Midwives
for Choice

Submission to the Committee on the Elimination of Discrimination Against Women (CEDAW) for its consideration in the context of examining Ireland's sixth and seventh period reports on compliance with the Convention on the Elimination of Discrimination Against Women

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About Midwives for Choice

Midwives for Choice is a voluntary, midwifery-led organisation founded in January 2016 as Ireland's national campaign to promote the human rights of women and girls in their sexual and reproductive lives.[1] Our mission is to uphold the rights of all women and girls to be safe and healthy before, during and after childbirth. In the absence of State funding, our members, comprising just over 50 women and midwives to date, give their time freely so that women[2] and girls can obtain care that is appropriate to their needs.

Introduction

Article 40.3.3 of the Irish Constitution (the Eighth Amendment) enshrines the equal right to life of the woman and foetus. In practice, however, this has meant that the foetus takes precedence. The impact of the Eighth Amendment, beyond restricting abortion rights, is substantial and far-reaching, affecting the fundamental human rights of every woman in pregnancy and childbirth, denying her rights to bodily autonomy and informed decision-making in relation to medical care and treatment that are recognised in every other aspect of her life.

Arguably, in voting for the Eighth Amendment in 1983, the people understood that they were voting about abortion only. However, the language of the Eighth Amendment itself, which refers to the 'life' of 'the unborn', has been interpreted to bring the duration of pregnancy, labour and birth within the Amendment's reach, thereby directly impacting on the right to choice in childbirth of some 70,000 women giving birth in Ireland annually. As such, pregnant women are the only group of competent decision-making capacity excluded from the National Consent Policy of the Health Service Executive[3], which stipulates:

> *"The consent of a pregnant woman is required for all health and social care interventions. However, because of the Constitutional provisions on the right to life of the "unborn" (Article 40.3.3 of the Constitution of Ireland 1937), there is significant legal uncertainty regarding the extent of a pregnant woman's right to refuse treatment in circumstances in which the refusal would put the life of a viable foetus at serious risk. In such circumstances, legal advice should be sought as to whether an application to the High Court is necessary."*

The consequences of vesting legal powers in medical staff to act as guardians of foetal rights is the enforced compliance of women with the interventionist medical model of maternity care which misfits the needs of the healthy majority. Midwives for Choice is aware of the common practice by hospitals of invoking the Amendment - with threat of, or actual, court order - to force women to comply with medical decision-making about their care and treatment with which they do not agree.

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[1] www.midwivesforchoice.ie

[2] While we use 'woman' throughout this submission, we recognise that not everyone who is pregnant is a woman

[3] National Consent Advisory Group. National Consent Policy. Health Service Executive 2014 (Revised May 2016):
http://www.hse.ie/eng/about/Who/qualityandpatientsafety/National_Consent_Policy/consenttrainerresource/trainerfiles/NationalConsentPolicyM2014.pdf

This means that pregnant women in Ireland are legally denied the abiding principle underpinning human rights in healthcare: that of informed decision-making and consent.

While the Eighth Amendment is by no means the only contributing factor to a culture where meaningful informed choice and human rights in pregnancy and childbirth are not properly observed, it is the single greatest obstacle to the realisation of this and hence to the attainment of the highest level of health that is the right of every pregnant woman for herself and her unborn baby.

Consent and Human Rights in Childbirth

Health depends on psychosocial and cultural factors as much as on medical indicators. Therefore, when we talk about preserving health in childbirth, we must recognise women's human rights to:[4]

- bodily integrity and freedom from inhuman and degrading treatment.[5]
- private life.[6]
- family life, including the right to parental autonomy.[7]
- healthcare information.[8]
- freedom from discrimination.[9]

Vindicating these rights[10] means that women cannot be subjected to medical treatment without their full, free and informed consent. It also means respecting competent pregnant women's

[4] See further the White Ribbon Alliance Charter http://whiteribbonalliance.org/wp-content/uploads/2013/10/Final_RMC_Charter.pdf

[5] *V.K. v. Slovakia* ECHR, November 8, 2011; *N.B. v. Slovakia* ECHR 12 June 2012; *I.G v. M.K. and R.H. v. Slovakia* [2012] ECHR 1910*; R.R. v. Poland* [2011] ECHR 828. See further Juan Méndez, UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc. A/HRC/22/53 (2013), 10-11 and Center for Reproductive Rights, *Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis* (2011).

