

Article 40.3.3^o and the *Protection of Life During Pregnancy Bill 2013*: The Impetus for, and Process of, Legislative Change

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This article serves as an introduction to this special edition of the I.J.L.S. on the recent developments on abortion law in Ireland. It briefly explains what were the two main drivers behind the introduction of the *Protection of Life During Pregnancy Bill 2013*, namely the European Court of Human Rights’ judgment against Ireland in the case of *A., B. & C. v. Ireland*, no. 25579/05 [2010] E.C.H.R. 2032 (16 December 2010) and the untimely death of Savita Halappanavar. It then reviews a series of public hearings, heard by the Joint Committee on Health and Children in January and May 2013, on how to best meet Ireland’s obligations under the European Convention on Human Rights and under the Constitution. Finally it details the genesis of this special edition and introduces the work of the contributors.

I – Introduction

This special edition of the I.J.L.S. has arisen out of recent developments in the area of abortion law in Ireland. In brief, the passage of the *Protection of Life During Pregnancy Bill 2013* (*2013 Bill*) through both Houses of the Oireachtas has been prompted by two main drivers. The first was the finding of the European Court of Human Rights (E.Ct.H.R.) in the December 2010 judgment of *A., B. & C. v. Ireland* that Ireland was not compliant with the European Convention on Human Rights (Convention).¹ This led to the setting up of an Expert Group whose remit was to examine how Ireland could comply with its obligations under the Convention. Their Report was published in November 2012.² Shortly before the publication of the *Expert Group Report* came the second main driver behind the *2013 Bill* – the tragic death of Savita Halappanavar in a Galway hospital in October 2012. As a result of these two

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¹ *A., B. & C. v Ireland*, no. 25579/05 [2010] E.C.H.R. 2032 (16 December 2010) [hereinafter *A., B. & C.*].

² S. Ryan *et al*, *Report on the Expert Group on the Judgment in A, B and C v Ireland* (Department of Health and Children, 2012) [hereinafter *Expert Group Report*].

events, Ireland's position on abortion, in particular the implications of *A.G. v. X*,³ was interrogated. In this article, the co-editors of the special edition will briefly explain the context behind these developments, will explain the process behind the publication of this special edition and will introduce the work of the contributors.

II – The A., B. & C. Case

As will be discussed in more detail in the article by Bacik,⁴ the *A., B. & C.* case involved an application by three women to the E.Ct.H.R. that their rights under the Convention had been breached by Ireland's restrictive abortion laws. Pursuant to Article 40.3.3^o and its interpretation in the *X.* case, a woman can only legally obtain an abortion in Ireland where there is a "real and substantial risk" to her life.⁵ Only one of the women, C, was successful. The problem identified by C in her successful application was that no doctor would state with any degree of certainty whether her pregnancy posed a threat to her life. She claimed in her application to the court that as a result of the "chilling effect of the Irish legal framework", she received "insufficient information as to the impact of the pregnancy on her health and life and of her prior tests for cancer on the foetus."⁶ The response of the Irish Government was two-fold: first, it argued that there were medical standards in place to determine whether a termination was constitutionally possible; and second, that if any issue arose in the course of that consultation, the issue could be considered by the courts. Ultimately, the E.Ct.H.R. found that neither the normal process of medical consultation, nor an application to the courts, were appropriate to determine whether a termination was constitutionally permissible in particular cases.⁷ The E.Ct.H.R. stated:

.... the uncertainty generated by the lack of legislative implementation of Article 40.3.3, and more particularly by the lack of effective and accessible procedures to establish a right to an abortion under that provision, has resulted in a striking discordance between the theoretical right to a lawful abortion in Ireland on

³ *A.G. v. X.* [1992] 1 I.R. 1 [hereinafter *X.*].

⁴ I. Bacik, "Legislating for Article 40.3.3^o" [2013] 3(3) I.J.L.S. 18.

⁵ *X.*, *supra* note 3 at 62. In *X.*'s case, this threat consisted of *X.*'s express statement that she would kill herself if forced to carry the foetus to term.

⁶ *A., B. & C.*, *supra* note 1 at para. 24.

