In the European Court of Human Rights

(Application No. 25579/05)

Between

A, B and C (Applicants)

And

Ireland (Respondent)

Joint Written Observations

By Doctors for Choice, Ireland, and the British Pregnancy Advisory Service, UK

Pursuant to Article 36.2 ECHR and Rule 44.2 of the Rules of Court

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Introduction

As requested, this submission will address statistical information about the numbers of women travelling to the United Kingdom for abortion, and address medical issues concerning the restriction of abortion in Ireland.

Doctors for Choice

Doctors for Choice represents medical doctors in Ireland who support a woman's right to choose abortion and seek the regularisation of abortion provision in a publicly funded health service. Doctors for Choice is a voluntary organisation that first came together in 2001 as a group of eight doctors campaigned against the 2002 proposed constitutional amendment. The proposed amendment, which was defeated, sought to further restrict abortion provision in Ireland. It proposed to remove a suicide risk as a legally accepted risk to the life of a pregnant woman that would justify abortion provision. This legal proposal represented the culmination of an extensive policy process on abortion, which began with the launch of a Green Paper on Abortion in 1997. We came together as Doctors for Choice because we were concerned about the harmful effects of abortion restriction on the lives and health of our patients.

Doctors for Choice is the voice of a significant and growing number of doctors (currently 200) working in Ireland in a wide range of specialities but most particularly family medicine, psychiatry and obstetrics & gynaecology. Doctors For Choice has also received significant support from doctors who feel unable to articulate their support publicly in the current legal and medical climate about abortion in Ireland.

Doctors for Choice hears from and represents those Irish doctors who through their professional work have direct experience of women patients whose lives and health are negatively affected by Ireland's lack of abortion provision. These effects are both physical and psychological and can be life-long. Clinical cases very similar to the A, B, and C cases have been experienced in differing ways by Doctors for Choice members in many parts of the country.

The British Pregnancy Advisory Service (BPAS)

The British Pregnancy Advisory Service (registered charity number 289145) was set up in 1968 after the implementation of the 1967 Abortion Act in order to provide services, train doctors and provide premises for safe legal abortion, at a time when the NHS not always able or prepared to provide abortion services. Among other male and female sexual health services, BPAS provides pregnancy consultation in England, Wales and Scotland and treatment for abortion up to the legal time limit.

Approximately 55,000 women each year have treatment for termination of pregnancy at BPAS after attending for non-directive pregnancy counselling and information, which is registered with the Department of Health. BPAS is the largest provider of early medical abortion in Europe (the 'abortion pill' method, used at under 9 weeks' gestation) having been largely responsible for introducing this non-invasive method to the UK in 1992. The UK now has a record number of abortions taking place at earlier gestations. In 2007, 90% of abortions were carried out at under 13 weeks gestation; 70% were at under 10 weeks.[1]

BPAS is also a specialist provider for women presenting late in pregnancy for abortion, which involves relatively small numbers of patients, but which tend to be women in especially complex and sensitive circumstances. BPAS undertakes most of the abortions taking place between 20 weeks' gestation and 23 weeks and 5 days' gestation in the England and Wales each year, under contract to the NHS. Beyond 24 weeks' gestation, all terminations in the UK take place in NHS premises. BPAS is regulated by the Healthcare Commission in England, Healthcare Inspectorate Wales, NHS Quality Improvement Scotland and the Department of Health. BPAS works closely on policy and training issues with the Royal College of Nursing, the Royal College of Obstetricians and Gynaecologists, and the Faculty of Family Planning and Reproductive Health Care. BPAS is a research-led organisation and facilitates academic and Department of Health research projects under the scrutiny of its independently constituted Research and Ethics Committee.

BPAS' abortion treatments, comprehensive counselling services, male and female contraceptive and sterilisation services and sexually transmitted infection testing and treatment services are all 'not-for-profit'. All of the charity's services are conducted according to the relevant professional guidance under the scrutiny of BPAS' independently-constituted Clinical Governance Committee. For further information about the charity or its services, please see www.bpas.org.

In 2007, BPAS saw 686 women requesting a termination of pregnancy from the Ireland. Of these, 98 women (14%) were under the age of twenty. As with all women travelling from the Ireland, these women including those under the age of 16 have to find the cost of their treatment, travel and accommodation in the UK. BPAS is run on a not-for-profit basis and provides more than 90% of its services under contract to the NHS, which restricts the income available to the charity. Nonetheless BPAS endeavours to provide assistance to women who present to us and are ineligible for NHS funding and cannot meet their fees. BPAS has a programme of loans and grants supported by a hardship fund. These resources are extremely limited and typically women coming from Ireland would be expected to make a contribution to the cost of their care, as BPAS is financially unable to meet the needs that these women present with.

Statistical information about Irish women travelling for abortion

The only data on abortion trends for Irish women is published by the Department of Health regarding abortions performed in England and Wales. Equivalent data is not published in Scotland regarding the treatment of Irish women, so the picture of Irish women's access to abortion in the UK remains incomplete. Additionally some Irish women accessing abortion in the UK will not be recorded as such. To preserve their confidentiality, or obtain abortion care

paid for by the UK NHS, some Irish women will give addresses in the UK at which they are not resident. These procedures will not be recorded as abortions to Irish women in data collection. In 2007, the last year for which statistics are available, there were 4,686 abortions provided in England and Wales to women from the Republic of Ireland, 66% of the total of 7,099 abortions provided in England and Wales to residents of other countries. Women from Northern Ireland accounted for a further 19% of this total.

Year	Number of Irish women notified as having an abortion in England and Wales
1975	1573
1980	3320
1985	3888
1990	4064
1995	4532
2000	6391
2001	6673
2002	6522
2003	6320
2004	6217
2005	5585
2006	5042
2007	4686

(Data from Department of Health annual abortion statistics (England and Wales) and Crisis Pregnancy Agency report number 19)

The 2007 total of abortions to non-residents is the lowest in any year since 1969.[2] The number of abortions to non-residents remained between 9,000 and 10,000 in the period 1995 to 2003 but since then, the number of women coming from Ireland to the UK for abortion care has fallen steadily. There is no central data collection of abortions to women resident in Ireland, but anecdotal reports are that Irish women are travelling to other healthcare providers in Europe, such the Netherlands for treatment.[3] The availability of the Euro, lower cost termination services in continental Europe, the advent of lower cost air travel with equivalent travel time, and English language skills among continental providers have all contributed to this. Irish women are also accessing early medical abortion medication (the 'abortion pill') from the Internet for home use without medical supervision, rather than travelling abroad for terminations.[4]

As noted above, service providers report that Irish women do not always provide their home addresses when they travel to Britain for terminations. Sometimes they will provide a British address, such as the address of their local accommodation. There is substantial anecdotal evidence within Doctors for Choice that significant numbers of Irish women continue to give UK addresses to preserve their confidentiality. This is also acknowledged in Clements and Ingham's report for the Crisis Pregnancy Agency, 'Improving knowledge regarding abortions performed on Irish women in the UK' as well as other qualitative studies in the area.

