In 1987, the year the first Safe Motherhood Initiative was launched by the World Health Organization, there were more than half a million maternal deaths annually. The women who were dying were often anonymous and their deaths never recorded or studied. They were mainly from poor and often rural backgrounds in developing countries, such as India. A study in India published in 1999 comparing 100 maternal deaths in a Rajasthan hospital in 1983–85 to 100 in 1994–96 found that: “Most of the women who died in hospital in 1994–96 would have died at home in the earlier decade.”1 What had changed was that they had reached a hospital and were therefore no longer anonymous, but they were still overwhelmingly women living in poverty with little or no access to skilled pregnancy and delivery care.

Contrast this with the death of Savita Halappanavar on 28 October 2012, a dentist from a privileged background in India, who miscarried 17 weeks into a very wanted pregnancy and died in the maternity ward of a hospital in Ireland, a country with a very low maternal death ratio.2* Savita’s death became iconic for a number of reasons. First, preventing maternal deaths has been a global priority since 1987 when the first World Health Organization Safe Motherhood Initiative was launched. Since 2000, reducing maternal deaths by 75% by 2014 has been the main target of Millennium Development Goal No.5, and since 2010 it has been one of five main goals of the UN Secretary-General Ban Ki-Moon’s Global Strategy on Women’s and Children’s Health.3 Hence, maternal deaths have started to be a news item globally, with journals like Reproductive Health Matters carrying studies and the media in many countries where deaths remain frequent, reporting successes and failures to reduce deaths, and individual stories regularly.

Secondly, holding governments accountable for their failure to provide the required services, both antenatal and delivery care and emergency obstetric care, to prevent avoidable maternal deaths

* The most recent figure published by WHO is thought by experts in Ireland to be too low, as data are incomplete by WHO measures. Ireland is in the process of shifting to using the UK system of determining the maternal death ratio; figures are due in 2013. For 2009-2011 data see: Maternal Death Enquiry MDE Ireland: http://www.mdeireland.com/index.html.
has become the subject of public protests by women’s rights advocates, of court cases, including in India, and of hearings by human rights bodies, particularly CEDAW, examining individual cases and making policy recommendations to governments.4

What was different about Savita’s death, however, was the fact that it was also about whether and when to terminate a pregnancy when it is not viable and the woman’s health and life are at risk, and how that intersected in Savita’s case with individual health professionals’ interpretation of Catholic health policy and the law on abortion in Ireland.

As a committee of the Irish Parliament considers proposals to offer limited legal abortion in Ireland, this paper explores how these issues came together around Savita’s death, the interpretation of Catholic health policy and the consequences for pregnant women.

Preventing maternal deaths as global policy

Maternal deaths, especially in countries where they remain frequent, are getting more and more media coverage. The Millennium Development Goals have made countries with continuing high maternal mortality ratios* conscious of their shortcomings, and civil society organisations are beginning to pursue justice and even compensation in individual cases.

In India, for example, a petition for legal redress was filed in the Delhi High Court in the case of Shanti Devi, who died in childbirth in January 2010 after two high risk pregnancies in which she received delayed and insufficient care. With the first of these two pregnancies, she fell down the stairs and afterwards could no longer feel the baby moving. Induction of the pregnancy was delayed until she required intensive care which, when she finally received it, was inadequate. With her health still very precarious, she became pregnant again six months later, went into labour prematurely at seven months, delivered the baby at home without a skilled birth attendant or any medical assistance, and within an hour after delivery, began haemorrhaging and died. This case ensured that the Court took into account not just the individual death but also the constitutional and human rights obligations of the central government of India.5

Some communities where women are at high risk because of the lack of routine and emergency obstetric care are also beginning to protest against maternal deaths. One such event took place in Uganda where, in May 2011, hundreds of concerned citizens and health professionals stormed the Constitutional Court in Kampala, Uganda, protesting the deaths of women in childbirth, in support of a coalition of activists who took out a landmark lawsuit against the government over two women who bled to death giving birth unattended in hospital.6

Another example from India comes from Barwani district, Madhya Pradesh, India, where there were local protests against 27 maternal deaths in the period from April to November 2010. In January 2011, an NGO fact-finding team found an absence of antenatal care despite high levels of anaemia, absence of skilled birth attendants, failure to carry out emergency obstetric care in obvious cases of need, and referrals that never resulted in treatment.7

Events like these are making the governments concerned highly sensitive to criticism. As an upper middle-class woman, Savita Halappanavar would have been highly unlikely to die in India from the appalling treatment experienced by Shanti Devi or the tribal women in Barwani. Yet, ironically, the Indian government was among the first to criticise those in Ireland who failed to prevent Savita from dying. For example, India’s ambassador to Ireland said on Friday that Mrs Halappanavar may be alive if she had been treated in India.8

Emergency obstetric care, termination of non-viable pregnancies and Savita’s death

Whether the details of the maternal death audit in Savita’s case will be made public, as Savita’s husband demanded in the weeks following her death, is uncertain at this writing. It is widely accepted by the medical profession that maternal death audits must remain confidential in order to have the desired outcome — open examination of the causes of death and the actions that need to be taken to prevent such a death in future, if such a death is indeed preventable. This is the basis on which the UK Confidential Enquiries into Maternal Deaths have been conducted every three years

* India’s is 200 deaths per 100,000 live births compared to only 6 per 100,000 live births in Ireland in 2010.2
and reported,* and the process followed for these enquiries has been a model for other countries. There is an assumption in these cases that the individual health professionals involved acted in good faith, and the point is therefore to ensure that any mistakes made are avoided in future, not to punish people for making them. This is quite different from addressing medical malpractice.