⁷ *Ibid.* at para. 255.

grounds of a relevant risk to a woman's life and the reality of its practical implementation.⁸

Thus, in order for Irish law to be compliant with the Convention, this discordance needs to be resolved. The E.Ct.H.R. stated that the circumstances in which a termination is permissible should be clear, stating:

[t]here is no framework whereby any difference of opinion between the woman and her doctor or between different doctors consulted, or whereby an understandable hesitancy on the part of a woman or doctor, could be examined and resolved through a decision which would establish as a matter of law whether a particular case presented a qualifying risk to a woman's life such that a lawful abortion might be performed.⁹

In the Programme for Government issued by the Fine Gael-Labour coalition in March 2011, it was stated that an Expert Group would be established whose purpose would be to make recommendations on how to implement the decision.¹⁰ This group was established in January 2012 and was chaired by Mr. Justice Seán Ryan. It reported on 27 November 2012 and stated that there were four ways in which Ireland could respond:

1. guidelines which would give clinical guidance on the availability of terminations of pregnancy;¹¹
2. statutory regulations which would “regulate the provision of lawful termination of pregnancy by way of primary legislation to empower the Minister for Health to regulate the area by statutory instrument”;¹²
3. legislation alone which would “regulate the provision of lawful termination of pregnancy by way of primary legislation”;¹³ or

⁸ *Ibid.* at para. 264.

⁹ *Ibid.* at para. 253.

¹⁰ Fine Gael/Labour, *Towards Recovery: Programme for a National Government 2011–2016* at 8 <<http://per.gov.ie/wp-content/uploads/ProgrammeforGovernmentFinal.pdf>> (date accessed: 24 July 2013).

¹¹ *Expert Group Report*, *supra* note 2 at 44.

¹² *Ibid.* at 44.

¹³ *Ibid.*

4. legislation plus regulations which would “regulate the provision of lawful termination of pregnancy by way of primary legislation, with certain matters left to the Minister for Health to regulate by way of secondary legislation”.¹⁴

Despite the clear ruling of the E.Ct.H.R. in *A., B. & C.*, the Government may well have prevaricated on the question of legislating for abortion for some time. However, two weeks before the publication of the Expert Group Report in November 2012, a case emerged which threw the issue into the public arena once more; the Savita Halappanavar case. Ms. Halappanavar arrived at Galway University Hospital on 21 October 2012, and died from pregnancy related issues on 28 October 2012. The case was made public by Kitty Holland of the *Irish Times* in November 2012,¹⁵ and the reaction was immediate, with vigils and protests being held throughout the country. The facts of the case were not immediately apparent, though it was clear that the woman in question had asked to terminate her unviable pregnancy and was told that she could not. Almost a year following the decision in *A., B. & C.*, the issue of legislating for abortion became urgent.

A Coroner’s Inquest carried out in April 2013 returned a verdict of “medical misadventure,”¹⁶ and an enquiry into the death was carried out by the Health Service Executive (H.S.E.), carried out by Sir. Sabaratnam Arulkumaran in June 2013. The cause of death established by the Coroner’s Inquest into the case was:

- 1(a) Fulminant septic shock from *E. coli* bacteremia.
- 1(b) Ascending genital tract sepsis.
- 1(c) Miscarriage at 17 weeks gestation associated with chorioamnionitis.
- (2) There were no co-morbidities.¹⁷

The *Final Report* notes that on 21 October 2012, following a deterioration in her condition, she was assessed by a Registrar, and as the Report states, the documented impression of that doctor was “... that a pregnancy loss was inevitable/impending and

¹⁴ *Ibid.*

¹⁵ K. Holland, “Woman ‘denied a termination’ dies in hospital” *Irish Times* (14 November 2012) <<http://www.irishtimes.com/news/woman-denied-a-termination-dies-in-hospital-1.551412>> (last accessed: 25 July 2013).

¹⁶ As noted in Health Service Executive, *Final Report: Investigation of Incident 50278 from time of patient’s self referral to hospital on the 21st of October 2012 to the patient’s death on the 28th of October, 2012* (H.S.E., 2013) at 4 [hereinafter *Final Report*].