It is of concern that Irish women are likely to access abortion treatment later than necessary after experiencing delays associated with legal restriction and travel. Clements and Ingham note that 'the percentage of abortions performed in the second trimester (13+ weeks) has fallen for Irish women, but is still higher than that for Great Britain. This is possibly due to the time involved in Irish women researching and referring themselves to abortion clinics and making and carrying out travel arrangements'.[5] There is no evidence to indicate that those Irish women who are determined to access an abortion and have the available resources to do so, will not do so because of the legal status of abortion in their own country. Worldwide, researchers are concerned at the burden placed on women by the legal restriction of abortion, with the resulting use of clandestine and unsafe methods. The authors of *The Lancet* paper "Induced abortion: estimated rates and trends worldwide"[6] conclude that there is little difference in abortion rate worldwide, regardless of whether the procedure is legal or illegal. The report concluded that 'ensuring that the need for contraception is met and that all abortions are safe will reduce maternal mortality substantially and protect maternal health.'

Medical issues concerning the restriction of abortion

Abortion as medical care

The international evidence shows that the restriction of abortion is associated with worse physical and psychological outcomes for women than the legal and accessible provision of abortion,[7],[8],[9].[10] Worldwide, death and ill health are reported where there is a lack of access to safe and legal abortion. Every year, nearly 80,000 women die and thousands more suffer permanent disabilities as a result of unsafe abortion.[11]

The review of maternal mortality 'Saving Mother's Lives 2003-2005' published by the Confidential Enquiry into Maternal and Child Health (CEMACH), explores deaths associated with abortion prior to the 1967 Abortion Act, providing compelling evidence on adverse health outcomes from restriction of access to abortion in the UK. This stated that: 'the most striking change during the first 50 years of this report has been the disappearance of illegal, unsafe abortion as a cause of early pregnancy direct deaths which followed the passage of the Abortion Act in 1967. The first CEMACH Enquiry Report, covering the years 1952-1954, described 153 deaths from 'abortion', of which 108 at the least had been procured illegally. […] Around 30 deaths per year from illegal abortion continued through the 1950s and 1960s. The first full working year of the Abortion Act was 1969 and the number of deaths "clearly due to illegal abortion", fell that year to 17.'[12]

CEMACH's 'Why Mothers Die 2000-2002' Report also notes that of these deaths prior to the 1967 Abortion Act, 'It is quite possible that the number of deaths from illegal abortion were underestimated. The 1979–81 Report noted that the number of deaths attributed to spontaneous miscarriage had decreased from 1970, in parallel with those from illegal abortion.' Sheldon also discusses various unofficial sources which put the figure of deaths associated with abortions at a much higher rate of between 200 and 500 a year.[13]

The 2000-2002 CEMACH report also notes that 'The success of the Abortion Act in Britain, and of similar legislation in other countries, is still to be mirrored in many parts of the world, where the scourge of unsafe abortion is still responsible for a large proportion of maternal deaths. In the international context, it is essential that renewed efforts are made to address this continuing challenge.'[14]

Although there is little evidence of illegal abortion in Ireland[15], we are concerned about the impact of backstreet services in those cases that have been reported.[16] We are particularly concerned that the government's response to a 2004 report about a back street operation going under the name "Gynaecological Services" and charging €500 for an abortion, was to continue to rule out the possibility of legislating for abortion provision.[17] In another reported case in March 2004, the Coroner's Court found that a 19 week foetus died following "a chemical and instrument-induced abortion".[18] The Gardai (Irish police) said that the woman would be sought for questioning should she return from the Philippines, where she fled after the botched abortion.[19] Another case saw a midwife from the Rotunda hospital express "concern to gardaí that the tablets [a woman] had been taking before the birth of her stillborn baby boy, born prematurely at 22 weeks on October 6th, 2003, acted as an abortifacient."[20] In this instance the Irish police considered prosecution but decided that there was not enough evidence. Another report involved a Romanian woman in June 2005, whose former partner made a complaint to the Garda National Immigration Bureau because she had a backstreet abortion without his knowledge or consent, illustrating the vulnerability of abortion-seeking women.[21]

Unintended pregnancy continues to be a serious public health problem. Data from the USA shows that 49% all pregnancies were unintended and that many couples who use contraception remain likely to experience unintended pregnancy. Typical or 'real world' contraceptive failure rates are as high as 8% of couples relying on the contraceptive pill. 15% of couples relying on male condoms experience an unintended pregnancy within the first year of use.[22] Restriction of access to abortion impacts adversely on the health of large numbers of women experiencing unintended pregnancy. For most women, fertility regulation by

contraception, sterilization, or legal abortion is substantially safer than childbirth.[23] However, termination at later gestations, while still safer than live birth, is riskier than termination at an earlier gestation.

In the experience of Doctors for Choice, most doctors involved in clinical work recognise that the availability of abortion in Ireland would directly and immediately assist the many women who have unwanted pregnancies. These women are either left to continue with their pregnancies or can terminate the pregnancy only by travelling abroad, at significant cost to their health and welfare. Although life-saving abortion is permissible under Irish law, the lack of guidance on what counts as a real and substantial risk to life means that it is very difficult for doctors to judge when intervention is legally justified. Doctors also know that they face the threat of criminal sanction with up to life imprisonment if they perform a termination which is subsequently judged not to qualify as life-saving. As a result women may not be getting the life-saving abortions to which they are legally entitled. The failure to permit abortion when pregnancy threatens an individual woman's health, means that health care professionals are compromised in their ability to provide the best medical care to women patients.

A risk to a woman's health can turn into a risk to her life in particular circumstances. It can be difficult in practice to make a bright line distinction between abortions that are necessary to preserve a woman's life and those that are necessary to preserve her health. It is also better medical practice to intervene when a significant health risk eventuates than to wait until the situation has deteriorated considerably.

