

# **Abortion: Exploring the Ethical, Legal and Political Challenges**

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## Table of Contents

|   |    |
|---|----|
| Abortion: Exploring the Ethical, Legal and Political Challenges .....     | 1  |
| Abstract: .....   | 3  |
| Introduction: .....   | 4  |
| Abortion and the Irish legal system:.....                                 | 4  |
| Abortion: A topic fraught with complexity. ....                           | 5  |
| Balancing Constitutional Rights; Is ‘Equal’ right to life realistic?..... | 5  |
| A matter for human rights?.....   | 6  |
| The nature or personhood of the ‘Unborn’ .....                            | 7  |
| Distinguishing between abortion and medical termination .....             | 8  |
| The Political Debate .....  | 9  |
| Conceptual Model .....  | 9  |
| Savita- To legislate or not to legislate? .....                           | 10 |
| The Medical Voice .....   | 11 |
| In Conclusion: Judgement Calls or Legislation?.....                       | 12 |
| Appendix A: Irish Cases of Interest with pivotal outcomes .....           | 14 |
| The X Case (1992).....  | 14 |
| A, B C vs. Ireland (2005) .....   | 14 |
| Savita Halappanavar Case November (2012).....                             | 14 |
| Appendix B: Irish Law and the Constitutional Changes. ....                | 15 |
| The offences against the person act (1861) .....                          | 15 |
| The Eight Amendment (1983) .....  | 15 |
| The Twelfth Amendment (1992) .....  | 15 |
| The Thirteenth Amendment (1992) .....                                     | 15 |
| The Fourteenth Amendment (1992) .....                                     | 15 |
| Twenty-fifth Amendment (2002) .....                                       | 15 |
| Appendix C: A brief Overview of Cultural variance and Abortion .....      | 16 |
| Appendix D: A Clinical Experience.....                                    | 17 |
| Reference list:.....  | 19 |
| Bibliography:.....  | 24 |

**Abstract:**

Ethical, legal and political challenges are embedded in nursing practice and inform clinical decisions. Abortion is an example of a complex contemporary issue where balancing the wellbeing of both the mother and the unborn has prompted considerable international discourse.

This paper explores the issue of abortion and its ethical, legal and political significance regarding public health. The search strategy employed explored evidence from international databases, political input from various media as well as Case analyses. The implications and subsequent recommendations are discussed.

Abortion remains a controversial and divisive human issue. Ambiguity surrounds the concept of personhood and the inception of human life. The imposition of the eight Constitutional amendment and the lack direction on the precise application of the X judgement requires clarity. The right to life of the woman and the unborn continues to lie in tension.

The abortion issue encapsulates ethical, political and legal factors in clinical decision making. Although the law may set out a legislative framework, it is impossible to legislate for every eventuality. Test cases will illustrate the application of new legislation. Ultimately the abortion debate requires a balance between legislation and clinical governance.

**Keywords:**

Clinical dilemmas, abortion, right to life, personhood, public health.

### **Introduction:**

The world of nursing is fraught with moral and ethical dilemmas where legislation may be outdated or unclear making clinical decisions extremely difficult (Tingle and Mc Hale 2009). ‘Sitting on the fence’ however is not an option and omission will also produce an outcome which could lawfully be considered an *actus reus* or wrongful act (Van Dokkum 2011). Often the healthcare professional (HCP) must act where outcomes may be unclear or unfavourable creating a crisis of conscience. Occasionally unfortunate outcomes may attract media attention, public outcry and heated political debate. This is evident in the Savita Halappanavar Case (2012) into which there is currently an inquiry (Appendix A). The purpose of this piece of work is to explore the relevance of ethical, legal and political factors in influencing practice through specific reference to the issue of abortion in Ireland.