¹⁷ *Ibid.*

that ... it was too late to stitch the cervix in an attempt to close it to prevent her from miscarrying.”¹⁸ It was felt at this stage that it “was probably a matter of hours before miscarriage” though the foetal heart was still heard.¹⁹ In the early hours of the morning of 22 October, she had a spontaneous rupture of membranes (*i.e.*, her “waters had broken”). The *Final Report* notes that on the morning of 23 October, the patient and her husband asked if a miscarriage could be induced, given the inevitability of the miscarriage, but the consultant noted during the hearing that the patient and her husband were advised of Irish law in relation to this:

[a]t interview, the consultant stated ‘Under Irish law, if there’s no evidence of risk to the life of the mother, our hands are tied so long as there’s a fetal heart. The consultant stated that if risk to the mother was to increase a termination would have been possible, but that it would be based on actual risk and not a theoretical risk of infection.’²⁰

The treatment of Ms. Halappanavar during the course of her stay at the hospital is well documented in the *Final Report*.²¹ From a legal perspective, it is important to note, as was stated above, that the medical team felt that their hands were tied by Article 40.3.3^o despite the inevitability of her miscarriage. As her condition deteriorated, the decision was finally made to terminate the pregnancy due to the risk of infection. She suffered a miscarriage “with the spontaneous delivery of the foetus and placenta” on the afternoon of 24 October 2012.²² Following this, her condition deteriorated further, with her eventual death by cardiac arrest following from severe infection on the morning of 28 October 2012.

The H.S.E. investigation into the case established that there were three key causal factors to her death: the first and third concern clinical management of pregnancies, but from a legal perspective, the second key causal factor is relevant. The *Final Report* found that a causal factor into the death of Ms. Halappanavar was: “[f]ailure to offer all management options [t]o a patient experience inevitable miscarriage

¹⁸ *Ibid.* at 26.

¹⁹ *Ibid.* at 26-27.

²⁰ *Ibid.* at 33.

²¹ *Ibid.* at 22-53.

²² *Ibid.* at 45.

of an early second trimester pregnancy where the risk to the mother increased with time from the time that membranes were ruptured.”²³

While acknowledging that it was not within the remit of the investigation to carry out a review of the law in Ireland regarding abortion, it was satisfied “[t]hat concerns about the law, whether clear or not, impacted on the exercise of clinical professional judgment.”²⁴ The *Final Report* states clearly:

[f]etal demise is certain in an inevitable miscarriage at 17 weeks where there is spontaneous rupture of the membranes and infection in the uterus. The risks to the mother can be reduced by expediting delivery. Continuation of the pregnancy is putting the mother at increasing risk with no potential benefit to mother or fetus. ... International best practice includes expediting delivery in this clinical situation of an inevitable miscarriage²⁵

The *Final Report* notes that there is currently a difficulty in medical practice in establishing what constitutes “a potential major hazard or threat to mother’s life”²⁶ and states: “[t]he interpretation of the law related to lawful termination in Ireland, and particularly the lack of clear clinical guidelines and training is considered to have been a *material contributory factor* in this regard.”²⁷ It warns that similar incidents could occur again in the absence of clarity in the law and an absence of clinical guidelines. From a legal perspective, the *Final Report* recommends:

[t]here is an immediate and urgent requirement for a clear statement of the legal context in which clinical professional judgement can be exercised in the best medical welfare interests of patients. ... We recommend that the ... Oireachtas consider the law including any necessary constitutional change and related administrative, legal and clinical guidelines in relation to the management of inevitable miscarriage... . These guidelines should include good practice guidelines in relation to expediting delivery for clinical reasons including medical and surgical termination based on available expertise and feasibility consistent with the law. ”²⁸

It remains to be seen whether the proposed legislative response to the decision in *A., B. & C.* adequately responds to this recommendation.

²³ *Ibid.* at 69.

²⁴ *Ibid.*

²⁵ *Ibid.* at 71.

²⁶ *Ibid.* at 72.

²⁷ *Ibid.* at 73 [emphasis added].

²⁸ *Ibid.* at 74.