An attempt in 2005[24] by a backbench MP in the UK Parliament to prohibit access to abortion in England and Wales, except in cases of rape or where the woman's life was at risk, prompted the Department of Health to assess the implications of such a measure. The number of unintended conceptions that would then be involved in claims of suicide or rape was estimated by the Department to 'range from 10,000 a year to 40,000 and 25,000 is considered to be realistic.'[25]

Pregnancy may aggravate the risk to women with pre existing medical and mental health conditions such as epilepsy, diabetes, congenital or known acquired cardiac disease, auto-immune disorders, obesity BMI of 30 or more, and severe pre existing or past mental illness. In recognition of this the CEMACH report of 2007 has recommended that women with such conditions receive pre-conception counselling.[26] These risks include blindness, stroke, kidney failure and heart damage.

Suicidal tendencies are one kind of threat to psychological well-being which pose a risk to life. More general risks to psychological health and well-being are common among those with unwanted pregnancy in the experience of Doctors for Choice, but not well recorded.

Termination of pregnancy is itself a low risk procedure. The risk of maternal death from legal abortion is associated with the lowest risk of adverse outcome resulting from pregnancy. Of the alternatives to abortion, live birth poses an intermediate risk and ectopic pregnancy and foetal death pose the highest risk. This holds true well beyond the 'early' stages of abortion in the first 12 weeks' gestation.[27] Even at the latest stages of legally available abortion, abortion is not more risky than continuing pregnancy and birth. Of the 106 maternal deaths directly associated with pregnancy, as reported by the Confidential Enquiry into Maternal and Child Health (CEMACH) in their 2000-2002 report, 3 deaths were associated with legal termination of pregnancy. The majority were associated with complications of late pregnancy and delivery including thrombosis and thromboembolism, hypertensive disorders and haemorrhage.

The available data suggests that Ireland has a relatively low rate of maternal mortality, a fact which is to be welcomed.[28] Doctors who are against all abortions sometimes interpret this as evidence that pregnancy is not producing life-threatening conditions and that therefore there is no or little need for abortion services. But in the view of Doctors for Choice, this claim conflates two different issues. Continuing a pregnancy to delivery is always riskier than abortion, even if risks associated with birth do not eventuate at moderate or high rates. Therefore a termination is more likely to reduce a significant risk to life or health than continuing the pregnancy. Secondly, doctors should be permitted to terminate a pregnancy in

order to protect a woman's health and not just at the point where the woman is about to die. Thirdly, the data on maternal mortality in Ireland has not been subjected to comprehensive analysis and is generally made available through the reports of the three largest maternity hospitals, the Coombe, the Rotunda, and the National Maternity hospital, and that of the Central Statistics Office. This data obviously does not include those Irish women who have terminated their pregnancies abroad.

Doctors who are against all abortions also argue that abortion produces negative adverse psychological health outcomes for women. However, across repeated studies this has not been shown definitively to be the case. To give one example, a recent study of women aged 15-25 in New Zealand[29] who experienced a pregnancy has been cited in the United Kingdom by MPs seeking to restrict abortion[30], as definitive evidence that abortion and the development of psychiatric conditions are causally linked. However, this view has no support from the authors of the paper, who acknowledge confounding factors that their research may not have accounted for. Under-reporting of abortion is a well-known problem with this type of research. The authors note: 'It is clear the decision to seek (or not seek) an abortion following pregnancy is likely to involve a complex process' and that as a result, 'it could be proposed that our results reflect the effects of unwanted pregnancy on mental health, rather than the effects of abortion *per se,* on mental health'.

The British Royal College of Obstetricians and Gynaecologists (RCOG) considered published studies on this issue, when drawing up its evidence-based guidance on abortion, stating: [31] 'Some studies suggest that women who have had an abortion may be more likely to have psychiatric illness or to self-harm than other women who give birth or are of a similar age. However, there is no evidence that these problems are actually caused by the abortion; they are often a continuation of problems a woman has experienced before'. After an independent inquiry by Parliamentarians in 2007 into abortion in the UK, the House of Commons Science and Technology Committee concluded that 'there is no strong evidence which contradicts the wording of the current RCOG guidelines on the risk to mental health of induced abortion.'[32] In 2008, the American Psychological Association Task Force on Mental Health and Abortion found that there was no credible evidence that a single elective abortion of an unwanted pregnancy in and of itself causes mental health problems for adult women.[33] The report evaluated all of the empirical studies published in English in peer-reviewed journals since 1989.[34]

As an abortion provider since 1968, BPAS has had little experience of women undergoing long term negative psychological consequences from abortion. We provide a post-abortion counselling service and our staff see a small number of women each year experiencing feelings of regret. These feelings are usually focused on regret regarding the circumstances of the unplanned pregnancy. Sometimes women report that they regret the fact of having an abortion, while still believing it was the right decision for them at the time. Some women continue to hold the belief that abortion is morally wrong, while continuing to believe it was right for them, and that choosing abortion was the 'least worst' option available to them at that time.

Early medical abortion

Irish women who are entitled to life-saving abortions and those who travel for abortion elsewhere are being denied access to early medical abortion, or are accessing it in poor medical conditions. Early medical abortion is non-invasive and the safest form of abortion, which is usually made available to women up to the point of 9 weeks of gestation.[35] In 2005, the World Health Organization (WHO) added Mifepristone and Misoprostol to its Model List of Essential Medicines, a list intended to guide governments in their selection of necessary drugs for distribution through national health systems.[36]

Medical abortion is an alternative to surgical abortion that involves the use of two medicines to end a pregnancy. The most common regimen calls for an oral dose of mifepristone

followed 36 to 48 hours later by an oral or intravaginal dose of a prostaglandin analog - either misoprostol or gemeprost - that causes contractions of the uterus, helping to expel the fertilized egg. This regimen, which can be initiated as soon as pregnancy is confirmed, is approximately 95% effective for abortion up to 49 days' gestation, and has been approved for up to 63 days' gestation in various countries, including the UK. Mifepristone, first approved for medical abortion in France in 1988, is also commonly known by its original French name, RU-486.

Medical abortion is the result of medical research and a significant advancement in reproductive health care for women. Irish women are being denied the benefits of these advances in medical research and reproductive health care. Those women who meet the legal test for life-saving abortion in Ireland are not being provided with medical abortion. Those women who travel abroad are either not accessing medical abortion because of the difficulties which travel imposes, or are accessing it in less than optimal conditions.[37] Medical abortion usually requires more than one clinic visit and occurs over 3-4 days. It is much more likely that Irish women will avail of surgical abortion when travelling abroad in order to cut down the period of stay. Medical abortion is available once a pregnancy has been confirmed whereas surgical abortion is usually made available from 6 weeks gestation.