### **Abortion and the Irish legal system:**

In contemporary times healthcare issues concerning care delivery are ‘rarely far from the headlines’ and with the role of the nurse becoming ever more expanded in nature it is a prerequisite that we understand our legal obligations and are ‘individually accountable through the law to our patients’ (Tingle and McHale 2009, p38). The primary function of law is for the preservation of public welfare and safety (Ellis and Hartley 2012). With litigation becoming increasingly common most notably in obstetrics the nurse must know the law and limits imposed on her as ignorance is no defence (Dimond 2002).

Abortion in Ireland is outlawed under the 1861 Offences against the Persons Act. This aged piece of legislation predating the foundation of the state itself deems abortion punishable by life imprisonment and criminalises provision of equipment for abortion or concealing the death of a child (Mills 2007). This and the 1937 Irish Constitution are what largely govern abortion law. Freeman (2008, p111) insightfully states that law ‘exists in a constant state of flux’ and this flux can be seen in developments and amendments to law and the constitution over the years (Appendix B). Law and changes to it are largely an outcome of ethical dilemmas which expose the need for revised methods of responding to increasingly prevalent issues. Ryan (2012) correctly observes that medicine is not static or frozen in time. In agreement

Freeman (2008) proposes that competing ethical views continually scrutinise dominant norms and place them under the threat of possible revision. With constant advances in technology dilemmas arise more and more as we question the ethical domain of legislating for circumstantial abortion.

### **Abortion: A topic fraught with complexity.**

Though abortion can be spontaneous it is therapeutic and elective abortion that induces major bioethical debate (Ellis and Hartley 2012). The issue of abortion is a multifaceted one where social, political, religious, personal and ethical issues collide (Ryan 2012). Historically many cases have exposed the complexity of making ethical decisions on this tense issue. Often cases create a tug of war between the enshrined human rights of the woman to self determination and autonomy and the right to life of the unborn (Jones and Chaloner 2007). Fundamental difficulties surround the topic of abortion and its discussion and often political debate on the issue descends in to chaos as strong moral and ethical values and political agendas collide (Ryan 2012)..

### **Balancing Constitutional Rights; Is 'Equal' right to life realistic?**

Ethical and legal issues go hand in hand and legal action taken is often due to practice considered to be unethical or in violation of ethical principles (Ellis and Hartley 2012, Chaloner 2007). An appreciation for the value of ethics in clinical practice is a vital part of the professional nursing role as an advocate for the vulnerable and sick (Chaloner 2007). Ethical dilemmas and challenges arise frequently in the health care setting out of conflict of interests (IHF 2013). The Eight Amendment (1983) acknowledged the right to life of the unborn with 'equal' regard for the life of the mother. This parody of terms has been disputed given that the foetus is but potential life who's existence is reliant on the woman (Jones and Chaloner 2007). Great controversy is also attributed to the X judgement which raises the question of what 'real' or substantive risk involves. This remains unclarified by law as does the precise application of the of the X judgement with regards to determining eligibility for a legal abortion (Dooley and McCarthy 2012, The Expert Group 2012). This is a predicament observed in the ABC vs. Ireland Case. At present both lives must be protected and held in 'equal' regard by law. However the Savita Case begs the question of whether it is ethical to postpone intervention until the trajectory of a

woman's ill health crosses the clinical boundary that satisfies a risk to her life (Dr P. Lane, personal communication 21 May 2013). Additionally how feasible is it for the clinician to clinically delineate the progression from a risk to health to a real and substantial risk to life? In an Ireland that has recently seen the national roll out of a Modified Early Warnings Scoring system to detect and treat patients early it is contradictory to disregard a woman's health in such a manner. To do so defies our very role as a nurse to prevent illness, promote and restore health and to alleviate suffering (ICN 2012). In the healthcare setting the window of opportunity to therapeutically intervene may be narrow and in most circumstances regardless of diagnosis early intervention is crucial in optimising outcomes. Ellis & Hartley (2012) argue that given a nurse's position of public trust failure to provide assistance to someone in serious danger is an ethical violation of that trust. It also violates the code of conduct and scope of ethical practice set out for us by An Bord Ailtránais (2007, 2000). It has been suggested that in Savitas case an overemphasis on the foetus contributed to her deteriorating health (Holland 2013). This Case emphasised the complexity in balancing the Constitutional rights of the mother and the unborn. It has been asserted that no clarity has been offered in the constitution on important issues (Constitutional Review Group (CRG) 1996). Ivana Bacik advocates for choice on abortion claiming failure of the government to legislate has created uncertainty around the law (McDonnell and Quinn 2012). Christine Quigley agreed with this view adding that Savita's death was unacceptable given the IMO's guidelines on medical abortions (McDonnell and Quinn 2012).