[6] See e.g. *Y.F. v. Turkey* ECHR 22 July 2003, *Juhnke v. Turkey* ([2008] ECHR 379; *Yilmaz v. Turkey* ECHR 1 Feburary 2011, *G.B. and R.B. v. Republic of Modlova* ECHR18 December 2012 ; *Csoma v. Romania* ECHR 15 January 2013 and *Konovalova v. Russia* ECHR 8 March 2016 (lack of informed consent)

[7] *Ternovsky v. Hungary* ECHR 14 December 2010, the notion of a right to become a parent involves some measure of freedom as it its exercise; *cf Dubska* ECHR 15 November 2016.

[8] See e.g. *R. R. v. Poland* [2011] ECHR 828 (delays in accessing ante-natal testing which would have enabled woman to make an informed decision about her pregnancy, and which exacerbated the plaintiff's existing vulnerability), *Tysiac v. Poland* [2007] ECHR 212 (lack of adequate information), *AS v. Hungary* CEDAW/C/36/D/4/2004 (lack of adequate information)

[9] *Alyne da Silva Pimentel Teixeira (deceased) v Brazil*, CEDAW, UN Doc CEDAW/C/49/D/17/2008 (2011)

medical decisions, even where they conflict with medical advice. [11] Recently, in *Montgomery v. Lanarkshire Health Board*,[12] the UK Supreme Court held that a woman '*is entitled to take into account her own values, her own assessment of the comparative merits of*' a proposed course of action in childbirth. She is entitled to decide that it is acceptable to take certain risks with her health and that of her child, even if her doctor considers them unacceptable. In that judgment, Lady Hale writes; '*Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being*'. In Ireland, in part because of the Eighth Amendment, those days are very much with us.

The Eighth and the Law on Overruling Pregnant Women's Choices.

When a pregnant woman in Ireland makes an informed refusal of treatment recommended by her medical team, and there are '*implications for the life or health*[13] *of the baby*', the National Maternity Strategy[14] and the National Consent Policy state that, under the Eighth Amendment, legal advice should be sought. As a result of this policy, the High Court has been asked to intervene in several cases in which women have made medical decisions in late pregnancy which, their doctors argued, placed their foetus' life or health at risk.[15]

The cases of *PP v. HSE*[16] and Miss Y[17] suggest that where the risk to an unborn child's life approaches certainty, even in relatively early pregnancy, highly invasive treatment may be used to preserve that

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[10] Some countries, such as Argentina (2009), Venezuela (2007) and Mexico (2014), prohibit or even criminalise breaches of these rights, using new laws against 'obstetric violence'. 'Obstetric violence' refers to abusive, dehumanizing or violent obstetric care. It can include unnecessary or non-consensual treatment; coercing treatment by over-emphasising maternal or foetal risk; silencing women's dissent using social authority; lying to women in the course of childbirth in an effort to coerce treatment; forcing intervention in labour; enforcing control over a pregnant woman's body including by use of restraints or sedation.

[11] For example, in the UK the courts will not entertain an application to overrule a woman's refusal of C-section unless her mental capacity is in issue. See e.g. *St George's Healthcare NHS Trust v. S* [1998] 3 All ER 673*; Re MB* [1997] 38 BMLR 175 CA

[12] [2015] UKSC 11

[13] In *IRM v Minister for Justice* [2016] IEHC 478, Humphreys J. suggests that the unborn has a wide range of constitutional rights, pre-dating the 8th Amendment and including the right to health. There is conflicting authority at High Court level (see especially *Ugbelese v. MJELR* [2009] IEHC 598), and this judgment is under appeal.

[14] *Creating a Better Future Together: National Maternity Strategy* (Dublin, 2016) 78, referring to the National Consent Policy.

[15] These judgments are unreported. They include *South Western Health Board v K and Anor* [2002] I.E.H.C 104; *Health Service Executive v F,* (High Court, *ex tempore,* Birmingham J., November 20, 2010. See also *Mother A v. Waterford Regional Hospital*, Hedigan J., March 11 2013 in which Hedigan J. was not required to make an order because the woman decided to have a C-section.

[16] [2014] IEHC 622; the 8th did not require subjection of a woman's body to somatic care after brain-death in order to preserve her pregnancy where the foetus could not be born alive. The court suggests that where the foetus is viable, more extensive treatment may be justified.

[17] Ms. Y unsuccessfully sought life-saving abortion under the Protection of Life During Pregnancy Act, 2013. Ms. Y was pregnant and suicidal and, arguably, accordingly there was a risk to the foetus' life. The Act contemplates that abortion may only be provided where it is the 'only' means of addressing the threat to the

life. The Supreme Court has held[18] that the Eighth Amendment means that, in these cases, none of the mother's constitutional rights or interests, besides her own right to life, can be weighed in the balance in assessing whether invasive treatment is justified.