There is evidence that Irish women are accessing unsupervised and unregulated treatment in the form of mifeprostol and miseprostone prescriptions via the Internet. When early medical abortion is accessed over the Internet, good quality information is often absent and the safety net of health care workers in a clinic is not available. Women in such circumstances are at risk of misunderstanding the method of use and any potential complications that may arise. They are also at risk of receiving fraudulent medical care as there are no safeguards to monitor standards. The reluctance to present for medical help, which probably contributed to using the Internet in the first place, can exacerbate any complications through delay.

When women use medical abortion over the Internet or at a clinic abroad they are exposed to a greater risk of surgical intervention and general anaesthesia afterwards. This is because they may experience heavy bleeding and their local doctors will be less familiar with abortion care than is optimal. Women may also be afraid to give doctors the full medical background as to any post-abortion symptoms which is also likely to result in sub-optimal care.The Irish Medicines Board has taken a stance against the provision of medical abortion via the Internet. They have issued warnings advising women not to purchase the abortion pill over the internet,[38] and in December 2007 tried to stop one web-based provider from sending the abortion pill to Irish women.[39]

Abortion *per se* is not likely to have an adverse effect on future pregnancies, with the RCOG stating that 'If there are no problems with your abortion it will not affect your future chances of becoming pregnant, although you may have a slightly higher risk of miscarriage or early birth. Your fertility may be affected if you have a serious infection such as PID or if you have an injury to your womb.'[40] The RCOG's 2004 professional guidance 'The care of Women requesting induced abortion', states under s16.8 in the summary of recommendations, 'Future reproductive outcome: there are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility. Abortion may be associated with a small increase in the risk of subsequent miscarriage or preterm delivery.'[41]

Post abortion care

Follow up care of all women returning to Ireland after an abortion abroad cannot be properly ensured under the current system. It is noted that women returning to an environment where health care professionals are not willing or able to provide a supportive service may be tempted not to divulge their full medical history in this event. In the event that complications are experienced it is clearly dangerous for the ongoing healthcare of women to have healthcare professionals caring for them without full knowledge of their medical circumstances. Additionally research and evidence-based policy making on the outcomes is impossible to undertake on Irish women because of the lack of comprehensive data concerning their treatment.

In the experience of Doctors for Choice, post abortion care in Ireland is random and of poor quality. Irish medical professionals are generally not trained in post-abortion care and so are not always aware of what to look for in terms of possible complications. Doctors for Choice are aware of women delaying in presenting for aftercare until complications are severe because they fear disapproval and a potential failure to provide health care if it becomes known they have accessed an abortion. Women patients who presented to clinics and Accident and Emergency departments with medical complications from abortion have reported feeling criticised and neglected by staff. Such medical complications usually consist of bleeding and infection and women will often pretend to have had a miscarriage rather than give a truthful history of an abortion. Irish women may also experience additional psychological burdens because of a perceived need to conceal the abortion.

The Crisis Pregnancy Agency[42] has recently adopted a publicity campaign to encourage women to use their crisis pregnancy counselling services for post-abortion care. As a result the CPA is recommending that women who have abortions go to 'Life' and 'Cura' which are organisations who are opposed to abortion. The International Federation of Gynecology and Obstetrics (FIGO) published recommendations in 1999 highlighting the importance of appropriate counselling to the context of pregnancy decision-making.[43] A review from the American Psychological Association[44] has summarised the literature on factors associated with negative responses to abortion and with difficulties in decision making. In 2008, the American Psychological Association's[45] latest comprehensive two-year review of published research on abortion and mental health was issued in draft form, evaluating studies in peer-reviewed journals since 1989. This found, similarly to the previous APA review, that women were more likely to experience negative psychological reactions following abortion if they were 'terminating a wanted pregnancy, perceived pressure from others to terminate their pregnancy, or perceived a need to keep their abortion secret from their family and friends because of stigma associated with abortion'. The RCOG's 2004 professional guidance 'The Care of Women requesting induced abortion' states at Recommendation 55 that 'Referral for further counselling should be available for the small minority of women who experience long-term post-abortion distress. Risk factors are ambivalence before the abortion, lack of a supportive partner, a psychiatric history or membership of a cultural group that considers abortion to be wrong.' In the light of this evidence, it seems unhelpful for the CPA to recommend that women in need of post-abortion support seek help from organisations who consider abortion to be wrong.

Foetal life

The latest reviews of the evidence on foetal viability shows that viability of infants born below 24 weeks of gestation has not improved, which is due primarily to the limitations of physical development before this stage. This raises difficult questions for neonatology units caring for babies born extremely prematurely.[46]New data from the UK confirms that 'survival of infants born at 24 and 25 weeks of gestation has significantly increased. Although over half the cohort of infants born at 23 weeks was admitted to neonatal intensive care, there was no improvement in survival at this gestation. Care for infants born at 22 weeks remained unsuccessful.'[47]

The House of Commons Science and Technology committee report of 2007 noted that 'Having considered the evidence set out above, we reach the conclusion, shared by the RCOG and the BMA, that while survival rates at 24 weeks and over have improved they have not done so below that gestational point. Put another way, we have seen no good evidence to suggest that foetal viability has improved significantly since the abortion time limit was last set, and seen some good evidence to suggest that it has not.'[48]

The evidence also suggests that foetuses or neonates of less than 26 weeks gestation are highly unlikely to be able to feel pain given that the cerebral cortex is not developed to the point of being able to perceive pain.[49] Foetal movement or response to stimulus is not in itself an indication of any capacity for sensation. 'Scientific Developments Relating to the Abortion Act 1967' concluded that: **'**while the evidence suggests that foetuses have physiological

reactions to noxious stimuli, it does not indicate that pain is consciously felt, especially not below the current upper gestational limit of abortion. We further conclude that these factors may be relevant to clinical practice but do not appear to be relevant to the question of abortion law.'[50] Therefore, it is difficult to justify restricting abortion before a foetus is capable of viability or sentience, especially when the evidence shows that women's health and well-being is enhanced by the provision of abortion. Given scientific knowledge about foetal development it is particularly difficult to justify, from a medical perspective, the failure to provide early medical abortion at less than 9 weeks gestation.