III – Hearings of the Joint Committee on Health and Children

Following publication of the *Expert Group Report* the Joint Committee on Health and Children (Joint Committee) held a series of public hearings on the matter. The first hearing took place over three days in January 2013 with the aim of gathering information and clarifications from relevant stakeholders and informing the subsequent legislation, with contributions from medical and legal experts in addition to representatives of various churches and advocacy groups.²⁹ Following the contributions before the Joint Committee the Heads of the *Protection of Life in Pregnancy Bill* (Heads of Bill) were published in May 2013. The Heads set out the general scheme proposed for dealing with this issue and were the subject of detailed legal analysis during the course of a second round of hearings before the Joint Committee in May 2013.³⁰

A. The January Hearings

The first day of hearings involved contributions from the medical community including the Masters of the primary maternity hospitals, consultants and interested groups. The most contentious issue on day one of the hearings centred around termination as a treatment for suicidal ideation. While the rarity of suicidal ideation during pregnancy was stressed by several contributors on day one of the hearings, including Dr. Sam Coulter Smith and the College of Psychiatry of Ireland, it was noted by Professor Veronica O’Keane, a professor and consultant of psychiatry, that suicide remained one of the leading causes of death among pregnant women.³¹ She suggested that the easy availability of abortion in the U.K. impacted on the statistics in this

²⁹ Houses of the Oireachtas Joint Committee on Health and Children, *Report on Public Hearings on the Implementation of the Government decision following the publication of the Expert Group Report on A, B, C vs Ireland: Volume 1*, 31/HHCN/011 (Dublin: Houses of the Oireachtas, 2013) at 547 <http://www.oireachtas.ie/parliament/media/Volume_1_142239.pdf> [hereinafter *Report on Public Hearings*].

³⁰ Houses of the Oireachtas Joint Committee on Health and Children, *Report on Protection of Life during Pregnancy Bill 2013 (Heads of)*, Volume 1, 31/HHCN/012 (Dublin: Houses of the Oireachtas, 2013) <<http://www.oireachtas.ie/parliament/media/committees/healthandchildren/Volume1.pdf>> [hereinafter *Report on Heads of Bill*].

³¹ *Report on Public Hearings, supra* note 27, at 25

jurisdiction as the majority of suicidal women would travel to the U.K. for a termination.³² Dr. Rhona Mahony, Master of the National Maternity Hospital, Dublin stressed the need for clarification in the law and the necessity to support and provide medical care to women in such a distressed state the committing suicide becomes an option.³³ The strongest argument against the inclusion of suicidal ideation as a ground for termination came from professor of psychiatry, Professor Patricia Casey. Professor Casey highlighted the fact that suicidal ideation is lower during pregnancy than at any other time in a woman's life and noted that there was no evidence that there were any benefits associated with abortion in these circumstances and accordingly, the appropriate treatment was close monitoring and treatment rather than termination.³⁴

A number of important legal arguments were discussed during day two of the hearings with focus on the issues of suicidal ideation and fatal foetal abnormalities across the speakers. The majority of expert speakers clearly articulated the view that a threat to the life of a woman emanating from suicidal ideation was a sufficient ground for the termination of a pregnancy at present under Article 40.3.3^o as interpreted in the *X.* case.³⁵ Professor William Binchy on the other hand suggested that to legislate for termination on the ground of suicidal ideation would result in a change in medical and legal practice and that the State was not bound by the European Court of Human Rights to implement the decision of the Supreme Court in the *X.* case, an argument strongly contested over the course of the hearings.³⁶

There was some divergence of opinion on the question of whether terminations of pregnancies were constitutionally permissible in situations where the foetus was not capable of surviving outside the womb with Jennifer Schweppe putting forward the strongest argument in favour of this position³⁷ and Justice McGuinness expressing

³² *Ibid.* at 25. Prof. O'Keane advocated a broadening of the current position to include terminations for women with several mental health issues.

³³ *Report on Public Hearings, supra* note 27 at 23.

³⁴ *Ibid.* at 17.

³⁵ *X.*, *supra* note 3.

³⁶ *Ibid.* at 585.

³⁷ *Ibid.* at 31. For further elaboration on this point, please refer to the article by J. Schweppe & E. Spain in this edition: "When is a Foetus not an Unborn? Fatal Foetal Abnormalities and Article 40.3.3^o" [2013] 3(3) *I.J.L.S.* 92.

some reservations on whether this was in fact possible under the constitution at present.³⁸ Indeed, Alan Brady on behalf of the Irish Council of Civil Liberties argued that as terminations are lawful in these circumstances under Article 40.3.3^o, the failure of the government to provide access to terminations amounted to inhuman and degrading treatment and a violation of Article 3 of the Convention.³⁹ All contributors agreed however, that should a foetus have any capacity to survive outside the womb, even for a very short time, a termination would not be permissible in the absence of a constitutional amendment.

