



Valuing Mother and Baby



Pro Life Campaign Submission to:

THE CRIMINAL LAW ON ABORTION, LETHAL FOETAL ABNORMALITY AND SEXUAL CRIME. A CONSULTATION ON AMENDING THE LAW BY THE DEPARTMENT OF JUSTICE.

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Introduction

The issues discussed in its document, 'The Criminal Law on Abortion'¹ by the Department of Justice have arisen in Ireland as in other jurisdictions around the world. The manner in which we address them goes to the heart of the value we place on unborn life and the care we give to pregnant women in deeply distressing circumstances. It is important that we reflect with understanding and compassion as we make policy to address these difficult cases. We welcome the opportunity given by the Department to participate in the consultation process.

Part 1 Lethal Foetal Abnormality

In its consultation document, the Department of Justice (the Department) proposes that certain lethal foetal abnormalities exist which the medical profession can determine are 'not compatible with life after birth'² (the example being given of cases of anencephaly, in which there is a failure of the brain and top of the skull to form properly). The Department wishes 'to meet the needs of women faced with the prospect of carrying to term a pregnancy where there is no chance of sustainable life after birth'³, and 'to enable a woman in that position to ask for the pregnancy to be terminated and for that procedure to be delivered by her own medical team in a hospital near to her home and family.'⁴

The Department proposes to change Northern Ireland's abortion law to 'create an exception to the criminal offence of having or carrying out an abortion, to allow women to choose to have a termination in the circumstances where a foetal condition has been assessed by medical practitioners as being incompatible with life, that is that there is a substantial risk that if the child were to be born at full term, it would be unlikely to survive birth, or unlikely to be capable of maintaining vital functions after birth, and a clinical judgment is made during pregnancy that no treatment will be offered after birth, as it is impossible to improve the chances of survival.'⁵

It appears that the Department has failed to interrogate the medical assumptions on which its proposals rely. Moreover, it has overlooked any approach other than termination of pregnancy to address cases of lethal foetal abnormality. This is regrettable. In this submission, we endeavour to redress the balance.

¹ Department of Justice, The Criminal Law on Abortion: Foetal Abnormality and Sexual Crime. <http://www.dojni.gov.uk/index/public-consultations/current-consultations/the-criminal-law-on-abortion-lethal-foetal-abnormality-and-sexual-crime.pdf> accessed 17 January 2015.

² para 4.4.

³ para 4.7.

⁴ para 4.12.

⁵ para 4.21.

Terminology – and the facts

The word 'lethal' is clear in its meaning – that it causes death. Notwithstanding that it is used in clinical practice to convey the poor condition of a foetus, the concept of lethality has come in for considerable criticism in recent years. A review of the international medical literature reported in the *British Journal of Obstetrics and Gynaecology* in 2012 revealed 'no agreed definition of a 'lethal fetal or congenital malformation'' and no agreed list of conditions that might fit this description.⁶ The malformations most commonly cited in lists of lethal abnormalities are not actually lethal in the strict sense, ie they do not invariably cause death in utero or in the newborn period regardless of attempted supportive treatment. Prolonged survival has been reported in all of the conditions usually described as lethal. Regarding the anencephaly examples given by the Department, studies have reported over 70% live births of offspring conceived with anencephaly.⁷ Cases have been reported of survival to 10 months and 2.5 years.⁸ Cases of prenatal diagnosis of Trisomy 18 and 13 have been cited as examples of lethal abnormalities in debate about the criteria for availability of termination of pregnancy in this jurisdiction. Survival of individuals with these conditions has been reported to 50 and 27 years respectively.⁹ Children who survive with these conditions have been reported to show awareness of people around them, to react to sound and to learn and remember.¹⁰

If these are the facts, one must ask why some prominent medical practitioners use such unhelpful terminology and even advocate the availability of termination of pregnancy in these circumstances. Many reasons have been offered. One suggestion is that medical practitioners may be ignorant of the facts. A survey of obstetricians in Australia, New Zealand and the UK regarding the survival of offspring with Trisomy 18 supports this view.¹¹ Practitioners may also be uncomfortable with uncertainty, or may feel that it might be easier for women to choose termination of pregnancy or palliative care if they believe that survival of the offspring is impossible. Wilkinson and others also observe, somewhat chillingly, that practitioners may be aware that death of the foetus/offspring is not inevitable, but believe that it will not have a life worth living.¹² Thus the use of this terminology may be laden with value judgments of medical practitioners, and mislead couples about the prognosis of a foetus or offspring with grave abnormality.

In summary, the use of terminology like 'lethal' or 'fatal' foetal abnormalities 'is used for a heterogeneous group of conditions to imply an ethical conclusion rather than to present a clear prognosis: it obscures rather than aids communication and counselling.'¹³ This terminology diminishes, if not removes entirely, the ability of a woman in these circumstances to make informed decisions about the management of her pregnancy and care of her offspring.