The position is less clear, but potentially equally troubling, where the risk to the child's life or health is less certain. In *HSE v. B*[19] the High Court recently outlined the applicable legal principles:

- **Autonomy:** A pregnant woman is exercising her constitutionally-protected parental autonomy when she makes a medical decision which may affect the health or life of her unborn child. As such, the state can only intervene to protect the child in exceptional circumstances. A remote risk to the unborn baby's life or health will not justify intervention.

- **Proportionality:** The court will take account of the type of intervention required to reduce or remove the risk to the child's life or health, and weigh it against the likely effect on the woman. In *HSE v. B*, the HSE sought an order compelling Ms. B to undergo a C-section, and allowing them to use 'reasonable or proportionate force and/or restraint' to ensure that she could not refuse. Subjecting a woman to invasive surgery is a serious infringement of her human rights. The court noted that the Eighth Amendment only requires the state "as far as practicable" to defend the right to life of the unborn. In *HSE v B,* the court found that a C-section was a disproportionate intervention given that the risk to the baby in this case was very low. It was therefore an impracticable step.

HSE v. B makes clear that women cannot be compelled to accept medical treatment in their unborn child's interest where (i) the risks to the baby from refusal are low and (ii) the proposed treatment is very invasive. However, it does not clarify precisely when women can be compelled to accept treatment short of surgery, or exactly how high the risk to the baby must be before serious unwanted medical, or other state interventions can be justified. [20] This lack of clarity generates serious difficulties for women and practising midwives.

The Eighth, Uncertainty and Coercion

The Eighth Amendment is inherently ambiguous in its meaning and scope and the courts have not been able to fully clarify its content. In the context of abortion provision, medical practitioners' inability to confidently interpret the constitution has had damaging consequences for women's human rights.[21] An analogous point might be made about the undue uncertainty surrounding the Eighth Amendment's application to refusal of medical treatment in childbirth. In *Ternovsky v. Hungary* the European Court of Human Rights noted that '*the right to choice in matters of child*

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pregnant woman's life. The High Court granted orders for Ms. Y's forcible feeding and hydration, and for a compulsory Caesarean section.

[18] [1992] IESC 1

[19] [2016] No. 8730P

[20] By contrast, in the UK a pregnant woman is permitted to refuse medical treatment even where the intervention is minor; *Re MB* (An Adult: Medical Treatment) (1997) 2 FCR 541

[21] *A, B and C v. Ireland* [2010] ECHR 2032. See similarly *P. and. S. v. Poland* [2012] ECHR 1853

delivery includes the legal certainty that the choice is lawful and [that women or health professionals are] not subject to sanctions, directly or indirectly.' Every pregnant woman is entitled to '*a legal and institutional environment that enables her choice, except where other rights render necessary the restriction thereof*.' That environment is not present in Ireland, as the experience of Mother A illustrates.

Mother A was pregnant with her second baby. Her first labour and birth had been a physically and psychologically traumatic experience involving forceps birth subsequent to induction of labour. Consequently, Mother A engaged the services of a self-employed community midwife (SECM) to give birth at home to give her and her second baby a better start.

On reaching 10 days post-term on her second pregnancy, she was advised by a hospital obstetrician that induction of labour was indicated due to the risks postmaturity posed to her baby, despite the fact that there was no clinical indication to do so. Rather, the hospital implemented a blanket policy of induction of labour at 10 days post-term.

The induction and acceleration of labour, accomplished by means of the same drugs and/or interventions, is common practice in Irish maternity care. Amniotomy is used both to induce and to accelerate labour by strengthening and speeding up contractions; it involves puncturing the membranes enclosing the protective waters surrounding the baby in the womb with an instrument resembling a crochet hook. While the evidence does not support its routine use as part of standard labour management and care,[22] 52.4 per cent of women giving birth at the National Maternity Hospital in 2009 had their waters broken.[23] Although women's views on the management of their bodies in labour are rarely sought, some studies show that women find this procedure unacceptable.

The induction and acceleration of labour is a cornerstone of the "active management" of women in labour. Active management is a set of obstetric protocols standardising the medicalisation of birth. Comprising the routine use of amniotomy and intravenous infusion of synthetic Oxytocin (the hormone that stimulates labour), active management speeds up the process of labour by dilating a woman's cervix at a rate of 1cm per hour, thereby providing for 3 births per labour ward bed in 24 hours.[24]

Causing painful contractions, whether or not a woman is in labour,[25] Oxytocin increases the demand for epidural anaesthesia, as women under active management strive to make labour more tolerable. Used in 47 per cent of births at the Rotunda,[26] and in 41 per cent at the Coombe,[27] epidural anaesthesia is associated with an increased risk of CS for foetal distress.[28] This form of anaesthesia is

