

**Implications of
Catholic health policy
for abortion
and
other reproductive health care**

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# Reproductive rights

- Reproductive rights: the right of (women/couples) to decide freely and responsibly the number, spacing and (timing) of children.

## Recognised in:

- 3rd World Conference on Women, Nairobi , 1985;
- International Conference on Population & Development, Section 7.3, Cairo, 1994;
- 4th World Conference on Women Platform for Action, Beijing, 1995

- To protect, respect and fulfill reproductive rights, among other things, health services should provide:
  - Maternity and emergency obstetric care
  - Contraception and abortion services
  - Infertility prevention and treatment
  - Sexual health services and sexuality information and education

# Religious institutions: image and role

- Religious institutions position themselves as a positive force for good, as the voice of ethics and morality, and as a voice for the poor and the world's victims, whether of violence, conflict or natural disasters.
- They are involved in a wide range of secular activities, e.g. health care, hunger, poverty, development, peace, environment and disaster relief. It keeps them in the public eye, in touch with secular power and able to influence the public and public policy, including through backroom lobbying, including on many aspects of health care.
- How to respond to this influence, and particularly how to oppose it successfully, is a very “sensitive” subject in today's world, to say the least.

## Religious institutions and health services

- Religious institutions contribute massively to the provision of health care in many countries, e.g. in sub-Saharan Africa 40% of the total, and in the USA, where 30% of hospitals are owned and run by Catholic institutions, parallel to and making up for failures of the public health system.
- In Ireland, provision of health services began in 18th century. By early 19th century there was a substantial growth in hospital and related services run by Catholic religious orders and lay organisations.
- In 1947 and 1949, two white papers proposed a national health service and social insurance system. The health service proposals foundered on “ferocious opposition” by the medical profession, the Catholic church and others. (Harvey 2007). By 2001, Section 65 (1953) funding to voluntary and community organisations, including those providing health services, was €486 million.

## Ireland has ± 71 acute hospitals

- These include psychiatric and specialist (such as maternity and orthopaedic) hospitals in 3 main categories:
  - 34 public hospitals, owned, managed, funded by state
  - 18 public voluntary hospitals, owned and managed by nonprofit bodies and funded primarily by the state. The main owners are Catholic religious congregations and the Adelaide & Meath Hospital (Tallaght Hospital).
  - 19 private hospitals which receive no direct public funding and derive their income primarily from patient charges, most of which are covered by private health insurance. Over half are nonprofit entities operated by Catholic religious congregations and the rest are commercial profit-oriented entities.
- = ± 27 of the 71 or 40% ??  
(Caring for Health in Ireland. 2012)

# Caring for Health in Ireland

- Publication of the Council for Justice and Peace of the Irish Episcopal Conference, 2012, involving many Catholic religious orders and others involved in Irish health care, many of them by Sisters' organisations.
- Excellent public health statement with laudable goals and health and social care-related ethical principles, especially involving the poor and vulnerable populations such as those who are ageing, or with mental health problems and disabilities.
- The word “women” is not in the document and maternity care is mentioned only once as per my last slide.

# Contested issues

- Un-natural contraception; emergency contraception; abortion; condom use for STI/HIV protection; assisted conception such as IVF; genetic and embryo research.
- Sexuality education and sexual health services for young people (beyond promotion of abstinence and faithfulness to one partner in marriage); sexual rights; support for criminalisation of homosexuality.
- Gender equality; rights for women, particularly in relation to who owns women's bodies and sexuality, and who owns women's pregnant bodies.

*What's left? Not much.*

## Current examples from other countries

- In Poland, there is an aggressive campaign to criminalise in vitro fertilization, led by Catholic clergy, activists and journalists associated with the Church. IVF children are depicted as monsters, born through “unnatural” means. (Radkowska-Walkowicz, RHM40, Nov 2012)
- In Costa Rica, IVF is banned because of Catholic health policy, though the Interamerican human rights court instructed the government to reverse the ban last year.
- In Brazil, sexual abuse of a 9-year-old girl led to pregnancy. The pregnancy would have killed her yet when her mother sought an abortion for her, the Catholic hierarchy opposed it. They said abortion was a worse sin and crime than rape, and excommunicated the mother and abortion provider.
- In Germany two clinics refused to provide a required rape follow-up examination in case the woman was pregnant.



