediate risk of loss of the woman's life from a physical illness and an abortion is immediately necessary to save the life of the woman. In these circumstances the medical procedure will be carried out by the medical practitioner making the assessment. The provisions in relation to emergency situations do not apply in circumstances where the risk to the life of the woman arises from suicidal ideation.

Section 9 provides for an abortion in circumstances where the risk to the life of the woman is from suicide. In these circumstances it is necessary for three medical practitioners to examine the woman and to jointly certify, in good faith, that there is a real and substantial risk of loss of the woman's life by way of suicide and in their reasonable opinion that risk can only be averted by carrying out the medical procedure. Again section 9(1)(a)(ii) states that the reasonable opinion of the medical practitioners must have regard to the need to preserve unborn human life as far as practicable. The guidelines now explicitly state that termination of a pregnancy by caesarean section or induction may be appropriate (DOH, 2014: 31). This raises difficult questions around at what point a foetus becomes viable and what are the ongoing risks for the woman and any baby that is delivered early in these circumstances (for further discussion see Enright, 2014a; Fletcher, 2014a). Sheldon (1997: 52-53) interrogates the medicalisation of reproduction in the UK and notes that in this process doctors are increasingly characterised as "the best representative of the foetus's interests" and as the "only one capable of representing the interests of the foetus (against those of the pregnant woman)." This is echoed in the provisions of section 9 of the 2013 Act. Of the three medical practitioners required to certify one must be an obstetrician, at least one must be a psychiatrist "who provides, or who has provided, mental health services to women in respect of pregnancy, childbirth or post-partum care," and one medical practitioner must be a general psychiatrist. Where practicable, and with the consent of the woman, her GP should be consulted by at least one of the medical practitioners required to certify the need for an abortion. The purpose of this consultation with the woman's GP is to obtain "information in respect of the woman from that general practitioner than may assist the medical practitioners in their decision as to whether or not to make a section 9

certification in respect of the woman." It is clear, therefore, that where the risk to the life of the woman arises from a threat of suicide there is a more onerous process involved as the woman has to demonstrate to all three medical practitioners that there is a real and substantial risk to her life. In circumstances where her GP is consulted an additional medical practitioner could potentially impact on the decision. The certifying obstetrician shall forward the section 9 certificate to an appropriate institution and "make such arrangements as may be necessary for the carrying out of the medical procedure" (section 9(5)(b)). The guidelines on the implementation of the 2013 Act clarify that the medical practitioners do not have to examine the woman together or at the same location (DOH, 2014: 17) but they must jointly certify that the legal test has been satisfied. The guidelines do suggest that it "may be appropriate for clinicians to consult with colleagues within a multi-disciplinary discussion in accordance with medical best practice." (DOH, 2014: 17).

Section 10 provides a review mechanism where the relevant medical practitioners have not certified the need for an abortion under section 7 (physical threat to life) or section 9 (suicide).[12] The woman must be informed in writing that she, or a person acting on her behalf, can apply to the Health Service Executive (HSE) to review the decision. The HSE are required under section 11 to establish and maintain a panel of at least 10 medical practitioners to carry out such reviews. Not later than three days from the date of an application for review the HSE shall convene a review committee to review the relevant decision. The composition of the review committee depends on whether the original decision was made under section 7 or section 9 and will mirror the initial requirements in terms of numbers and specialisation – that is to say that two medical practitioners will suffice where the risk to life is from a physical illness and three are required where the risk to life is from suicide. The review committee has seven days to complete a review of a decision and is required to examine the pregnant woman, not just her medical records (DOH, 2014: 34). Again the guidelines suggest that it is not necessary for the review committee to examine the woman together, "no further requirements are imposed in relation to the manner or location of this examination" (DOH, 2014: 34). However, under section 14 the pregnant woman is entitled to be heard by the review committee and where the committee is informed of this wish such arrangements as may be necessary shall be made in order to hear the woman or a person acting on her behalf. This seems to suggest that the committee would sit together as a panel to hear such submissions.[13] This would appear to be in addition to the requirement to examine the woman. The committee can either jointly certify that the statutory test is satisfied and notify the woman of this in writing, or it can refuse to certify in which case the woman must also be notified in writing.