The issue of inevitable miscarriage was also addressed during day two of the hearings with Dr. Simon Mills taking a wide reading of the *X.* case and including a clause in his draft bill which would allow a termination in cases of inevitable miscarriage where allowing the miscarriage to continue naturally would pose a threat to either the life or health of the mother. This issue will be addressed in more detail in the article co-written by Dr. Mills and Simon Glackin in this edition.⁴⁰ The third day of the hearings involved submissions from the various churches and advocacy groups. Representatives of the Catholic Church advocated holding a referendum to address the difficulties caused by the Supreme Court decision in the *X.* case rather than legislating in line with it. Bishop Christopher Jones argued that the decision was an unsound basis upon which to legislate.⁴¹ By contrast, representatives from the other major religions including the Church of Ireland⁴² and the Methodist Church⁴³ welcomed the decision to legislate and provide clarity. Not surprisingly, diverse views were aired by the advocacy groups invited to appear from both the pro-life and pro-choice sides of the debate.

The striking and unexpected outcome of the hearings was the rebuffing of extreme positioning and the emergence of the middle ground at the centre of the debate. Contributors, including Dr. Simon Mills and Mrs. Justice Catherine McGuinness, emphasised the existence of a large group of citizens holding neither strong pro-life or

³⁸ *Ibid.* at 29

³⁹ *Ibid.* at 28. Based on the decision of the E.Ct.H.R. in *R.R. v. Poland*, no. [27617/04](#) (November 28, 2011) and *P. & S. v. Poland*, no. [57375/08](#) (January 30, 2013)

⁴⁰ S. Glackin & S. Mills, "Termination of Pregnancy, Article 40.3.3^o, and the Law of Intended Consequences" [2013] 3(3) I.J.L.S. 76.

⁴¹ *Report on Public Hearings*, *supra* note 29 at 258.

⁴² *Ibid.* at 35-36.

⁴³ *Ibid.* at 40.

pro-choice views and whose voices are often lost in the debate.⁴⁴ Justice McGuinness expressed a desire to avoid “aggressive debate on the matter”⁴⁵ and implored the joint committee to “look to the middle ground and to the middle people of Ireland who do not keep going after the members all the time”⁴⁶ thereby giving voice to the members of the public who are not mobilised on either side of the debate but represent the majority of citizens.

B. May Hearings

A second round of hearings took place in May 2013, again hearing from medical and legal experts.⁴⁷ The first day of the hearings was devoted to submissions from the medical profession and it was clear that while the medical profession had some concerns about the proposed legislation, they were broadly supportive of the introduction of clarity in this area. The Institute of Obstetricians and Gynaecologists posited that terminations should be made available to women in prescribed circumstances in all government-approved hospitals in certain circumstances. Interestingly, a very stark difference of opinion emerged between the Masters of the country’s two main maternity hospitals on the inclusion of suicidality as a ground for termination. Dr. Rhona Mahony, Master of the National Maternity Hospital noted that “[w]e are legislating here for the risk of death. When you commit suicide, you die. This bill is not about legislating for suicidal intent in pregnancy. This bill is not about suicide, it is about the risk of a woman dying, whether that is mental or physical”⁴⁸ Dr. Sam Coulter Smith, Master of the Rotunda Hospital, on the other hand expressed concerns about the lack of evidence on the efficacy of termination as a treatment for suicidal ideation. He suggested that a requirement to carry out a termination in these circumstances created a profound ethical dilemma for obstetricians, particularly given that they could be requested to terminate at any time during a pregnancy.⁴⁹

⁴⁴ *Report on Public Hearings*, *supra* note 29 at 547.

⁴⁵ *Ibid.* at 587.

⁴⁶ *Ibid.* at 593.

⁴⁷ *Report on Heads of Bill*, *supra* note 30.

⁴⁸ Reported in M. Regan, “Obstetricians clash over suicide grounds fears” *Irish Examiner* (18 May 2013) <<http://www.irishexaminer.com/ireland/obstetricians-clash-over-suicide-grounds-fears-231664.html>> (date accessed: 19 July 2013).

⁴⁹ *Report on Public Hearings*, *supra* note 29 at 43.