# Public views on Catholic hospitals before Savita

- In August 2011, in a readers' poll published on **irishhealth.com** people were asked whether, in the wake of the Cloyne report on sexual abuse in health care institutions, the Catholic church should be allowed to maintain any involvement in health care.
  - 75% said no, 21% said yes, 4% were unsure
- *“The poll result reflects public concern over continuing church involvement in the running of many hospitals, including children's hospitals, in light of the [sexual] abuse scandals of recent years.”*

## Excellent pregnancy and maternity care...

- Many faith-based organisations, including Roman Catholic ones, have provided excellent pregnancy and maternity care, information on natural family planning methods, and HIV care and support – and it is accepted that people must go somewhere else for the rest.
- This has been the status quo in many countries for a long time.
- After Savita's death, however, assumptions about Catholic-run pregnancy and maternity care being safe for women can no longer be taken for granted.
- Instead, I believe Catholic policy and practice – in particular on emergency obstetric care – have to be investigated – and not only in Ireland.
- This is not just an issue of abortion per se. Savita's case has exposed several important, unresolved problems.

# Savita and Catholic health policy

- In November 2011, Savita Halappanavar miscarried at 17 weeks of pregnancy and died of septic shock in an Irish Catholic-run hospital.
- An avoidable maternal death is always terrible. What was different about Savita's death was the fact that it raised the issue of the failure/refusal of health professionals to save a pregnant woman's life by terminating a pregnancy that was not viable.
- Why did this happen? What has emerged **via the media**, and we need to be very clear that official investigations are yet to be made public, is that in the hospital concerned, the interpretation of Catholic health policy acted upon appeared to be that termination of pregnancy could not be carried out as long as there was a fetal heartbeat, i.e. the baby was alive.

# This is how Savita's mother understood it

*"In an attempt to save a 4-month-old fetus,  
they killed my 30-year-old daughter..."*

(Bloomberg Business Week News, 15/11/12)

## Official Irish Catholic health policy

- *“The Catholic Church has never taught that the life of a child in the womb should be preferred to that of a mother. By virtue of their common humanity a mother and her unborn baby are both sacred with an equal right to life.*
- *Where a seriously ill pregnant woman needs medical treatment which may put the life of her baby at risk, such treatments are ethically permissible provided every effort has been made to save the life of both the mother and her baby.*
- *Whereas abortion is the direct and intentional destruction of an unborn baby and is gravely immoral in all circumstances, this is different from medical treatments which do not directly and intentionally seek to end the life of the unborn baby. Current law and medical guidelines in Ireland allow nurses and doctors in Irish hospitals to apply this vital distinction in practice while upholding the equal right to life of both a mother and her unborn baby.” (Standing Committee, Irish Catholic Bishops’ Conference Statement, November 2012)*

## Meaning of this policy

- The requirement to uphold “*the equal right to life of both a mother and her unborn baby*” (also found in the Irish Constitution) is the crux of the problem. In a case like Savita’s, and many others, the mother and fetus do not have an equal chance of survival. Even if the baby had been born alive at 17 weeks, it could not have survived.
- This text appears to support treating the woman to save her life, but it is highly equivocal, precisely because it still insists on doing everything to save the baby before the woman – and gives no ground in its opposition to abortion.
- Indeed, it is an exercise in linguistic obfuscation. At its heart, it represents a refusal to provide abortion for emergency obstetric care in a maternity hospital setting.

# The fatal heartbeat

- *“According to the generally accepted standards of care in miscarriage management, abortion is medically indicated under certain circumstances in the presence of fetal heart tones... In each instance, the physician must weigh the health impact to the woman of continuing the pregnancy against the potential viability of the fetus.”* (Freedman et al, 2008) This is the accepted standard of care.
- Although only Savita’s life could have been saved, that was apparently not how those who took the decisions saw the situation, or at least not what determined their actions.
- Based on what was reported in the media, because there was still a fetal heartbeat, termination of the pregnancy appears to have been delayed, either in the misguided hope of saving both lives and/or because they believed they were adhering to Catholic health policy.