There is no provision in the legislation for a further appeal to the Circuit Court or High Court. In the Irish Human Rights Commission's (IHRC) observations on the statutory framework (as set out in the Bill) there was an assumption that the decisions of the review committee would be subject to Judicial Review - "a decision of a review committee, being one made pursuant to statute, will be open to judicial review" (IHRC, 2013: 31, para.70). This was on the basis that the committee could be considered to be an "organ of the State" because it is based on legislation and has a statutory remit (IHRC, 2013: 27, para. 64). As part of the judicial review process the court will be able to consider whether the legislative provisions were adhered to, whether the committee acted in a manner compatible with the State's obligations under the ECHR and whether the woman's rights under the Constitution were upheld. Significantly the IHRC recommended that to ensure that any judicial review of a negative decision "is accessible and

effective, an expedited procedure before the High Court should be provided, with provision for legal aid, and anonymity" (IHRC, 2013: 4). This recommendation is not reflected in the 2013 Act and so there is a question mark over whether the legislation is in compliance with Article 6 and Article 8 of the ECHR. The possibility of further litigation is only briefly referred to in the guidelines which state that if the review committee does not certify "the woman also has a constitutional right of access to the Courts" (DOH, 2014: 35).

The Act also provides, in section 17, for a right of conscientious objection for medical practitioners, nurses and midwives. Where a person has a conscientious objection he or she is required to "make such arrangements for the transfer of care of the pregnant woman concerned as may be necessary to enable the woman to avail of the medical procedure concerned." As noted above the 2013 Act while repealing the provisions of the Offences Against the Person Act 1861 introduces an indictable offence of the intentional destruction of unborn human life. This is punishable by a fine or imprisonment for a term not exceeding 14 years, or both. A prosecution under this section can only be brought by or with the consent of the DPP. This ensures that the threat of prosecution continues to hover over those who may step outside the very narrow confines of the legal framework, including both doctors and women.

It is clear, therefore, that the shape of the 2013 Act, which introduces a more complex process for women who are suicidal to obtain an abortion has been shaped by the negative discourse and narratives around this issue outlined in Part III. While this continued stigma around suicide is disappointing there are very real practical consequences for vulnerable women in Ireland as the likelihood is that the legal framework is both unworkable and deeply damaging to women. This was illustrated in the first case, known as the case of Miss Y, to be dealt with under the terms of the new legislative framework which is discussed in Part V (Enright, 2014b).

Part V: Evaluating section 9 of the Protection of Life During Pregnancy Act 2013

There are a number of practical difficulties that can be identified with the procedure contained in section 9 and these are set out below. While it is useful to highlight these, as they impact on the viability of the procedure and the extent to which it is in compliance with the ECHR, it is also important not to become too caught up in technical detail and to lose sight of the more fundamental difficulties with the 2013 Act. This part of the article therefore also sets out the philosophical concerns with the statutory process. To understand the practical difficulties with the provisions contained in the 2013 Act it is necessary to appreciate the realities of the Irish situation. There was a concern that the statutory requirement under section 9 for the participation of a psychiatrist who provides or has provided mental health services to women in respect of pregnancy etc. may create difficulties as there are only three practicing perinatal psychiatrists in Ireland, all of whom are located in Dublin. This would have created very serious practical challenges for those women who live outside of the capital city and its environs. However, the guidelines clarify that this psychiatrist, while requiring expertise in this field, "does not need to be a perinatal psychiatrist." (DOH, 2014: 18). This may increase the accessibility of the statutory process for women who live outside the capital city depending on the numbers of psychiatrists in Ireland who satisfy the criteria.