[22] Smyth RMD, Markham C, Dowswell T. Amniotomy for shortening spontaneous labour. Cochrane Database of Systematic Reviews 2013, Issue 6. Art. No.: CD006167. DOI: 10.1002/14651858.CD006167.pub4
[23] http://www.bump2babe.ie/national_maternity_hospital/statistics/ [accessed December 2016]
[24] See Kieran O'Driscoll, Declan Meagher and Peter Boylan, Active Management of Labour: The Dublin Experience, London: Mosby, 1993
[25] See Kieran O'Driscoll, Declan Meagher and Peter Boylan, Active Management of Labour: The Dublin Experience, London: Mosby, 1993
[26] Rotunda Hospital. Annual Clinical Report 2014
[27] Coombe Hospital. Annual Clinical Report 2014
[28] Anim-Somuah M, Smyth RMD, Jones L. Epidural versus non-epidural or no analgesia in labour. Cochrane Database of Systematic Reviews 2011, Issue 12. Art. No.: CD000331. DOI: 10.1002/14651858.CD000331.pub3

often accompanied by continuous electronic fetal monitoring, thereby compounding the risk of CS in uncomplicated labour.

Electronic fetal monitoring limits women's mobility, including the option of using a shower/bath, to help with comfort and control during labour, thus increasing the need for pharmacological pain relief. Evidence shows no benefit of electronic fetal monitoring over intermittent monitoring for the healthy mother with a healthy baby. On the contrary, it shows an association with significant increase in CS and instrumental births,[29] due to erroneous interpretation of the produced fetal heart graph.

Mother A's concerns about the risks of induction to her and her baby were dismissed by the obstetrician who informed her that if she should decline his advice, a court order would be obtained to enforce her admission and induction. Faced by the prospect of arrest by the police force, Mother A submitted to enforced induction of labour in hospital where the associated risks that she had feared materialised: following some 24 hours of painful contractions, amniotomy and Oxytocin infusion failed to establish labour while causing foetal distress requiring emergency Caesarean section. Mother A's premature baby was admitted to the neonatal intensive care unit for treatment of hospital-acquired infection due to prolonged amniotomy, while she herself was detained on the postnatal ward for intravenous antibiotic treatment of the same infection.

While the National Maternity Strategy emphasises the importance of communication with the refusing woman, this was not borne out by the experience of Mother A, or by the experience of many women like her availing of maternity care in Ireland. In a national survey, conducted by the Association for Improvements in the Maternity Services Ireland, of 2,836 women who had given birth in Ireland between 2010 and 2014, 47.2 per cent of respondents had not been fully informed of the benefits, risks and potential outcomes of tests, procedures and treatments during labour and birth, and 49.8per cent were denied the opportunity to make an informed refusal of a test, procedure, or treatment.[30]

These experiences suggest that the inherent ambiguity of the Eighth Amendment has generated sets of 'working interpretations' built on the assumption that the duty to protect unborn life justifies expansive pre-emptive control of women's birthing choices. Whether or not these 'working interpretations' are well-intentioned, they contribute to a culture of coercion around childbirth in Ireland. Within this culture:

- women's capacity to plan childbirth in an informed way is undermined.
- arbitrary violations of women's rights to private life and bodily integrity are normalised.
- the family life which women share with their partners, other children and new baby is badly disrupted.

As already noted, it is not clear whether the courts would support these 'working interpretations' of the Eighth Amendment. In our experience, however, they go unchallenged in practice because

[29] Alfirevic Z, Devane D, Gyte GML. Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour. Cochrane Database of Systematic Reviews 2013, Issue 5. Art. No.: CD006066. DOI: 10.1002/14651858.CD006066.pub2

[30] http://aimsireland.ie/what-matters-to-you-survey-2015/womens-experiences-of-consent-in-the-irish-maternity-services/

rather than contest them, women understandably submit to unwanted medical intervention. Women perceive that the Eighth Amendment is used cynically to punish non-compliance with medical advice, and to justify interventions which instrumentalise women as mere child-bearers.

Recommendations

- Hold a referendum to repeal the Eighth Amendment. Establish legislation to regulate abortion and decision-making in pregnancy and childbirth to allow women equal access to the highest attainable standard of reproductive health.
- Provide a human rights compliant framework for abortion and decision-making by women in pregnancy and childbirth in law in line with international best-practice in health care and international human right norms.
- Provide information on how the State reconciles its obligations regarding women's reproductive health under the Convention with its restrictive abortion laws and policy denying women's rights in decision-making in pregnancy and childbirth arising from them.