### **A matter for human rights?**

The landmark X case (1992) decision is considered to be the law of the land declared by its highest court (Ryan 2012). In X the Supreme Court deemed it permissible for a termination to be granted where there was a 'real and substantial risk to the life of the mother' (Mills 2007). This case manifested the sheer impossibility of reconciling the 'equal' rights to life of the mother and unborn when the two conflicted (CRG 1996). The admission of a suicidal disposition as grounds for abortion remains highly controversial some years following the X case judgement. It remains to be seen that conflict of medical, political and public opinion on the issue is still rife. Ryan (2012,

p3) believes that in its judgement the Supreme Court identified ‘an existing constitutional right’ which should be ‘available and enforceable’. Much is written in law about illegal abortion yet little is revealed regarding circumstances that warrant a legal abortion in Ireland if any. Though the X case ruled the right to circumstantial abortion, these circumstances have as of yet remained undefined as shown in ABC v’s Ireland. De Burgh (2000) suggests that exporting the problem leads to a sense of shame and judgement by ones country for those experiencing crisis pregnancies. Does forcing a woman to travel for termination disregard her human rights? As ethical agent’s nurses owe a duty of care to the patient and need to consider their autonomy as central to their care. Human rights are inherent in nursing with both law and legal institutions owing a duty to protect, respect and fulfil human rights (ICN 2006, WHO 2001). The WHO (2001) however argue that there is a lack of understanding on how to invoke human rights to prevent and remedy wrongs. Human rights have been argued in cases such as A, B C vs. Ireland but the unborn is afforded no such rights. The unborn’s existence is unrecognised and unprotected by law arguably by virtue of the differential assumptions on the nature or personhood of ‘unborn’ life (Dimond 2002, Lewis 2003).