The requirement for a joint certification may also cause difficulties as it will be possible for one medical practitioner to veto the decision to certify that the woman meets the test, and therefore is entitled to an abortion, even in circumstances where the other two statutorily required

medical practitioners (and possibly the woman's GP) agree that it is appropriate. It is unclear why, in circumstances where the risk to the life of the woman is from suicide, that an obstetrician should be involved in making that decision and why he or she should be able to veto the determination of two psychiatrists. However, the guidelines on implementation of the Act state that "the role of obstetricians is central to the process of assessment, certification and treatment under the Act, and they are also likely to play a key role in the referral pathway, regardless of whether the risk arises from physical health risk or suicide intent." (DOH, 2014: 7). The referral pathways set out in the guidelines state that it is acceptable to refer a woman whose life is at risk from suicide to the consultant obstetrician before the consultant psychiatrists, seemingly on the basis that joint certification from all three medical practitioners is required (DOH, 2014: 9-10).[14] This raises considerable concerns given that a consultant obstetrician has no expertise is assessing risk to life from suicide. These difficulties with the 2013 Act were identified by commentators (Murray, 2013b; Doctors for Choice, 2013) but ignored by the legislature and the consequences were played out in the Miss Y case with very real implications for the vulnerable young woman involved. This case concerned a young woman, pregnant as a result of rape, who was seeking asylum in Ireland. She was residing within the direct provision system and had very limited financial resources (for further discussion on direct provision see Thornton, 2013; 2014). As Enright states Miss Y was "sited at several punishing junctures of Irish abortion law" (Enright, 2014b). As a result of a number of delays and failures in care (a HSE investigation is currently underway to determine the cause of those delays and failures) she was not provided with the information, visas or resources to enable her to travel outside the jurisdiction for an abortion when she first sought one at an early stage in her pregnancy (around 8 weeks). By the time she was assessed by HSE psychiatrists as satisfying the statutory criteria under section 9 of the 2013 Act, because she was suicidal, the decision was made that the foetus was viable and so was delivered alive by caesarean section (for detailed discussion of the complexities of this case see Enright, 2014a; Enright, 2014b; Fletcher, 2014a; Fletcher, 2014b; Duffy, 2014). In the case of Miss Y it seems that both psychiatrists agreed that her life was at risk from suicide (and therefore satisfied the test set out in the X case and replicated in the 2013 Act) but the obstetrician intervened on the basis that the foetus was viable and therefore the correct course of action was to perform a caesarean section rather than an abortion. As noted above this approach has since been reified by the guidelines.

Issues also arise in relation to young women who may wish to avail of abortion services in Ireland (remember that the young woman in the X case was 14, the young woman in the C case was 13,[15] and the young woman in the D case was 17[16]). In these circumstances who provides consent to the abortion? The law in relation to consent to medical treatment by minors is complex in Ireland. The Non-Fatal Offences Against the Person Act 1997 states that it shall not be an offence to provide medical, surgical or dental treatment where consent has been obtained from a person who is aged 16 and over. The location of an age of consent to medical treatment within a criminal defences legislative provision is unusual, to say the least, but it would seem clear that once a young woman is over the age of 16 she is legally entitled to consent to medical treatment, presumably including a procedure such as an abortion. Whether such a definitive approach would in fact be adopted in practice is another matter – particularly if a young woman went to a family GP as an initial point of contact. The guidelines state in Appendix 10 that once a young woman is over the age of 16 it is not necessary to seek parental consent. However, her parents are presumed to have the right to see her medical records under the Freedom of

Information Act 1997 until she is 18, unless this would not be in her best interests, and medical practitioners are advised to inform patients of this position (DOH, 2014: Appendix 10). The issue is more complicated if the young woman is under the age of 16. The concept of the mature minor – introduced into the law in England and Wales in the *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112 case – has not yet been adopted into Irish law by the courts in this jurisdiction. It is unclear whether the Irish courts would follow the English approach and what impact the provisions of the Constitution would have on the approach of the courts (for further discussion see Madden, 2011: 513; Donnelly, 1995; Donnelly, 2002: 35-36). Ideally the Government would introduce much needed legislation in relation to young people and the capacity to consent to medical treatment to complement the legislation on abortion, the Law Reform Commission (2009; 2011) have issued recommendations on this matter, but a detailed discussion of this issue is outside the scope of this paper.