The second day of hearings focused on contributions from psychiatrists and proved to be a controversial session with significantly diverging interpretations emerging from members of the profession during the course of proceedings. Not surprisingly, suicidality dominated the hearings, particularly the issue of abortion as a treatment for suicidality. Many psychiatrists appearing before the Joint Committee took the view that abortion was not a treatment for suicidality and questioned its introduction through legislation.⁵⁰ There was little divergence on the first element of this debate, notably, the view that termination is not a treatment for suicidal ideation. However, others, including Dr. Anthony McCarthy, president of the College of Psychiatrists of Ireland, and a consultant child and adolescent psychiatrist he went on to state that there is no treatment for suicidal ideation and psychiatrists attempt to prevent suicide by identifying reasons for suicide and if possible, “dismantling the causes”.⁵¹ The dangers of a restricted regime were further highlighted by Dr. Peadar O’Grady and Professor Veronica O’Keane both noting the increase in suicidality linked to restricted abortion services.⁵²

Concerns were also raised during the course of the hearings about the ability of psychiatrists to accurately predict suicide and the lack of evidence about suicidality in pregnancy and the efficacy of termination as a treatment. Several doctors including Dr. John Sheehan, a perinatal psychiatrist attached to the Rotunda Maternity Hospital, and Professor James Lucey of St. Patrick’s University Hospital, suggested that it is impossible for any psychiatrist to accurately predict which women will commit suicide in pregnancy⁵³ and there would be a high risk of over-diagnosis. However, several psychiatrists noted that existence of well understood clinical markers for psychiatrists, which while not providing certainty, assisted doctors in their assessment of a patient’s

⁵⁰ These psychiatrists included Prof. Kevin Malone, Prof. James Lucey, Prof. Patricia Casey, Dr. Jacqueline Montwill and Dr. Seán Ó Domhnail. Several psychiatrists also noted the rarity of circumstances in which a termination would be a treatment for suicidality, if ever, including Dr. Anne Jeffers and Dr. Joanne Fenton. Dr. Fenton, a perinatal psychiatrist in the Coombe Hospital, stated that she did not believe termination to be a treatment for mental illness, it was not possible to state that a situation would not arise where termination is a life saving option. *Ibid.* at 35-37.

⁵¹ *Ibid.* at 35, *per* Prof. Veronica O’Keane.

⁵² *Ibid.* at 36.

⁵³ *Ibid.* at 35-6. This point was reiterated by Dr. Bernie McCabe of Navan Hospital.

mental state and their management of risk.⁵⁴ Dr. McCarthy first noted that “suicide in pregnancy is real and a real risk”⁵⁵ before reiterating comments made by Dr. Mahony during the first day of hearing that it is impossible to gather evidence in this area due to the rarity of the event and the ethical implications of research of this nature.⁵⁶

The final day of submissions focused on legal and ethical issues. One of the major issues debated was the obligation to legislate under the E.Ct.H.R. ruling. Several legal experts appearing before the committee argued that the state was not under any obligation to legislate in line with the *X*. case.⁵⁷ It was suggested by some contributors, including Mr. Paul Brady, that should the proposed legislation be introduced, it would mark a significant change in the current legal position.⁵⁸ The issue of temporal limits was also addressed during the course of the hearings. Dr. Maria Cahill and Mr. Brady posited that it was difficult to envisage the legislation being interpreted as prohibiting a termination at any time during a pregnancy, including late or full-term abortions.⁵⁹ However, this was strongly refuted by the Government, asserting that an early delivery rather than a termination would be offered to a woman in the later stages of pregnancy.⁶⁰

The proposed criminalisation of pregnant women also proved troubling for contributors on the final day including Dr. Ruth Fletcher, echoing submissions made in previous days.⁶¹ Dr. Fletcher called on the committee to reconsider the decision to criminalise women which she described as a “disproportionate and unfair response”⁶² and suggested that at the very least, the maximum term of fourteen years imprisonment should be reduced.⁶³

⁵⁴ *Ibid.* at 35. See comments of Dr. McCarthy, Prof. Veronica O’Kane, Dr. Anne Jeffers and Dr. Joanne Fenton.

⁵⁵ *Ibid.*

⁵⁶ *Ibid.* at 42. Views echoed by Dr. Eamon Moloney of University College Hospital, Cork.

⁵⁷ *Ibid.*, at 13, *per* Mr. Paul Brady, Dr. Maria Cahill and Prof. William Binchy.

⁵⁸ *Ibid.* at 44.