### **The nature or personhood of the ‘Unborn’**

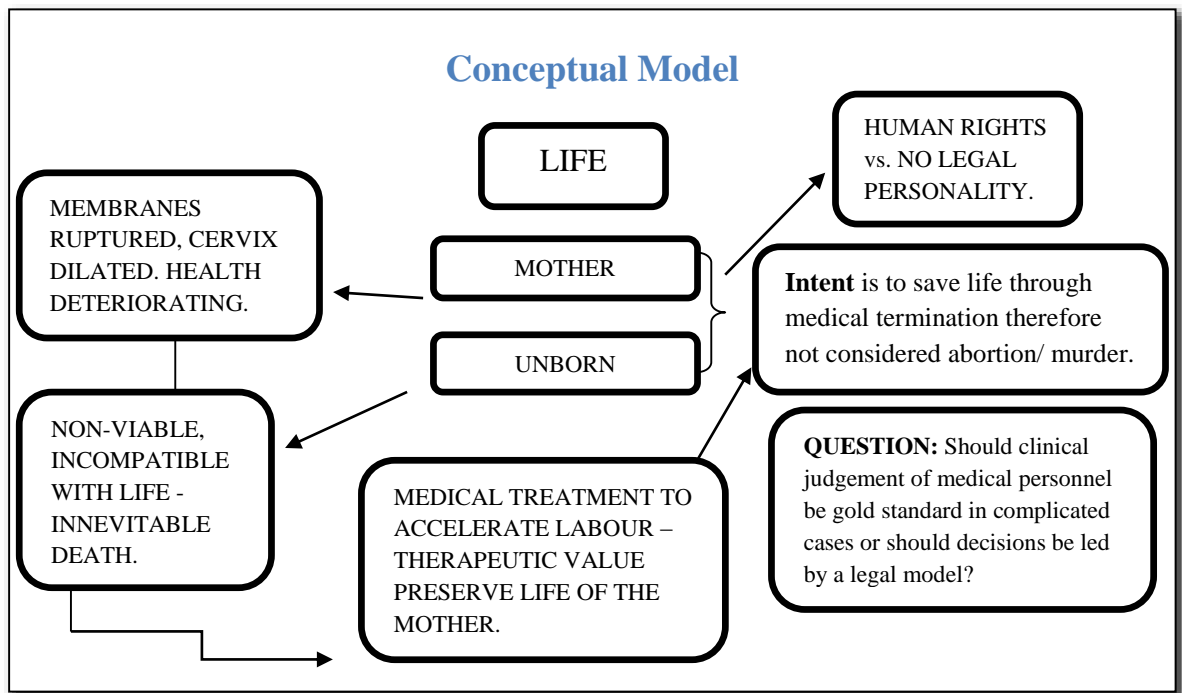
Moral disagreement regarding the sanctity of life surrounds the contentious subject of abortion (Lipp 2008). The CRG (1996, p252) found that the state of law pre and post the X case decision ‘gives rise to much dissatisfaction’. There is no universal definition of the ‘unborn’ and no general consensus regarding the inception of life and its interpretation. The difference in global gestational limits on legal abortion is testament to this (Appendix C). There is no clarification or point of agreement as to when humanity begins or sets in rather opinions are generated on the distinctions considered important in development (Dooley and Mc Carthy 2005). Scientists argue conception is not valid until implantation occurs (Ellis & Hartley 2012). Others claim the foetus cannot be considered human life until sufficiently viable outside the womb (Ellis & Hartley 2012). The approach taken by Irish lawmakers seems to support implantation as the beginning of life (Mills 2007). Considering the ‘unborn’ currently has no ‘legal personality’ (Dimond 2002 p315) in the context of legislating for

abortion we must identify the ‘moral status’ (Jones and Chaloner 2007 p46) of the foetus and provide definitive answers and a specification for circumstances where a pregnancy can be ‘legitimately’ terminated and ‘by whom’ (CRG 1996, p252). The issue of personhood and abortion has become even more complex in light of recent developments and the expansion of medical technology including genetic selection, surrogacy and advances in neonatology. Healthcare is evolving at an incredible pace and with these advances new politico-ethical dilemmas emerge which inevitably challenge existing laws.

### **Distinguishing between abortion and medical termination**

The CRG (1996) exposed the lack of legal distinction between medically allowable termination and unlawful or illegal termination. The IMO’s (2009, P21) stance advocates medically terminating pregnancy in rare obstetrical cases to ‘protect the life of the mother’ and with all attempts to preserve the baby’s life. If interpreting this in the context of the Savita Case hypothetical termination could be defended as necessary to avoid life threatening sepsis and in order to ‘protect’ Savitas life. The use of language should be given due consideration here. Abortion is a loaded term and and it’s use conjures up an emotive response. An example of this is where abortion is used to describe miscarriage. This can be extremely distressing for a woman as the term abortion is often associated with or suggestive of a deliberate and intentional killing of the foetus. There exists an important distinction between abortion and medical termination of pregnancy. This difference lies in intent, a disparity not yet written into law. In the Savita Case it was never intended to end the life of the mother or the unborn (Figure 1). This was a wanted pregnancy and the circumstances were unfortunate. The predicament of considering progression of her pregnancy should not have been a legal question. Rather there was a need for the healthcare team to employ critical clinical judgement based on the objective and subjective data available on Savitas condition culminating in an evidence based decision to invoke the X judgement. This beneficent approach would demonstrate the ethical principle of utilitarianism or acting for the greater good (Smeltzer et al. 2010). In such circumstances there is scope for the healthcare professional to use evidence based clinical findings to inform how decisions are made.