An additional complicating factor arises where the young girl/woman is in the care of the State. This situation has already arisen (C and D cases referred to above) and so it is reasonable to assume that it will arise again. In these circumstances is the State obliged to inform the parents/guardians of the young woman that she wishes to obtain an abortion? How is the matter to be resolved if the State is of the opinion that an abortion is appropriate in the circumstances but the parents of the child object to this? Is the District Court to continue to have oversight of these matters as it does in respect of other child care matters? Or is it to be dealt with entirely under the new statutory regime set out in the 2013 Act? The guidelines do not offer much assistance in relation to this issue merely stating "[i]n some circumstances a court order may be required before proceeding with a medical or psychiatric assessment and/or treatment and advice should be sought from the HSE in such cases" (DOH, 2014: Appendix 10). The precise legal issues that arise in each case may be determined by the nature of the care order in place and the guidelines do note that where no contactable parent/guardian can be identified the District Court may authorise a relevant social worker to give consent on behalf of the young person.

There is also a concern around who will be eligible to examine women for the purposes of certification under section 9 of the 2013 Act. The College of Psychiatry in Ireland raised the issue of the absence of guidance for GPs in accessing suitable psychiatrists to examine the woman (Holland, 2014). The usual practice if a person requires psychiatric evaluation is for the GP to refer her to the regional HSE psychiatrist. However, certain psychiatrists have very clearly and publicly stated that they do not believe that abortion is ever a treatment for suicidal ideation[17] and this has raised concerns that women referred to these psychiatrists would have difficulty obtaining a certification required under the 2013 Act. The existence of a power of veto within the certification process creates very legitimate concerns around the possibility of the statutory process being undermined from within. This gave rise to a call for a mechanism which allows a GP to "by-pass" the local HSE psychiatrist if the GP is concerned about the psychiatrist's ideological stance on abortion (Holland, 2014). The guidelines address this to the extent that they state that if a GP has difficulty in accessing a local consultant psychiatrist then he/she can refer to the relevant Executive Clinical Director (Mental Health) to organise an appropriate assessment (DOH, 2014: 9). This would apply in a situation where the local consultant psychiatrist refused to assess a woman for the purposes of the 2013 Act. The guidelines also clarify that it is open to a woman to seek a second opinion if the original assessment does not result in certification (DOH, 2014: 21), but again this increases the expense for the woman and

also gives rise to the possibility of delay. A similar concern arises in relation to the composition of the review panel - section 11 of the 2013 Act states that the Executive shall request the representative bodies of the medical profession[18] to nominate practitioners for appointment to the panel. Again, if members of the panel are ideologically opposed to abortion in circumstances where the risk to the life of the woman is from suicide and there is no requirement that this be disclosed then there is the potential to undermine the operation of the review mechanism from within.

Questions can also be raised about the practicality of the timeframes for review set out in sections 12 and 13 of the 2013 Act given that these procedures will only be initiated in circumstances where the life of the woman is at risk. Under the terms of the legislation there is the possibility of a delay of up to 10 days for a review decision to be provided to the woman seeking an abortion. In circumstances where the risk to the life of the woman arises from suicide there is the possibility that she will have to convince six medical practitioners that there is a real and substantial threat to her life – the initial process requires that she is examined by three medical practitioners and the review committee will consist of another three medical practitioners. It also appears that she may have to recount her story multiple times – while the Act requires joint certification it does not require joint examination. It may well be necessary for the woman to travel to different locations to be examined by each of the medical practitioners adding to the expense and distress already associated with the process.