⁵⁹ *Ibid.* at 44.

⁶⁰ *Ibid.* Refutation offered by Junior Minister for Primary Care Alex White

⁶¹ For example, see contribution of Dr. Peter Boylan.

⁶² *Ibid.* at 821.

⁶³ *Ibid.*

C. Conduct of the Hearings

In sum, a broad range of views were aired before the Joint Committee during this process and given the nature of the topic that there was diversity among the experts was unsurprising. Ultimately though, experts, advocacy and religious groups deepened the understanding of legislators and the public on this contentious and complex area. What was striking about the Hearings was the measured, calm and thoughtful analysis that was given to the medical, legal and ethical issues surrounding the debate by the experts, Committee members and politicians involved in the debate. Committee members seemed genuinely interested in asking experts what their views were on the correct interpretation of the law or medical practice, rather than scoring political points. The Chair, Deputy Buttimer, did an admirable job of ensuring that the Hearings were conducted in a professional, composed and – perhaps most surprisingly – timely manner. Rather than the divisive and polarised debate which has characterised the abortion issue in the past, the hearings were nuanced, respectful and engaging.

IV – The Special Edition of the I.J.L.S.

Just as Ms. Halappanavar's death and the publication of the *Expert Group Report* on the *A., B. & C.* case prompted the recent legislative developments in Ireland, they promoted the organisation of this special edition of the I.J.L.S. This edition is the culmination of a two-stage project on the issue of abortion and Article 40.3.3^o. The first stage was a Blog Carnival on various aspects of the abortion debate which was run on RightsN.I. on 16 January 2013.⁶⁴ We limited our call for contributors to legal academics and practitioners as it was thought that their perspectives would provide a useful backdrop to the various issues surrounding Article 40.3.3^o and the *A., B. & C.* case and thereby providing context to the debate on the need for, and scope of, any legislative or regulatory regime introduced to ensure Ireland's compatibility with the Convention. We also sought to be as inclusive as possible, asking people with different

⁶⁴ A final blog summarising the various contributions and providing links to the various contributors can be accessed here: Dr. C. O'Sullivan, Dr. J. Schweppe & E. Spain, "Legislating for Article 40.3.3: Blog Carnival Conclusion" <<http://rightsni.org/2013/01/legislating-for-article-40-3-3-blog-carnival-conclusion/>> (last accessed: 24 July 2013).

legal, moral and ethical perspectives on the debate to contribute. In alphabetical order, the contributors were Professor Ivana Bacik, Professor William Binchy, Paul Brady, B.L., Dr. Maria Cahill, Dr. Brenda Daly, Professor Fiona de Londras, Dr. Simon Mills, B.L. who co-wrote an entry with Dr. Shane Glackin, Professor Siobhan Mullally, Dr. Claire Murray, John O'Dowd, Dr. Fergus Ryan, Jennifer Schweppe who co-authored a blog with Dr. Eimear Spain, Ciara Staunton and Dr. Liam Thornton.⁶⁵

The second stage of the project was the production of this issue of the I.J.L.S. The majority of the articles were submitted prior to the publication of the *2013 Bill* but after the publication of the Heads of Bill. The *2013 Bill* was published and presented to Dáil Éireann on 14 June 2103. When they were proofing their work, various authors took that opportunity to update it to include reference to the specifics of the *2013 Bill*. However for a number of authors this was not necessary as the focus of their article had not been affected by any differences between the Heads of Bill and the *2013 Bill*.

The list of contributors is narrower than those who contributed to the Carnival, but our contributors to the Carnival were told that submitting an article was optional and for various reasons authors were unable to or declined to contribute an article. In total five articles appear in this issue of the I.J.L.S. Again in alphabetical order, the first of these is by Senator Ivana Bacik, whose article, "Legislating for Article 40.3.3°", is a helpful companion piece to this introduction to the special edition. It provides a review of the historical context behind the recent developments, starting with why Article 40.3.3° was introduced into the Irish Constitution, and detailing the various controversies and flashpoints that followed. In particular, the author examines the role that feminist activists have played in arguing for a change to Ireland's abortion laws from 1979 on, when the first Women's Right to Choose group in Ireland was established, and concludes by advocating for the deletion of Article 40.3.3° from the Constitution.