Pregnant women's other medical care

Life-saving treatment

Women patients in Ireland are also being denied medical treatment other than abortion. This happens because such treatment could potentially harm foetal life, or because treatment options for particular diagnoses would usually include abortion. Pregnant women are being denied life-saving medical care such as treatment for cancer because some doctors and hospitals will not treat them while pregnant. Doctors for Choice is aware of a number of patients who were receiving chemotherapy and have been told that there is nothing that can be done for them while pregnant. In addition to having their life-saving treatment denied or delayed, these women have had to endure the stress and expense of organising travel abroad for a termination.[51] In one case of which we are aware, a woman who was being treated for breast cancer was told her treatment couldn't proceed when she became pregnant. She travelled abroad for a medical termination, bled on returning home, went to hospital and was given a D and C, or dilation and curettage, under general anaesthetic. Had she been able to access medical abortion at home, in the care of personnel with the relevant expertise, it is much less likely that she would have had invasive surgery and general anaesthesia with their attendant risk factors, before returning to cancer treatment.

Genetic diagnosis and health information

Doctors for Choice has also heard from women who suffered severe foetal anomalies [e.g. Edwards syndrome] in their pregnancies and were denied treatment. They are denied abortion services at home if they wish to end the pregnancy and they are denied genetic diagnosis at home if they travel abroad to end the pregnancy.[52] In effect, these women can only access full genetic diagnosis and information about their health conditions if they continue the pregnancy to term and deliver a baby who cannot survive, of if they pay privately for diagnosis services in the country where they have the termination. But the cost of genetic diagnosis is prohibitive for some. Denying women abortion and genetic diagnosis in cases of severe foetal abnormality causes them unnecessary distress, denies them the right to grieve a wanted pregnancy, and exposes individual women to delayed treatment and possible increased health risk given the need to travel for care.

As Senator Mary Henry MD has argued, the "Minister for Health and the obstetricians involved in such cases could make better arrangements for these patients. Formal approaches could be made by the Minister to some major obstetric centres in Northern Ireland and Great Britain. The patients could be referred to obstetricians in these centres for a second opinion and, if there was agreement on diagnosis, an abortion could be performed. The Minister for Health would pay for the procedure. He does, after all, already refer patients abroad for treatment which is unavailable here… I have written to the Minister for Health and Children and to Prof John Bonnar, chairman of the Institute of Obstetrics and Gynaecology, hoping such a procedure could be implemented as soon as possible."[53]

Concealment and abandonment

Abandonment of newborns and concealment of pregnancy are not unusual in an Irish context. Such practices are a further indication of women's difficulties with unwanted pregnancies, and pose a particular challenge for healthcare professionals. Concealed pregnancy has been

defined as a situation where a woman presents for antenatal care past twenty weeks' gestation, without having availed of antenatal care or without disclosing the pregnancy to her social network Irish and international research data on concealed pregnancy is scarce. A recent Irish study estimated that 1 in every 625 births in a Dublin maternity hospital was concealed and that 1 in every 403 births in a rural maternity hospital was concealed.[54] Conlon's search of the archive of the *Irish Times* between 1996 and 2005 revealed that a total of 24 newborn babies (live and deceased) were reported as found, 18 of whom were deceased and six of whom were alive. The majority of newborn babies' bodies were discovered in rural areas whereas the majority of live newborn babies were found in cities (Conlon, 2006: 27). In January 2008, the Health Service Executive (HSE) placed a public notice asking the mother of a baby abandoned in Cork in October 2003 to come forward by January 26th, 2008 or the baby would be adopted by her foster parents.[55]

Patient welfare and autonomy

As health care professionals and reproductive service providers we also have duties to promote the welfare of patients while respecting their autonomy and rights. The restriction of abortion has adverse affects for women's wellbeing and is related to poor outcomes for children. The UK Department of Health found that 'there is likely to be a significant rise in the number of children that suffer neglect, abuse and harm as a result of women and their families being unable to cope with the financial and emotional commitments of unintended children, although some unintended children, especially babies, may be handed over for adoption.'[56]

Women with little or no independent income, women with care responsibilities, disabled women with mobility difficulties, women with mental illness, younger women, and women of uncertain residency status who are already likely to be disadvantaged and marginalised, are particularly burdened by the restriction of access to abortion. Restricting abortion also clearly denies women autonomous decision-making over their reproductive capacities. Members of Doctors for Choice have significant direct experience of the failure to provide abortion in Ireland resulting in some women having to continue a pregnancy when this is expressly against their wishes and compromises their welfare. It is particularly apparent in adolescent women who are underage and thus have difficulty in exercising their autonomous right to travel without their parents' knowledge, even though they are clearly capable of mature independent self-determining health decision-making. BPAS is aware that young people aged less than 14, who are especially in need of quality sexual health services, are particularly at risk where greater restriction is placed on abortion.

The Brook Advisory Service has shown that that confidentiality is key to young people's willingness to access sexual health services[57]. 53% of 729 respondents attending Brook Advisory Centre's sexual health services who were aged between 12 and 25 and 'who gave a single answer as requested, said that confidentiality was the single most important thing for them when they were seeking sexual health advice. The next most popular answer was 'not being judged by anyone', accounting for 19% of responses, closely followed by 'that it is free', which was the answer chosen by 18% of respondents. The findings suggest that confidentiality is particularly important for young people under the age of 16. 62% of this age group said that confidentiality was the single most important thing for them. 18% said not being judged was the most important thing for them, and 14% said that the fact the services were free was most important.' It is BPAS' experience that the great majority of young people voluntarily involve their families when accessing services in any case, and where they are not able to do so, they report compelling reasons for this. In a survey conducted on adolescent BPAS clients in 2007[58], responding centres found that no client aged under 16 had attended her abortion consultation or treatment appointment alone. The most frequent accompanying person in any category was one or both parents, with 56% of clients attending with their mother, whether or not accompanied by additional escorts.

Women with uncertain residency status face particular problems in trying to access abortion services. First, they must get the necessary travel documents to go abroad when they have

very little in the way of social support. Second, migrant women who speak little or no English have to access information in circumstances which native English speakers find difficult to negotiate. In 2004, Ms Begas, Director of the Dublin Well Woman Clinic said that around 15 to 20 women with no spoken English were coming to the Centre a week seeking pregnancy counselling services. She said the women were mainly from Eastern Europe, Sub-Saharan Africa and China and often arrived without an interpreter.[59] These women are sometimes unsuccessful in getting travel documentation and must continue a pregnancy that compromises their welfare and autonomy. Doctors for Choice are aware of cases where the British embassy has refused an entry visa and of cases where women have been so delayed that they have missed the 24 week time limit. One reported case concerned an eastern European woman who was seeking humanitarian leave to remain in Ireland and was refused permission to travel for an abortion. The woman, who was 10 weeks' pregnant, was married with children and living in Cork.