The considerable delay in publishing the Clinical Guidelines on the operation of the 2013 Act[19] was described by the Chief Executive of the College of Psychiatrists, Miriam Silke, as "very haphazard and unsatisfactory" and members of the College were advised not to participate in the review panel until the guidelines were in place. While the delay was not ideal, perhaps more importantly it highlights the powerful impact of the narratives interrogated in this article. The constant rhetoric surrounding the danger of legislating for suicide and the need for complex safeguards to prevent the floodgates opening has created a situation where the statutory framework is multi-layered, with unworkable timeframes, and relies for implementation on medical practitioners who remain unclear about what is required of them. A very real concern, reinforced by the practical difficulties with the provisions of the legislation outlined above, is that the legislation was merely a fig-leaf to ensure surface compliance with the judgment of the ECtHR in *A, B and C*. It is very difficult to plausibly claim that the pathway set out for women whose lives are at risk from suicide and who wish to access an abortion under the 2013 Act is an effective and accessible procedure as required by the ECtHR. The reality is that the situation will remained largely unchanged with Irish women who can afford to do so continuing to travel abroad to access reproductive services or purchasing abortion drugs online and self-medicating.

The consequences for dignity

In addition to the practical difficulties with the 2013 Act, it is perhaps more important to recognise and to articulate the profoundly negative messages contained in section 9 for those women seeking abortions on grounds of suicidal ideation. Through section 9 the State is communicating to this small and vulnerable group of women that they are not believed, that they are different to the other women whose lives are at risk from physical illnesses, and that they are less trustworthy. In so doing the regulatory framework is harming the dignity of those women who will be compelled to engage with the statutory process. Often when discussing dignity in a legal context we do so with reference to due process and the rule of law. This places

emphasis on the right to be heard and to give an account of yourself. Waldron (2012: 202) in attempting to offer a definition of dignity states that the dignity of a person "…assumes she is capable of giving and entitled to give an account of herself (and of the way in which she is regulating her actions and organising her life), an account that others are to pay attention to." This appears to be a reasonable position in respect of the criminal justice system and in relation to civil law disputes – areas where we accept that it is appropriate for the rule of law to operate. Yet the requirement in the 2013 Act for a woman to provide repeated accounts of her distress and the intimate details of what is an intensely private matter appears to be an affront to her dignity rather than an integral aspect of respecting her dignity. Perhaps this discord can be explained if we recognise that there are areas where it is disrespectful for law to operate at all and the decision by a woman to have an abortion in circumstances where she is experiencing suicidal ideation is one of those areas. It is a deeply personal and private decision based on clinical factors and perhaps is most appropriately arrived at following discussion between a woman and her doctor.

The affront to dignity contained in the 2013 Act is compounded by the awareness on the part of the woman that the reason for the regulatory process she is involved in is that the State perceives her to be untrustworthy. Carol Sanger's work on decisional dignity (2009; 2012) illustrates that these concerns are not unique to Ireland. Her work focuses on judicial bypass hearings in the US for minors who wish to access an abortion but who, for a variety of reasons, feel they cannot obtain the parental consent that is required in many States. Sanger aims to develop a broader conceptualisation of the harms imposed by law on women who seek to end an unwanted pregnancy – this includes the harms women suffer by virtue of abortion regulation, even when they are, in the end, able to obtain a legal abortion (Sanger, 2009: 417). While the legislative process contained in the 2013 Act is not a judicial one, and so can be distinguished from the judicial bypass process in the US, some of the issues addressed by Sanger relating to dignity are relevant. There is an affront to the dignity of women in Ireland who are experiencing suicidal ideation or thoughts but whose pain and suffering is not believed, who are characterised by the legal system as inherently untrustworthy. These women come to the process as rights bearers – they have a constitutional right to access an abortion in Ireland provided that they satisfy the legal test – yet additional barriers and hurdles are placed in their way before they can access that right because of the nature of the threat to their life. This involves the system of regulation in making a moral judgement in relation to this particular risk to life, by reason of suicide, and it operates to "other" these women through the legal process by placing additional burdens on them. Sanger (this volume) notes that "hyper-regulation may not in every instance be intended punitively. It is, however, based on a particular conception of women." In the Irish context this conception of women is grounded in the existing narratives of the untrustworthy, unreliable and hysterical woman. Even if women are "successful" under section 9 of the Act, and are found by the two psychiatrists and an obstetrician to satisfy the X case test (or the review committee certifies that the legal criteria have been met) and therefore can access an abortion in Ireland, they will have been damaged by the process which operated to single them out as a case apart and not to be trusted.