**Figure 1**

### **The Political Debate**

In considering the complex and immensely sensitive abortion issue significant socio-political forces are in play not least political cowardice and avoidance of implementing socially unpopular decisions. Maslin-Prothero and Masterson (2002, p.108) claim that politics ‘affects every aspect of nursing’ occurring at micro and macro level. Ripples of the stone that is the Savita case have made their way through the river of society from the ward to the homes of every Irish citizen, ending at the Oireachtas. Protests and vigils were held locally and internationally. The fact that Savita was of Indian origin and treated in an Irish hospital has given weight to the pro-choice campaign furthering political tension on legal reform as international influence from countries with more liberal abortion laws has weighed in. In recent years with the Catholic Church suffering a very public fall from grace and with our society becoming more multicultural and religiously diverse there is a change in the axis of church and state power. The Catholic Church has had a huge influence on

abortion remaining illegal in Ireland over the years. Now that the Churches powerful grip has loosened and a culturally diverse society has their say the issue is now up for negotiation. The government have been mandated with the role of legislating for abortion guided by recommendations set out in a report by a group of experts.

Legislating for abortion in circumstances such as the X Case has sparked much controversy and according to Senator Ronan Mullan has left obstetricians split on opinion and the psychiatrists ‘hopelessly divided’ (Cullen et al. 2013). Professor Kevin Malone and Senator Fidelma Healey-Eames shared the view that the inclusion of a suicide clause risks normalising or legitimising abortion (Cullen et al. 2013). Several studies (Sullivan et al. 2003, Marishane and Moodley 2005) have highlighted suicide as a leading cause of maternal mortality. Nonetheless evidence suggests that suicide during pregnancy is relatively rare and that it predominantly presents in the initial post partum period often associated with psychopathology and social co morbidities (Ratnaik 2006, Hammond and Crozier, Mc Gowan et al. 2007, Drife 2005). This may be suggestive of pregnancy being a protective mechanism against suicide (with the exception of young mothers) (Marishane and Moodley 2005). There is a distinct lack of evidence however to adequately substantiate that unwanted pregnancy can cause suicidality. Suicidal ideation is a subjective experience which cannot be clinically measured. Although the risk of suicide can be measured predictability cannot (Houses of the Oireachtas 2013). Therefore with no objective means to predict suicide and a lack of evidence to validate abortion as a therapeutic intervention for it the question must be asked – should abortion be offered as a solution to such a dilemma and what kind of message does this send out?

### **Savita- To legislate or not to legislate?**

Issues surrounding the Savita Case were examined on Prime Time (2012) where Dr. Boylan proposed the main issues were where the threat to life is not as ‘apparent’ voicing ‘people’s perception of risk is very different’. Arguably risk or substantive risk in the medical context is not something that can be neatly defined by law rather it is measured by healthcare professionals based on evidence based guidelines and tools and through careful examination of clinical manifestations. One of the recommendations put forward by Dr Ciaran Mc Loughlan in light of the Savita enquiry was that the IMO should clarify precisely when doctors may intervene to save the life of a mother so that this can be known to doctors and patients (Bowers 2013). Although there may be merit in providing such clinical guidance even with clarification circumstances may still arise outside the scope of what is presented as