Paul Brady's article, "A Critical Analysis of the Heads of Bill and the Legal Necessity of Legislating for X.", focuses on the inclusion of suicidal ideation in the

⁶⁵ *Ibid.*

Heads of Bill. This article is an interesting counter-balance to other articles in this volume in that the author argues that a careful analysis of the key E.Ct.H.R. principles and the *X.* case establishes that there is no legal obligation on the Oireachtas to enact primary legislation providing for abortion on the grounds of risk of suicide. As such, the author is very critical of Head 4 of the Heads of Bill, which was transposed unaltered into section 9 of the *2013 Bill*, and its potential unintended or unforeseen consequences.

Professor Fiona de Londras and Laura Graham's article, "Impossible Floodgates and Unworkable Analogies in the Irish Abortion Debate", examines claims made by those who are opposed to the introduction of legislation on the basis that it would open the floodgates to abortion on demand. They argue that such concerns are unfounded given the presence of Article 40.3.3° in Irish law which strictly curtails the availability of abortion in Ireland and will not (and cannot) be modified by legislation. Of particular interest in this article is the examination of critiques of the lack of any time limit in the *2013 Bill* and the specific application of floodgates arguments to suicidal ideation. A consistent thread throughout the article is the belief that it is unhelpful to refer to the law in Britain, as is frequently done in order to substantiate floodgates concerns, because of the constitutional protection of the right to life under Irish law.

Shane Glackin and Dr. Simon Mills's article, "Termination of Pregnancy, Article 40.3.3°, and the Law of Intended Consequences", examines claims that an abortion is never necessary in order to save the life of the mother, focusing specifically on the doctrine of double effect which distinguishes between direct/intentional and indirect/unintentional terminations. Although the authors acknowledge the intuitive force of the distinction, utilising the specific example of ectopic pregnancy they reject the doctrine on the basis that it cannot make morally plausible distinctions between permissible and impermissible termination methods.

Finally, and in addition to this article, Jennifer Schweppe and Eimear Spain have also contributed another article entitled "When is a Foetus not an Unborn? Fatal Foetal Abnormalities and Article 40.3.3°." Their article is critical of the failure to

include a clause in the *2013 Bill* allowing for terminations in cases of fatal foetal abnormality. Utilising the text of Article 40.3.3^o they make three distinct arguments to support their position that it would be constitutionally permissible to include such a provision. Drawing on the text already provided in section 7 of the *2013 Bill*, they draft a sample provision allowing for a termination in such circumstances. They regretfully conclude that the legislature has missed an important opportunity to provide clarity on this matter and that it is inevitable that such a case will appear before the Irish courts.

V – Conclusion

Ultimately, we hope that bringing together this group of experts will deepen understanding of the *2013 Bill* and of the wider context in which it will operate, should it become law. This is by no means certain. As previously noted, the *2013 Bill* was published and presented to Dáil Éireann on 14 June 2013, beginning a rigorous process of legislative scrutiny in both houses of the Oireachtas. It was passed by the Dáil on 12 July 2013 and by the Seanad on 23 July 2013. However, the process is not yet complete as, pursuant to Article 25.4.1^o, a Bill does not become an Act until it is signed into law by the President. The President can decline to do this under Article 26 if, after consulting with the Council of State, s/he has concerns about its constitutionality as a whole or the constitutionality of any of its provisions. In such cases, the Bill is sent to the Supreme Court for their assessment. In light of the divisive nature of the *2013 Bill*, it is unsurprising that President Michael D. Higgins has decided to convene the Council of State to decide whether the *2013 Bill* should be referred to the Supreme Court for a decision on its constitutionality or whether it should be signed into law.⁶⁶ Whatever the outcome of this process, it is to be hoped that some lessons have been learned by our legislators, in particular the value of inviting experts in at an earlier stage of the legislative process. Allowing experts to contribute their views on the content of both the Heads of Bill and the *2013 Bill* has helped to improve the quality of contributions from many of our elected representatives at various stages of the debate. We hope that

⁶⁶ H. McGee, “Higgins to consult Council of State on abortion Bill” *Irish Times* (25 July 2013) <<http://www.irishtimes.com/news/politics/higgins-to-consult-council-of-state-on-abortion-bill-1.1474031>> (date accessed: 25 July 2013).

you will find the articles in this special edition informative and we would like to express our thanks to all of our contributors for their involvement at one or both stages of this project.