The State, through the legislative framework introduced, is compounding the already difficult circumstances of these women. It is not unreasonable to suggest that many women who are experiencing suicidal ideation and who want an abortion will continue to leave this jurisdiction in order to obtain abortion services. The result will be that only those women with extremely

limited financial means or very serious mental distress, who may not be in a position to avail of the option to travel for an abortion or to purchase medication, will be compelled to engage with the proposed system. Consequentially only the most vulnerable women within this category will be subjected to further trauma through the legal process. The 2013 Act also reinforces the two-tier approach to healthcare that exists in Ireland in the specific context of reproductive healthcare as those with sufficient resources will be able to by-pass the difficult and undignified statutory procedure and those who lack the socio-economic capital will be compelled to remain. This discrimination between women was raised by the UN Human Rights Committee during the review of Ireland's compliance with the ICCPR in July 2014.

Conclusion

Any jurisdiction-specific analysis of abortion law must be aware of the social and legal context in which developments are occurring. In Ireland the discourse on abortion always takes place in the shadow of Article 40.3.3 of the Constitution and the decision of the Supreme Court in the X case. More recently the judgment of the ECtHR in the *A, B and C* case and the death of Savita Halappanavar focused the spotlight once more on abortion and the need for clarification of the legal position in Ireland. Relatively early in the debate it became clear that legislation would be introduced and from that point on the discussion revolved almost exclusively around whether or not a risk to life from suicide should be included within the statutory framework. As illustrated in Part III of this article there were a number of very negative narratives which influenced the tone and nature of this debate. The narratives revealed a level of misogyny in Irish society as they characterised suicidal pregnant women seeking abortions as untrustworthy, manipulative and hysterical. They also highlighted an ongoing stigma in relation to those who experience suicidal ideation with this being classified as a less serious threat to the life of the woman (a threat to life by suicide cannot come with the emergency provisions in section 8) and one that needs to be tested and proved before being believed. These narratives were extremely powerful and ultimately had a very significant impact on the shape of the legislation that was introduced in the Protection of Life During Pregnancy Act 2013 – illustrated by the inclusion of a separate and more onerous procedure where the risk to the life of the woman is from suicide. However, these narratives were also met with counter-narratives which highlighted the importance of listening to and believing vulnerable women.

While the introduction of a statutory framework regulating the provision of abortion services in Ireland after a 20 year delay might appear to be a victory for the reproductive rights of women it may well prove to be of the pyrrhic variety. As set out in Part V the framework in place gives rise to very considerable practical difficulties for women who wish to access an abortion under section 9, it will be damaging to those women who do engage with it (as evidenced in the Miss Y case), and for the vast majority of women in Ireland the position will remain unchanged because they will continue to travel abroad to obtain these services. The narratives that shaped the legislation will impact on the operation of the process. The State, through its laws, will continue to fail many Irish women.

However, there are some positives that can be drawn from recent developments in the Irish legal landscape in relation to abortion. The hearings of the Joint-Oireachtas Committee on Health and Children demonstrated that it was possible for informed and robust debate on what has historically been a very fraught issue to take place in a measured and respectful manner. It is to be hoped that any further developments in this field are approached in a similar manner.

The counter-narratives from the medical profession, outlined in Part III, were a new and welcome development. Whatever the motivations behind these, and we can assume that they are varied and complex, it is important in a system which vests considerable authority in the medical profession that prominent members of that profession are seen to publicly recognise the women concerned as valid rights-holders who are entitled to respect and to be believed. Finally, the introduction of abortion legislation in Ireland, albeit inadequate legislation, does at least open up a space to begin to critique the legislation, to improve it through amendment, and to monitor the provision of abortion services through the recording and reporting requirements.[20] Perhaps most importantly it has also reinvigorated the dialogue around reproductive rights in Ireland, as evidenced by new activist groups, such as Speaking of I.M.E.L.D.A[21] and the Abortion Rights Campaign,[22] coming to the fore. This is significant because these groups have the potential to begin the process of developing new narratives around abortion and reproductive rights in Ireland and, as this article has illustrated, narrative can be extremely influential.