Ms Gertrude Cotter, co-ordinator of the Irish Immigrant Support Centre in Cork, was reported in the media as saying that "the woman in question has been told by the Department of Justice to go to her embassy and get an abortion in her own country. But how can she go to her embassy when she is seeking protection from the government of her country?"[60] Ms Cabrini Gibbons, then legal policy officer with the Irish Refugee Council, was reported as saying that she had come across a similar case the previous year in Dublin where a single mother from Nigeria had an appointment for an abortion at a clinic in Brixton. The woman was refused the necessary travel documents and also had to cancel her appointment. Concerns were raised that this woman may have had a back-street abortion in Dublin. Ms Gibbons also explained that in her experience, women who had failed in their asylum applications and applied for humanitarian leave to remain “are free to leave the State but they will almost certainly not get back in. Also they won't gain entry to Britain without a visa and they won't get a visa if they don't have travel documents to get back into Ireland."

Women who are pregnant as a result of sexual assault[61] are exposed to further trauma and degradation by the failure of the Irish health service to provide access to safe and legal abortion. Doctors for Choice are aware of cases of women with disabilities such as mental illness or poor mobility who must continue unwanted pregnancy because they do not know that they have the option of abortion abroad or because they are unable to travel independently for reasons of disability. One case reported to us concerned a psychiatric patient whose doctor stopped her medication when she became pregnant and assumed that her child would be taken into care when it was delivered.

There is substantial international evidence of a social class gradient in abortion uptake when women face unwanted pregnancies. Women living in poverty are more likely to have unplanned pregnancies but are significantly less likely to opt for abortion. The Department of Health’s regulatory impact assessment on the restriction of abortion noted that ‘the consultation indicates that some pregnant women from lower socio-economic groups may be disadvantaged, especially where they lack the financial means to travel abroad to obtain abortions, and could be faced with seeking back-street abortions, suffering strong financial and emotional hardships raising an unintended child or handing babies over for adoption’.[62] There is no direct research evidence in this area in Ireland.[63] But there is considerable anecdotal evidence among service providers that the cost of travel and private terminations is prohibitive for some women and contributes to delay and distress for many women as they borrow the money from different sources. Doctors for Choice regularly see low-income patients who have had to borrow, in some cases from moneylenders, in order to get the finances together. These women are disadvantaged not only by a lack of independent income but also by the fact that they generally do not take trips abroad and do not have credit cards or passports readily available. They are not able to take advantage of cheap flights via the Internet and they have to order and pay for a passport or other relevant ID in order to travel.

In BPAS’ experience, the denial of abortion causes deep distress to women. We are concerned for the well-being of women who present to us seeking abortion, but who are unable to access treatment as they are beyond the legal gestational limit. We ensure that these women are promptly referred into antenatal care and are concerned about their needs

for appropriate emotional support to cope with this. Many women in Ireland will not have access to this kind of support at any gestation of pregnancy. As Doctors for Choice member and consultant child psychiatrist Peader Kirby has written, "the evidence is that lack of support from the medical profession for a patient's choice of abortion increases morbidity due to insufficient medical attention, as well as increasing emotional and psychological sequelae".[64]

Privacy and confidentiality in medical care

Patients have a right to expect privacy and confidentiality in the context of reproductive health care and abortion provision. In our experience Irish women do not expect to have their privacy and confidentiality respected in the context of abortion decision-making. They often keep their abortion experiences secret in order to avoid criticism and judgement. We are also aware of cases where women have had to reveal their decision to travel for abortion to state officials in order to make the necessary travel arrangements. Women have also reported being criticised by state officials and/or health care workers for considering abortion or for having had an abortion.

The 1998 Women and Crisis Pregnancy study interviewed 88 Irish women whose crisis pregnancy ended in abortion, and found that of those 20 women who had attended a General Practitioner, "women also feared that if they told their doctors, their pregnancies would not remain confidential, so they did not trust the confidentiality of the doctor-patient relationship."[65] In the experience of Doctors for Choice, women frequently ask 'can doctors tell I've had an abortion by examining me?' because they fear they will be criticised or neglected if their regular doctors know they have had an abortion. BPAS' Liverpool clinic manager remembers "two sisters who travelled here independently of each other, and who met in the waiting room. They were close as sisters but the stigma of abortion made them unable to confide in each other. All other life experiences they had shared, yet this was one they felt they couldn't because of the stigma attached. Another, was a young girl who could turn to nobody, had never travelled outside Ireland and who told her parents she was going for a job interview in Liverpool, then asked me to write and post to her a mocked-up letter saying she had not been successful in a job application, to verify her story to her parents."[66]

Doctors for Choice knows of one case of an Irish national who had to reveal her decision to travel for an abortion to officials in the Passport Office in order to demonstrate her need for an emergency passport as travel ID. Asylum-seeking women are legally required to identify their decision to travel abroad for abortion to the police and to the Ministry for Justice in order to get permission to travel.[67] One report in July 2004 noted that 40 women had sought and received temporary travel papers from the Department of Justice to travel to Britain for abortions.[68] Migrant women resident in Ireland as visa-holders have to apply to the British embassy for permission to enter in order to access abortion services there, and may have to re-apply for entry into Ireland.

In May 2007, a case concerning a 17-year-old woman in the care of the Health Service Executive who sought to travel abroad for an abortion came before the High Court.[69] The young woman, known as Miss D, was four months pregnant with an anaecephalic foetus who could not survive after birth because of its undeveloped brain. When Miss D revealed her plans to travel to a social worker, the Health Services Executive asked the Gardai to prevent her from travelling, prompting Miss D to take the case. The judge ultimately took the view that there was no statutory or constitutional impediment to Miss D travelling for the purposes of terminating her pregnancy. This case is a clear example of the way in which Irish women who have rights to travel abroad face obstruction from public employees who do not respect their privacy and confidentiality in the context of abortion. Miss D had to further expose herself to public and media scrutiny in order to challenge this obstruction and enforce her travel rights.

The restriction of abortion also has an indirect impact on the ethos of medical institutions and personnel when it comes to recognising patient, and professional, privacy. Health workers

who have anti-abortion views are more likely to feel supported in discouraging abortion as a treatment and infringing patient privacy. Our women patients have reported coming under significant pressure from health care workers opposed to any abortions. For example, one woman was told that she should never set foot inside her doctor's surgery again if she had an abortion. We are also aware of women who have attended 'rogue agencies' in their search for information and support in travelling for an abortion. Rogue agencies are agencies who present themselves as crisis pregnancy counselling services but are interested in dissuading women from choosing abortion. Members of Doctors for Choice have been advised to keep their membership secret so as to protect their career progression.