criteria. Discussing whether inducing labour is considered abortion in a non-viable foetus Dr Clements reported dilation of the cervix to be key meaning there's 'no chance' of bringing the foetus to 'viability' (Prime Time 2012). This idea of 'no chance' with regard to viability of a foetus is an evolving concept which has been reflected in the revision of the gestational limit on abortion from 28 to 24 weeks. Advances in Special Care Baby Units have meant that babies born more and more prematurely are surviving. Nonetheless the intervention of SCBU's in extremely premature infants may be ethically questionable and creates dilemmas of its own. Savitas husband alleges doctors told them her cervix was dilated and miscarriage was inevitable (Cullen 2013). So did a lack of legal clarity prevent termination of her pregnancy as per medical guidelines? Billy Kelleher (TD) acknowledged the difficulties and complexities in clarifying legislature on such a complex topic (Prime Time 2012). He brought both arguments together, recognising the need for a middle ground between pro life and pro choice; not advocating abortion on demand but giving guidance and support to HCP's and keeping maternity services safe. Barrister Maria Steen alternatively claims that the law is 'crystal clear' and that 'if there was no clarity we would see doctors being prosecuted and we simply don't' (Frontline 2012). She asserted her fears cleverly describing legislation as a 'blunt instrument' and warned that if we legislate circumstances may arise where the outcome would have been better had there been no change. It is an impossibility to legislate for every eventuality.

### **The Medical Voice**

The argument for regulating the provision of abortion remains a bone of contention with neither side willing to compromise their ethical principles. On the 5/4/2013 the IMO after tense debate rejected a motion to provide abortion on grounds of substantial risk to the mother, rape, incest or non viable foetal abnormality (Wall 2013). Speaking in the context of X Dr John Keogh stated that traumatic conception should not be grounds for aborting normal healthy babies however opposing this view Dr O' Grady believed it to be backward to force a young girl against her will to continue her pregnancy (Wall 2013). Even in the medical profession there is no general consensus and clinical experiences often create questions with no answers (Appendix D). If

abortion is legalised even in minute circumstances the implications will be profound. The effects of any amendments to law cannot be fully appreciated until test cases emerge over time. This is when learning will be more advanced and meaningful in its application to clinical scenarios. Data collection from hospitals, clinical audits and statistical analysis would need to be undertaken to provide important information on the prevalence of terminations and the rationale given for them. Setting gestational limitations on abortion is an important area for consideration but this is undeniably complicated when basing legislature on the X Case (on grounds of maternal suicidality). It may transpire that what is legislated for advances to areas not previously provided for leading to more than was originally intended by the modification. Such boundary stretching has been the case in many countries which have legalised circumstantial abortion. Chaloner (2007, p42) correctly observed 'agreeing what is 'right' can be challenging'.

#### **In Conclusion: Judgement Calls or Legislation?**

Clearly healthcare issues encompass ethical, legal and political factors and abortion is no different. In the context of healthcare provision ethical dilemmas often have no perfect solution. It is no coincidence that the precise application of the X judgement has not yet been clarified. Issues regarding the sanctity of life create a division in society in a debate that has raged on over generations. A debate compounded by disagreement on key issues of whether legislation is required or may serve to create more problems than it solves. Gray areas will perpetually exist as evolution continues and new dilemmas are born. Healthcare is an inexact science and is not always advanced enough to manage complex medical dilemmas when provided at its most fundamental level based on one uniform approach. There is no one size fits all when managing the dynamic complexities that lie in the human condition and this should be understood in the context of amending legislature. Although there is merit in providing enhanced guidance for HCP's there is little substitute for clinical expertise and professional judgement. Perhaps what is needed is not further legislation but further education for all HCP's on how to interpret existing legislation, guidelines and policies in order to advocate and provide best outcomes for patients while protecting their practicing registration. Due consideration and a careful reasoned approach must

be taken towards implementing any changes. Matters of public safety and public trust in the medical profession must be at the fore of any decisions made.