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Notes

[1] The Act was signed into law by the President of Ireland on the 30th July 2013 and commenced on the 1st January 2014. There are also a number of statutory instruments relating to the 2013 Act: S.I. No. 537 of 2013, S.I. No. 538 of 2013, S.I. No. 539 of 2013 and S.I. No. 546 of 2013. The statutory instruments set out forms for use by medical practitioners under the terms of the 2013 Act.

[2] The terminology used when discussing abortion is very often an indication of where a person is situated, broadly speaking, in respect of the issue. Those who oppose abortion generally identify themselves as "pro-life." Those who are in favour of broader access to reproductive health services tend to characterise themselves as "pro-choice." Both of these terms are problematic as they are interpreted as offensive by the other group – many of those who oppose abortion are not generally opposed to people having choices, just as those who are in favour of accessible reproductive health services are not anti-life. Replacing these terms with "pro-abortion" and "anti-abortion" is also unsatisfactory. While these terms do at least focus on the issue under consideration they also reduce the debate to very simplistic positions and the reality is that this is a complex and multi-faceted issue and most people occupy the extensive grey space between these black and white positions. This created a difficulty in choosing the terminology to be used in this article but ultimately the author has opted for the widely used terminology of "pro-life" and "pro-choice" as these are the terms the various groups have chosen to describe themselves and these were the terms most commonly used during the recent debates in Ireland on the introduction of the Protection of Life During Pregnancy Act 2013.

[3] See para 189 of the judgment in *A, B and C v Ireland* where the Irish Government stated in submissions that "there had been no criminal prosecution of a doctor in living memory."

[4] Dáil Debates on the Protection of Life During Pregnancy Bill 2013: Report Stage 11th July 2013. See http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2013071100062 (last accessed 5th July 2014).

[5] This characterisation of Article 8 is contained in para 212 of the judgment of the ECtHR in *A, B and C v Ireland* [2010] ECHR 2032.

[6] See the website of the Iona Institute http://ionainstitute.eu (last accessed 16th June 2014).

[7] *Norfolk and Norwich Healthcare NHS Trust v W* [1996] 2 FLR 6; *Re L* (5 December 1996, Unreported), Fam Division; *Re MB (An Adult: Medical Treatment)* [1997] 2 FLR 426; *Bolton Hospitals NHS Trust v O* [2002] EWHC 2871.

[8] *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FCR 274; *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762.

[9] This statement was made during the hearings of the Joint Committee on Health and Children on the 8th of January 2013. The full text of the submission to the hearings is available here: http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/DebatesWebPack.nsf/committeetakes/HEJ2013010800027 (last accessed 6th July 2014).

[10] Section 2 of the 2013 Act defines "relevant speciality" as "(b) relevant to the care or treatment of the physical illness in respect of which the risk of such loss arises."

[11] Section 6.4 of the Guidelines states: "Once certification has taken place, a pregnant woman has a right to a termination of pregnancy as soon as it can be arranged. The clinicians responsible for her care will need to use their clinical judgment as to the most appropriate procedure to be carried out, in cognisance of the constitutional protection afforded to the unborn, i.e. a medical or surgical termination or an early delivery by induction or Caesarean section. Following certification, if the pregnancy is approaching viability, it is recommended that a multi-disciplinary discussion takes place to ascertain the most appropriate clinical management of the case."

[12] Note that the guidelines also state that if one of the medical practitioners refuses to certify it is open to the woman to seek another specialist opinion in accordance with normal medical practice. If she is unable to get a second opinion she can then activate the formal review procedure if she wishes to (DOH, 2014: 21).