Professional need for legal clarification and guidance

Those Irish health professionals who wish to care for patients needing abortion services do so under the threat of criminal sanction and without clear legal or policy guidelines. Those Irish health professionals who do not wish to care for patients needing abortion services are supported and endorsed by law and policy, in a manner which conflicts with basic principles of medical care – do no harm, promote good, and respect autonomy - in the view of Doctors for Choice. Although abortion is lawful in circumstances where there is a risk to the life of the pregnant woman there are no legal or ethical guidelines to assist doctors in assessing whether a particular risk qualifies as a risk to life. The Medical Practitioners Act, 1978 section 69(2) gives the Medical Council responsibility for providing guidance to the medical profession on ethical conduct, by specificying that: "It shall be a function of the Council to give guidance to the medical profession generally on all matters relating to ethical conduct and behaviour." However, the current ethical guidelines contain no specific guidance on abortion provision.[70] Rather paragraph 24.6 notes:

> The Council recognises that the termination of pregnancy can occur where there is real and substantial risk to the life of the mother and subscribes to the views expressed in Part 2 of the written submission of the Institute of Obstetricians and Gynaeclogists to the All Party Oireachtas Committee on the Constitution as contained in its Fifth Progress Report, Appendix IV, page A407

Part 2 provides:

> In current obstetrical practice rare complications can arise where therapeutic intervention is required at a stage in pregnancy when there will be little or no prospect for the survival of the baby, due to extreme immaturity. In these exceptional circumstances failure to intervene may result in the death of both mother and baby. We consider that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example for social reasons, and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother.

During the 2002 referendum campaign the Masters of the 3 major maternity hospitals[71] made a joint statement in their personal capacities calling for a yes vote, arguing that "at present if we carry out life-saving operations on pregnant women, we are breaking the law of the land", and supporting the right of women to a termination of pregnancy when the foetus would not survive birth. Their statement and press conference illustrated the confusion and lack of clarity over the scope of the law.[72] The law of the land at the time did (and does) permit abortions where there is a real and substantial risk to life, but has not been ruled to apply to pregnancies where foetuses have lethal abnormalities. Although Doctors for Choice has never heard of any cases where life-saving abortions have been performed in Ireland, the X case judgement does state that life-saving abortions are legal. The Masters were calling for a 'yes' vote on grounds that were arguably unnecessary, and in spite of the fact that the amendment would not have (explicitly at least) legalised terminations they supported, that is where the foetus has an lethal genetic abnormality.

Doctors for Choice have seen patients who are distressed and angry about the impact of abortion restriction on their lives, but none who feel able and willing to go to court to seek

permission for a termination of pregnancy rather than travel abroad. The risk of exposure, the time delay, the stress and the considerable expense involved in going to court with little or no prospect of have made this an unfeasible option for patients who are experiencing a crisis pregnancy. As the doctors of women who have faced serious crisis pregnancies, we cannot imagine advising a woman to go to court to seek legal clarification, when the option of abortion abroad is available. We are not aware of any other instance where court permission is required in order for competent women to have medical treatment.

The Department of Health has permitted some women to have abortions abroad at public expense under the E112 scheme,[73] which provides medical care in another EU member state at home state expense.[74] There are a number of such cases a year and members of Doctors for Choice have been involved in the coordination of arrangements in particular cases, usually concerning termination for severe foetal abnormality. In May 2007, the *Irish Times* reported that the Health Services Executive had funded the cost of an abortion in the UK for a woman whose baby had serious congenital abnormalities that were incompatible with life outside the womb, and that approximately six other abortions for women in similar circumstances were funded by the HSE over the previous year.[75] To receive authorisation to have a termination abroad at state expense under the E112 scheme, a consultant gynaecologist must sign a form confirming a service is needed and a Department of Health official then countersigns the form authorising funding.

Doctors for Choice welcomes and supports this initiative,[76] but we would like further clarification about the criteria by which public funding of necessary abortion services is authorised. Women who may be eligible for medically necessary terminations under the E112 scheme may not be accessing them because of a lack of information and clarity about the qualifying criteria. Secondly, we would much rather provide our patients with direct unfettered access to services they need in a timely manner.

Members of Doctors for Choice have also had asylum-seeker patients who have had to seek official permission to travel abroad for a termination of pregnancy, as they are not legally permitted to travel while their asylum claim is being assessed. We welcome this state action in permitting travel for abortion, but would rather provide our patients, especially the most vulnerable, with the medical services they need.

Need for professional training

At present, Irish doctors, nurses and midwives do not receive any training in abortion techniques as a result of the legal restriction of abortion. As a result, even if they were willing to provide abortions which could possibly meet the legal standard of avoiding a real and substantial risk to life, they do not have the professional training required. Secondly, this lack of training means that they are compromised in their ability to provide high quality post-abortion care as they are not familiar with abortion procedures. Although specialised training is required for later abortions (20-24 weeks), the training required for post-abortion care, medical abortion and for surgical abortion at less than 12 weeks, is minimal. The state could easily meet its obligations to ensure that all Irish healthcare professionals are trained in abortion techniques and comfortable with providing abortion-related services. In the experience of Doctors for Choice most general practitioners are willing to provide basic abortion services but unwilling to take a public stand in the absence of state support.

Interestingly, a 2008 book chapter argues that training in abortion techniques was a standard part of medical training in post-independence Ireland of the 1930s and 1940.[77] Morris refers to medical text-books which regard abortion as both legal and therapeutically necessary and include explicit instructions on how and when to perform abortions. Three of these textbooks were written by Browne (1936), Fitzgibbon (1937) and Solomons and Falkiner (1937) who were each Master of the Rotunda hospital in Dublin, either before or after their books were written. As Morriss notes, “they were therefore amongst the leading obstetricians in Dublin at the time. It is perhaps worth adding that all these books are currently in the library of the National University of Ireland, Galway (formerly University College Galway), and would

certainly have originally been put there for teaching purposes. These were texts from which Irish medical students would have been taught in the late 1930s and 1940s."[78]

Dr Michael Solomons, who was a gynaecologist and Assistant Master of the Rotunda from 1948 to 1951, gave evidence to the Oireachtas committee that as a student he saw abortions performed in the Rotunda on such medical grounds as the risk to a mother who had heart disease, and that part of the teaching of the Rotunda in his time was to describe such medical reasons"[79]. Morriss concludes that the common view (as cited for example in Kelly's *The Irish Constitution* 2003: 1496-7) that in Irish medical practice a pregnancy would be terminated only where such result was the indirect consequence of an attempt to save the mothers life is simply wrong.[80]

Women seek to avoid harm by ending their pregnancies in a variety of situations and need specialised care and support in doing so. It is not possible to give these women the joined-up care they need under the present conditions of enforced travel for healthcare. Irish healthcare students and workers who try to provide a quality support service to abortion-seeking women receive no professional support. Many doctors are unwilling to provide post abortion care because they do not want to be stigmatised as abortion doctors. As a result women who seek and access abortion outside of Ireland do so substantially alone and with no healthcare provider support.