⁶ DJC Wilkinson and others, 'Fatally flawed? A review and ethical analysis of lethal congenital malformations' (2012) 110(11) *British Journal of Obstetrics and Gynaecology* 1302-1307.

⁷ Monika Jaquier, Report about the birth and life of babies with anencephaly' (2006), www.anencephalie-info.org/e/report.php, accessed 17 January 2015; M Jaquier, A Klein, E Bolthausen, 'Spontaneous pregnancy outcome after prenatal diagnosis of anencephaly' (2006) 113(8) *British Journal of Obstetrics and Gynaecology* 951-953.

⁸ G McAbee and others, 'Prolonged survival of two anencephalic infants' (1993) 10 *American Journal of Perinatology* 175-177; TK Koogler, BS Wilfond, LF Ross, 'Lethal language, lethal decisions (2003) 33 *Hastings Centre Report* 37-41.

⁹ B Bhanumathi, N Goyal, Z Mishra, 'Trisomy 18 in a 50-year-old female' (2006) 12 *Indian Journal of Human Genetics* 146; Y Yunca, J Kadandale, E Pivnick, 'Long-term survival in Patau syndrome' (2001) 10 *Clinical Dysmorphology* 149. Further examples, including in cases of other foetal conditions usually described as lethal are described in the Wilkinson paper, n 6 supra.

¹⁰ M Barr, MM Cohen, 'Holoprosencephaly survival and performance' (1999) 89 *American Journal of Medical Genetics* 116-120; LJ Fenton, 'Trisomy 13 and 18 and quality of life: treading softly' (2011) 155A *American Journal of Medical Genetics* 1527-1528; B Yorgason, *One Tattered Angel: A Touching True Story of the Power of Love* (Shadow Mountain 2003).

¹¹ DJC Wilkinson and others, 'Perinatal management of trisomy 18: a survey of obstetricians in Australia, New Zealand and the UK' (2014) 34 *Perinatal Diagnosis* 42-49.

¹² n 6, 1305.

¹³ *ibid*, 1302.

The change in the law proposed by the Department

The Department's consultation document proposes that termination of pregnancy is available not only where it is (mistakenly) deemed certain that a foetus with a particular condition will not survive to birth, but also where the offspring once born is 'unlikely to be capable of maintaining vital functions after birth, and a clinical judgment is made during pregnancy that no treatment will be offered after birth, as it is impossible to improve the chances of survival.'¹⁴ How many children and adults have assistance with 'maintaining vital functions', even where it may not prolong, but merely improves their lives? The medical literature demonstrates that life-prolonging treatments might indeed be inappropriate for some of these offspring following birth, in cases where the burden of treatment would cause suffering to the offspring which would outweigh any benefit which the treatment might produce. Equally, treatment aimed at prolongation of life including intensive care might be appropriate, depending on the circumstances. These decisions are made on the basis of information which is available following the birth of these offspring.

The Department proposes that these foetuses are terminated because they are seriously abnormal. Their lives may well be short. Medical practice on this island has been to care for both patients as far as is practicable, and to strive for natality rather than mortality. In this instance, the Department proposes more than non aggressive management of these foetuses, and more than the deliberate hastening of their demise. The Department proposes deliberate foeticide on the basis of assertions by ill-informed medical practitioners. This would constitute a radical departure from the doctor's primary duty to do no harm, and from the duty to practice evidence based medicine insofar as is possible.

No mention has been made of perinatal palliative care in the consultation document. This is astonishing, given that this is the gold standard, offered in our leading maternity hospitals. Where it is clear that a baby will have a very short time to live, perinatal palliative care offers a safe and caring environment for the couple and their baby. There are initiatives in this jurisdiction to establish a dedicated perinatal hospice.¹⁵

¹⁴ n 5, supra.

¹⁵ For more on perinatal care and the proposed initiatives, see <https://www.youtube.com/watch?v=tY7mq1g9pGk#t=286> accessed 17 January 2015 and <http://onedaymore.ie>

Part 2 – Sexual Crimes

The Pro Life Campaign does not endorse an abortion as a 'solution' to the tragedy of a sexual assault on a woman, which results in pregnancy.

The Pro Life Campaign believes that to offer an abortion in such circumstances ignores the fact that it involves the taking of an innocent unborn life and the exposure of the women to emotional hurt and possible psychological harm. The reality is that our willingness to offer social support is the single most important factor influencing a better psychological outcome for women in crisis after a sexual assault.