[13] This impression is reinforced by section 14(2)(b) which permits the committee to require a medical practitioner or former medical practitioner to "attend before the committee and to give to the committee such assistance and answer such questions as it may require." The committee may (subject to the provisions of the Act) "determine its own procedures" and will be provided with administrative facilities.

[14] "If a GP considers a pregnant woman's life to be at real and substantial risk from suicide, he/she should refer her urgently to the local consultant psychiatrist, or a consultant obstetrician in an appropriate institution or through the appropriate emergency pathway depending on her condition and how critical her situation is." See Guidance Document at p. 9.

[15] *A. & B. v Eastern Health Board and C* [1998] 1 IR 464; [1997] IEHC 176. This case involved a 13 year old girl (C) who became pregnant as the result of rape and who was taken into the care of the State. The High Court accepted psychiatric evidence that there was a real and substantial risk, in the form of suicide, to C's life and a direction was issued authorising the Health Board to travel abroad with her for the purposes of an abortion.

[16] *D (A Minor) v District Judge Brennan, the Health Services Executive, Ireland and the Attorney General*, unreported judgment of the High Court. This case occurred in 2007 when a 17 year old (D) brought a case against the HSE when it attempted to prevent her from travelling to Britain to have an abortion. In this case D was four months pregnant and had learned that the foetus had a fatal abnormality incompatible with life outside the womb. She had been in the care of the HSE for a period prior to the case. D stated that although she was deeply traumatised at the prospect of losing her baby she was not suicidal. The High Court ruled that there was no impediment to her travelling outside the jurisdiction for the purpose of terminating the pregnancy and emphasis that the case revolved around the right to travel rather than the substantive issue of abortion.

[17] See the statement issued on 25th April 2013, prior to the passing of the legislation, on behalf of 113 consultant psychiatrists practicing in Ireland which read "As practicing psychiatrists we are deeply concerned at the Government's stated plan to legislate along the lines of the X-case, as this will mean legislating for suicidality. We believe that legislation that includes a proposal that an abortion should form part of the treatment for suicidal ideation has no basis in the medical evidence available." This statement was issued on foot of a survey conducted by four psychiatrists, among them Professor Patricia Casey, patron of the Iona Institute, who frequently acts as a spokesperson for the "pro-life" movement. The survey was apparently sent to 302 of the 350 or so psychiatrists within Ireland. Of the 302 surveyed 127 responded and 113 of those queried the inclusion of suicide within the legislation. The particular questions included in the survey were not reported. This statement was strongly criticised by Professor Veronica O'Kane, a member of Doctors for Choice and also a professor of psychiatry in UCD. Nevertheless, the survey does indicate that there undoubtedly is a body within the psychiatric profession in Ireland who do not believe that suicidality should have been included within the statutory framework and who will bring this belief with them when engaging with the statutory process set out in the 2013 Act.

[18] The Institute of Obstetricians and Gynaecologists, the College of Psychiatrists of Ireland, the Royal College of Surgeons in Ireland and the Royal College of Physicians of Ireland.
[19] The 2013 Act commenced on the 1st January 2014 and the guidelines were released to certain medical practitioners in July 2014 and subsequently published in The Guardian newspaper in August 2014. The final version of the Guidelines was published on the Department of Health's website in September 2014.
[20] Sections 15 and 20 of the 2013 Act provide for the recording and reporting of statistics in relation to the numbers of abortions carried out in Ireland in accordance with the legislation and the numbers, reasons and outcomes of reviews carried out under the statutory provisions.
[21] Speaking of I.M.E.L.D.A. is a direct action feminist performance group challenging the ongoing problem of I.M.E.L.D.A. – Ireland Making England the Legal Destination for Abortion.
[22] The Abortion Rights Campaign is described as a movement for choice and change in Ireland. Their aim is to promote broad national support for a referendum to repeal the 8th Amendment by the Irish parliament, to push for the introduction of extensive abortion legislation by the Northern Ireland Assembly, and to ensure the health and rights of women in pregnancy are protected in line with international human rights standards.