Doctors for Choice and the British Pregnancy Advisory Service seek to promote and provide the best possible reproductive medical care to Irish women seeking abortion. But we are not able to achieve this in a context of policies and practices which have harmful effects on women's reproductive lives. We are aware that Irish women are not accessing medical and counselling services which are available to them because they are confused about the law and afraid of the abortion restriction. For example, Mahon and Conlon reported in 1996 that 10% of Irish women going to England for abortions received counselling prior to departure.[81]

Members of Doctors for Choice are committed and willing to develop services to provide termination of pregnancy both surgical and medical. The provision of such services is accepted as good medical practice and is a standard of healthcare provision provided in almost all developed countries. As an organisation we have a particular interest in the provision of medical abortion in a primary care setting. We believe that women should be able to access these basic reproductive health services close to home, with the support of their general practitioners, and the back-up of hospital services.

BPAS believes it is essential that women have access to pre- and post- abortion counselling, to enable informed decision-making and support whatever the woman has decided. Restriction of legal abortion makes these processes less available.

Conclusion

Doctor for Choice are willing, ready and able to provide termination services for our patients, especially early medical abortion, but are prevented from doing so under Irish law. We believe the current legal situation compromises our ability to care for our patients to the best possible health standards. We object to the harm that Irish women suffer through compelled pregnancy and through the failure to provide basic reproductive health services.

BPAS is concerned that the basic healthcare of Irish women and their families and the recognition of their rights is significantly compromised by continuation of the denial of the relevant care and support in their home country.

Endnotes

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[59] "Women's group warns over 'back-street' abortions", *The Irish Times*, 8 July 2004

[60] "Woman not allowed to travel for abortion", *The Irish Times*, 22 February 2005

[61] See further: H McGee, Garavan, R., De Barra, M., Byrne, J., Conroy, R., *The SAVI Report - Sexual Abuse and Violence in Ireland* (Dublin: Liffey Press, 2002), and H McGee et al. SAVI Revisited 2005, available at http://www.drcc.ie/about/publications.htm

[62] Department of Health, 'Summary Costs and Benefits Table', in 'Partial RIA: Prohibition of Abortion', 2005, at paragraph 5.5.8, http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=8905&Rendition=Web

[63] A recent Irish report commented that: "The experience of socio-economic disadvantage can be harmful to a mother's health and can influence a child's health in the long term. Research in Ireland indicated that babies born in 1999 to parents who were unemployed were over twice as likely to have low birth weights as babies born to higher professionals (McAvoy 2006)" C. Farrell, McAvoy, H., Wilde, J. and Combat Poverty Agency, *Tackling Health Inequalities* (Dublin: Combat Poverty Agency/Institute of Public Health in Ireland, 2008) at p 37. http://www.publichealth.ie/

[64] Letter to the Editor, *Irish Medical News*, 15 January 2008

[65] E. Mahon, C. Conlon and L. Dillon, *Women and Crisis Pregnancy* (Dublin, Government Publications, 1998) p. 523

[66] Personal correspondence, November 2008, on file with the authors.

[67] Section 9(4) a of the *Refugee Act* 1996 provides: "An applicant shall not leave or attempt to leave the State without the consent of the Minister" and section 9(7) makes a person contravening subsection 4 liable to a fine of £400 or one month imprisonment on a summary conviction. See further: R. Fletcher, "Reproducing Irishness: Race, Gender and Abortion Law", (2005) 17(2) *Canadian Journal of Women and the Law* 365-404 at 396-404.

[68] "Back-street abortion", *The Irish Times*, 13 July 2004

[69] The judgement is currently unavailable from the usual court reporter sources; "AG tells court girl has right to travel for abortion", *The Irish Times,* 2 May 2007

[70] (Sixth edition, 2004) The guidelines are currently under review.

[71] Dr Sean Daly, Master of the Coombe Women's Hospital, Dr Declan Keane of the National Maternity Hospital in Holles Street and Dr Michael Geary of the Rotunda Hospital.

[72] Carol Coultor, 'A Yes vote will protect doctors', *The Irish Times,* 28 February 2002

[73] http://www.dohc.ie/public/information/hospitals/hospital_treatment_abroad.html?lang=en

[74] "New Legal Challenge to Abortion Law looms", The Sunday Business Post, 30 March 2008, http://archives.tcm.ie/businesspost/2008/03/30/story31632.asp.

[75] Mary Carolan, Dr Muiris Houston and Carl O'Brien, "AG tells court girl has right to travel for abortion", *The Irish Times*, 2 May 2007

[76] Doctors for Choice member, Dr Juliet Bressan, was reported in the national media to be "urging women who cannot afford an abortion to apply for E112 funding from their health board… There are women who desperately want an abortion but cannot afford one. They often try to perform an abortion on themselves, which can be very dangerous. We want people to apply for funding via this form", in "Taxpayers Money Used to Fund Abortions Abroad", *The Irish Examiner*, 15 June 2002, http://archives.tcm.ie/irishexaminer/2002/06/15/story30259.asp

[77] Peter Morriss, The Statute Law On Abortion in Ireland", in Jennifer Schweppe (ed.), *The Unborn Child, Article 40.3.3 and Abortion in Ireland* (Dublin: The Liffey Press, 2008) pp 288-296

[78] Morriss, text accompany footnote 37. Morris goes on to note “all state explicitly that in certain circumstances the doctor *should* perform an abortion. Fitzgibbon, for instance, states that in cases of cardiac failure in the early months of pregnancy, it is 'best... to terminate the pregnancy' (1937: 381). He then has a section describing how to perform such an abortion, and a long list of conditions that would warrant performing it (1937: 423-6).”

[79] Evidence of Dr M. Solomons, given on 4 May 2000, to the Oireachtas Committee on the Constitution hearings on Abortion (All-Party Oireachtas Committee on the Constitution, 2000: A140)

[80] Morris, text accompany fn 40

[81] Evelyn Mahon and Catherine Conlon, “Legal Abortions carried out in England on women normally resident in the Republic of Ireland” (Dublin: Constitution Review Group, 1996)