## Consequences for pregnant women

- In the weeks after Savita's death was reported, half a dozen Irish women came forward and reported having been in a similar situation, with their deaths being averted only by them coming to Britain for a termination. There have been published reports of similar cases in the U.S. and several Central American countries as well – all in Catholic hospitals.
- In these cases, a decision to refuse treatment must be understood as prioritising the life of the fetus *over and above* the life of the pregnant woman.
- So I ask: how many other health professionals, believing they are adhering to Catholic health policy, are refusing to terminate such pregnancies or have been refused ethical permission to do so because a non-viable fetus is still alive?




## Catholic policy actually unclear

- In the U.S. the manual of Catholic hospital ethics committees, which doctors use to help them interpret and apply Catholic directives states: *“The mere rupture of membranes, without infection, is not serious enough to sanction interventions that will lead to the death of the child.”* (Catholic Health Association, 2007) According to this manual, then, uterine evacuation may be carried out only after the woman becomes ill.
- Thus, a U.S. study that examined similar cases in the U.S. concluded that: *“...despite Catholic leaders’ desire for strict standardization of Catholic-owned health services, varying interpretations and executions of Directive 47 exist both at the individual (practitioner) and institutional (hospital ethics committee) levels.”* (Freedman et al, Am J Public Health, 2008)

# Ethical and Religious Directives for Catholic Health Care Services (USA)

- *“Directive 47. Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.”*
- *“Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted.”*  
(United States Conference of Catholic Bishops, 2009.)
- The question is, how ill must the woman be? This is a life-threatening ambiguity at the heart of Catholic maternity policy. It cannot be allowed to persist unchallenged.



*“There is only one way to be sure  
a woman’s life is at risk,  
that is, after she dies.”*

(Christian Fiala, 2012)

# Does this ambiguity cause medical malpractice?

- Taking account of the dozen or so cases reported to date, most in one 2008 US study and the Irish media last year, I believe there should be rigorous investigation in Catholic maternity services of treatment provided and outcomes for pregnant women with inevitable miscarriage, those affected by serious illness, those with severe fetal anomalies, and other non-viable pregnancies who require a termination to protect/save their life.
- If research unearths a history of refusal to treat and save women's lives, I believe the hospitals involved should be stripped of their right to provide maternity services and emergency obstetric care.

# Recommendations

- To do this would cause a crisis in any country where these hospitals are an important proportion of or the only existing maternity services locally or nationally.
- In such cases, government should:
  - ensure all pregnant women are informed at their first antenatal visit which services these hospitals will not provide and offered an alternative hospital;
  - take over these services if possible, or
  - make every effort to replace them with non-religious-run services, and/or
  - at the very least, require that non-religious staff are available at all times in them specifically to take charge of such cases in order to prevent morbidity and deaths.

# Conclusions

- Some faith-based health care organisations, hospitals and other health services claim the right to withhold necessary services, among them maternity, abortion, and other SRH services, with potentially serious consequences for health and human rights.
- This is “institutional conscientious objection” to providing legitimate, necessary and sometimes emergency health care. Conscientious objection is an individual right, but no medical professional body supports “institutional conscientious objection” (FIGO). In my opinion, it is medical malpractice and should be prosecuted.
- Religion must never trump necessary care and religious institutions should be allowed to provide specific forms of care only if they agree to do so without compromising patient safety.

## Two postscripts

- Maternal death audits must be held in private and individual health professionals should never be named or shamed for their part in any mistakes made, because otherwise they will never tell the truth and acceptance and agreement on how to avoid errors in future will be crucially hindered. Neglect or malpractice, institutional or individual, on the other hand, should be punished in line with professional guidance and the law.
- Savita's death is about more than abortion. It is about Catholic health policy and health services far more widely, but it is also at its heart about the failure of medical professionals to act on the fact that every abortion requested by a woman protects, respects and fulfills her right to health and prevents her life being put at risk. It should be irrelevant whether they approve of it or not.

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