There are very few peer reviewed studies on pregnancy following sexual assault but a study by Sandra Mahkorn¹⁶ called Pregnancy and Sexual Assault showed that there is a better social and personal outcome for women who chose to continue a pregnancy, despite harrowing initial circumstances. Recent peer reviewed studies from Finland and New Zealand,^{17 18} to name just two, also show a better outcome for women who continue their pregnancy compared to women who opt for abortion.

The landmark Roe v Wade decision, which legalised abortion in the United States, is a very clear example of how abortion advocates uses emotive cases simply to promote abortion. Ms Norma Mc Corvey (Jane Roe from Roe v. Wade) admits she was exploited by pro-abortionists at the time and now campaigns publicly against abortion.

Punishing the rapist not the child

If we are to be truly concerned about protecting women we would seek stronger sentences for rapists and real justice for those who are victims of rape. Rape is an unimaginable and horrendous crime – however we do not suggest ending the life of an innocent to rectify any other crime.

¹⁶ Mahkorn S: Pregnancy and Sexual Assault. In Psychological Aspects of Abortion Mall and Watts (eds) 5:

¹⁷ Gissler M. et.al., "Injury, Deaths, Suicides and Homicides Associated With Pregnancy, Finland, 1987 - 2000", European Journal of Public Health; Vol.15 (5):459-463, 2005.

¹⁸ Fergusson et.al., 'Abortion in young women and subsequent mental health,' Journal of Child Psychology and Psychiatry 47:1 pp 16-24, 2006

Part 3 – Conscientious Objection

The right to life is universally and ethically recognised, legally recognised, and in this jurisdiction, also explicitly recognised constitutionally for the unborn. The right to conscientious objection is therefore a fundamental human right grounded in an objectively and universally recognised ethical, religious and moral human standard. Article 9 of the ECHR provides for freedom of thought, conscience and religion. The Parliamentary Assembly of the Council of Europe (PACE) acknowledged in a 2010 resolution the ‘right to conscientious objection within the framework of legal medical care.’¹⁹

Accommodation of conscientious objection in the health care context represents ‘a recognition that the legal permissibility of certain (morally contentious) medical practices and their availability within health care institutions does not eliminate the reality of moral disagreement at the level of practice’.²⁰ The ECHR has declared that ‘freedom of conscience has in the past all too often been paid for in acts of heroism.’ The law guarantees freedom of conscience today, so that this price is not exacted.

Since the consultation document was written, the UK Supreme Court has handed down its judgment in the Doogan and Woods case. We are cognisant of its decision, and note the proposals of the Department.

If the Department’s proposals become law in Northern Ireland, we consider it critical that provision is made also for the exercise of conscientious objection by hospital personnel, as is the case in the 2013 Protection of Life During Pregnancy Act in this jurisdiction. Conscientious objection to participation in medical intervention or treatment does not arise where that medical intervention or treatment is necessary to save life in a medical emergency. Termination of pregnancy has not been demonstrated to be necessary to address any other complication of pregnancy, notwithstanding that it is permitted by law in many jurisdictions. In all cases other than medical intervention or treatment necessary to save the life of a woman, therefore, we submit that the right to conscientiously object must be afforded to hospital personnel.

¹⁹ In this resolution, PACE declared that ‘no hospital, establishment or person may be subjected to pressure, be held responsible or suffer discrimination of any kind for refusing to carry out, accommodate or assist an abortion, an induced miscarriage or an act of euthanasia, or to submit to such procedures, nor for refusing to carry out any intervention aiming to cause the death of a foetus or human embryo, for whatever reason’.

<http://assembly.coe.int/ASP/APFeaturesManager/defaultArtSiteView.asp?ID=950>

²⁰ M Campbell, ‘Conscientious Objection, Health Care and Article 9 of the European Convention on Human Rights.’ (2011) 11(4) Med Law International 284-304.

Conclusion

As a society, we cannot claim to be true defenders of human rights unless we also protect the right to life of unborn babies. What's at stake in this debate is the value of life, and the sad experience is that once laws permitting abortion are introduced, they diminish the society's respect for the inherent value of every human life, born or unborn.

There is an unceasing challenge on law makers and society at large to create a more welcoming and inclusive environment for expectant mothers and their unborn children. By all means, let us debate these issues openly, honestly and with all the facts in front of us. But equally, we cannot shy away from the implications and brutal reality of what legal abortion entails for the mother and her unborn child.

About the Pro Life Campaign

The Pro Life Campaign (PLC) is a non-denominational human rights organisation, drawing its support from a cross-section of Irish society. The Campaign promotes pro-life education and defends human life at all stages, from conception to natural death. It also campaigns for resources to support and assist pregnant women and those in need of healing after abortion. The Pro Life Campaign was granted special NGO consultative status by the UN's Economic and Social Council in 2011.