## **Appendix A: Irish Cases of Interest with pivotal outcomes**

### **The X Case (1992)**

A young girl aged 14 involuntarily pregnant due sexual abuse travels to England accompanied by parents to seek an abortion. The Attorney General is granted a high court order preventing X from leaving Ireland for a period of 9 months. On returning to Ireland X and her parents contest the order as X expresses suicidal intentions if forced to continue the pregnancy. The Supreme Court rules on appeal that termination is permissible if there is a “*real and substantial risk to the life*” but not necessarily the health of the mother “*termination is permissible*”. (IFPA 2013, Expert Group 2012)

### **A, B C vs. Ireland (2005)**

In 2005 three women (A, B & C) took a complaint to the European Court of human rights claiming that Ireland’s restrictions on abortion compromised their human rights. In two of the three women the court ruled no breach of rights but that in the case of applicant C there was a violation of article 8. C became pregnant while in remission of cancer and had an abortion as she was unable to get clear advice on how the pregnancy may affect her health/life or what medical treatment may do to the foetus. The Court found that there was uncertainty in the application of the X judgement and on how one qualified for lawful abortion. As C could not establish whether she was entitled to a legal abortion the Court awarded damages of €15000 for anxiety and distress caused. (Expert Group 2012)

### **Savita Halappanavar Case November (2012)**

On the 21<sup>st</sup> of October 2012 Savita, a 31 year old woman presented to Galway University Hospital at 17 weeks gestation and was found to be miscarrying. Though her membranes had ruptured and cervix was dilated she was not considered for medical termination due to the presence of a foetal heartbeat. She finally miscarried a female foetus on the 24<sup>th</sup> October by which time she was critically ill with life threatening sepsis. She was moved to the ICU where she died of multi-organ failure on the 28<sup>th</sup> October. Throughout the recent inquest into her death there were several areas of her care were queried including failure to record vital signs at regular intervals, failure to follow up blood samples, post date inclusions in the medical notes and poor communication between the multidisciplinary team, the patient and her husband. The inquest into her death concluded a unanimous verdict of medical misadventure and Coroner Dr Ciaran MacLoughlin put forward a number of recommendations as a result (Bowers 2013).

## Appendix B: Irish Law and the Constitutional Changes.

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| <b>The offences against the person act (1861)</b>   |
| The Act criminalises performing or procuring an abortion, providing equipment for an abortion or concealing the death of a child and imposes sentences from 2 years to life imprisonment.   |
| <b>The Eight Amendment (1983)</b>   |
| This acknowledges the right to life of the unborn while awarding the same or 'equal' right to life to the mother.   |
| <b>The Twelfth Amendment (1992)</b>   |
| This proposed to nullify the X Case decision and remove the threat of suicide as grounds for abortion. It was rejected with a majority vote of 65%.   |
| <b>The Thirteenth Amendment (1992)</b>  |
| The thirteenth amendment allows freedom of travel to obtain an abortion in another state.   |
| <b>The Fourteenth Amendment (1992)</b>  |
| This allowed information regarding abortion services be made available while the Regulation of Information (Services Outside the State for Termination of Pregnancies) Act 1995 ensured that information would not actively promote or advocate these services. |
| <b>Twenty-fifth Amendment (2002)</b>  |
| This bill would have removed the threat of suicide as a ground for abortion and increased the penalties for helping a woman have an abortion. It was rejected but only by a mere 50.42% of the vote.  |

*Table 1 Adapted from Expert Group (2012, p9), Took and Donnelly (2013a) (2013b) and Mills (2007).*

## Appendix C: A brief Overview of Cultural variance and Abortion

Ellis & Hartley (2012) highlighted the fact that in some states (of the USA) late term abortions were permitted while paradoxically in that same state should a road traffic accident claim the life of a pregnant woman and her unborn child the offending driver would be convicted of two counts of manslaughter. This is in contrast to countries like England where the person at the time of the alleged killing must have been born (Mills 2007).

In the US Supreme Court in the case of Roe vs. Wade 1973 the court ruled that laws preventing the right to termination in the first trimester were unconstitutional. The woman was considered to have a right to privacy and determination of what happened to her body. However it was ruled that in the second and third trimester the right of the foetus took precedence over the mother (Ellis & Hartley 2012).

In China a one child policy was implemented in 1979 as a result of the massive population which was perceived to be a burden (Somera 2008) Sons in China are valued highly while daughters are considered an economic liability. Family planning authorities in China countries regularly enforce this policy forcing women to have late abortions due to violating the quota. An upsetting example of this was seen in the media recently as Feng Jianmei and graphic images of her aborted 7 month were presented (Shears 2012). Due to gender identification the ratio of sons to daughters being born has changed due to the aborting of female foetuses with the potential of disruption to societal structure (Rabinovich 2013). According to (Walker 2012) due to family planning regulations on the 'one child policy women are subject to humiliating and degrading treatment.

It is legal for abortion to be carried out in New Zealand up to 20 weeks gestation and up to 24 weeks in limited circumstances (Collyns et al. 2009).

Though Abortion is legalised in England, Scotland and Wales acceptance of it 'remains an ethically contentious subject (Jones and Chaloner 2007, p45). Moral issues surrounding the issue continue to perplex the British population (Ainsworth 2008).

UN (2007) Provides a comprehensive global look at the variations in abortion law.



## Appendix D: A Clinical Experience

Whilst on maternity placement I was encouraged to observe both natural births and Caesarean sections. One of these elective sections was on a woman of the travelling community who was being induced post dates. She arrived into the theatre calm but nervous. She was fearful of the procedure but looking forward to holding her son whom she had already named John (pseudo name) after a family relative. When she had been given spinal anaesthetic she was assisted into the correct position and prepped for the procedure. She seemed restless and agitated as the surgeon tested the skin before making an incision. When asked was she in pain she replied no and was reassured that she may feel some 'tugging' and 'stretching' sensations. The medical staff continued making the incision. As the surgeon reached the uterus the woman became extremely agitated moving her legs and crying out. This was particularly unnerving to observe. The anaesthetist and medical team tried to ascertain if she was in pain or discomfort without much enlightenment. She remained agitated and distressed. She was asked if she wanted to be put to sleep and soon afterwards she was. I was later glad of this fact. The baby was delivered a short time afterwards. He was flat on delivery not breathing and had a weak pulse. I could tell something was very wrong by the body language of the medical and nursing staff but also from observing the abnormally large skull, underdeveloped ears and talipes of the feet. They performed infant resuscitation for 40 minutes but to no avail and the baby was declared dead.

This was an unusual and harrowing case to witness particularly since the abnormalities were not detected on the scans of which the paediatrician registrar later declared were of poor quality. I felt profoundly sympathetic to the woman who was about to wake to be informed that she would not be bringing a healthy baby home.

On deeper reflection and in the context of abortion I considered the scenario had she known earlier that the baby had a fatal abnormality. Would the outcome have changed? Would she have still carried the pregnancy to full term? I considered the anencephalic foetus with no chance of survival past a matter of days and the maternal pain of carrying a doomed baby to full term. Would the grief of this woman have been lessened had she had early termination of her pregnancy or was there comfort and

dignity in bringing that baby to existence and meeting her son? Should we be allowed decide which babies we bring into the world and which we do not? This is an extremely contentious question. It has been said by Jones and Chaloner (2007) that the question of how society views disability is at the heart of the abortion debate. If we legislated for abortion in Ireland in certain circumstances like anencephaly would this pave the way towards aborting babies with Down syndrome, autism and other genetic disorders? Through clever manipulation of the legislation and examining other countries who legislated for abortion (UN 2007) I do not doubt that it would. In a society where we are trying to advocate inclusion in the community for those with intellectual disability this would be an enormous step backward.

This experience certainly left me with a lot of questions but as is the nature of the subject very few answers. I felt mixed in emotions between sadness, empathy, confusion and guilt. I took the stance that it was possibly for the best and that things must happen for a reason. This baby may have experienced daily pain had it survived or have been extremely disabled. Perhaps this is just my way of coping with a difficult situation. Had it been an otherwise healthy baby I'm not sure my reaction would have been the same. Realising my prejudice in this regard leaves me feeling a certain level of guilt.

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