Savita’s husband may or may not have understood why such audits are confidential when he demanded that the enquiry into her death be carried out in public, but his demand, according to the newspapers, was because he believed the doctors involved may have been covering up information, at least in terms of what they were willing to say to him and his solicitor.

In Savita’s case, and in others summarised below that are similar, the question of whether or not the deliberate decision not to terminate the pregnancy does constitute malpractice is highly relevant.

Part of the treatment required to save Savita’s life, which should have been carried out without delay, was the evacuation of her uterus to terminate the pregnancy. She was 17 weeks pregnant. Because her cervix was fully dilated, the pregnancy was no longer viable, that is, there was no way for treatment to make it possible for the pregnancy to continue long enough for the baby to become viable. Moreover, had the baby been born alive at 17 weeks, it would not have survived. Thus, only Savita’s health and life were at stake, as only she might have been saved. This was not, apparently, how Savita’s doctors saw the situation, or at least not what determined what action they took. Based on what was reported in the media, termination of the pregnancy appears to have been delayed beyond the point where her death may have been prevented because there was still a fetal heartbeat.†

But why?? What appears to be the answer arises from the reported statement by the doctors involved in Savita’s case that “this is a Catholic country” and in other cases reported in the media afterwards of direct reference to personal or hospital-wide interpretation of what doctors and nurses believe to be Roman Catholic health policy as regards treatment of miscarriage by Catholic health professionals.

“Evacuation of the uterus” is another way of saying “induction of abortion” or “termination of pregnancy” and this is where the problem lies, even though this was a wanted pregnancy that required an emergency obstetric response. Termination of pregnancy to save a woman’s life is legal in Ireland under the Offences against the Person Act 1861, and indeed in all but five countries in the world. Termination to save the woman’s life should be understood to mean to prevent a pregnancy from becoming life-threatening before it is already life-threatening. One would have thought that includes termination to complete an inevitable miscarriage and to end an unviable pregnancy, both of which could easily become septic, as well as termination when the woman has or develops a life-threatening illness while pregnant. However, there is nothing in writing that specifies what “termination of pregnancy to save a woman’s life” actually means, nor when it applies.

This was made even more complicated in Ireland since a 1983 Constitutional amendment, whose aim was to prevent termination of pregnancy ever becoming legal or indeed ever carried out, which states: “The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.” (Article 40.3.3, 1983).9

Savita’s case and others before it have brought this lack of clarity to light. For example, according to a report in Wikipedia, an Irish woman named Sheila Hodgers became pregnant in 1983, one year after surgery for breast cancer and while still on treatment. The Wikipedia text states: “Since the anti-cancer drugs she was taking could harm the fetus, she was stopped from taking them. Hodgers began experiencing severe back pains and could hardly stand. Her husband urged the hospital to induce her pregnancy or perform a caesarian but they refused as it would damage the fetus. They also


†It was also reported in the media that Savita had developed a serious infection, possibly via her dilated cervix, which caused sepsis and contributed to her death. This paper is not about what caused her death, however, but rather about why there was a delay in one aspect of her treatment, i.e. termination of the pregnancy.
refused painkillers. The hospital had to abide by ‘The Bishop’s Contract’, a code of ethics drawn up with the Catholic Church.” Both she and the baby died soon after the birth. In 2007, a 17-year-old known as Miss D had an anencephalic (non-viable) pregnancy and went to the Irish High Court to stop the Health Service Executive from preventing her from travelling to obtain an abortion. The High Court ruled that she had a right to travel. Ireland has been supposed to develop policy and guidance on these matters for many years, and especially since a directive by the European Court of Human Rights arising from a case heard in 2010, in which a woman with a rare form of cancer had gone to the UK for an abortion to protect her health but argued that she should have had the right to an abortion in Ireland. The Court held in her case that there had been a “failure to implement the existing Constitutional right to a lawful abortion in Ireland”. Thus, clarifying the law on abortion in Ireland had long been an issue in Ireland when Savita died. Her death became the subject of public protest by those angry at Ireland’s failure to act on the European Court’s directive, and especially those supporting women’s right to abortion, rather than as a failure to carry out a life-saving emergency obstetric procedure. Yet the two are intimately linked.

In January 2013, in evidence to the government committee considering, at writing, what to do about the law in Ireland, three experts – Dr Jennifer Schweppe from the University of Limerick, Ciara Staunton from NUI Galway, and Dr Simon Mills of the Law Library – gave evidence that they had prepared independently. Each of them said that a Supreme Court ruling in the case Roche v. Roche in 2009, delivered by Susan Denham, who has since become the Chief Justice, meant that if a fetus cannot survive beyond pregnancy it does not enjoy the protection granted in the Irish Constitution to the “life of the unborn”.

What is Roman Catholic policy on termination of pregnancy as part of emergency obstetric care?

A statement issued in November 2012 by the Standing Committee of the Irish Catholic Bishops’ Conference appears not to contradict the interpretation of Irish law above:

“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.”

However, the requirement “to uphold the equal right to life of both a mother and her unborn baby” is the crux of the problem, because in a case like Savita’s and many others, the mother and fetus do not have an equal chance of survival. Catholic policy signally fails to acknowledge this and pronounce on it, to women’s great detriment. This text appears to support treating the woman to save her life, but it is highly equivocal, precisely because it still insists on opposition to all abortions.

Historically, in the United States, the Ethical and Religious Directives for Catholic Health Care Services of the United States Conference of Catholic Bishops, first published more than 60 years ago, aimed to ensure strict obedience to Catholic principles by all employees of Catholic-owned hospitals, without local variation. The 5th edition (2009) states that: “abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted.” In regard to cases such as Savita’s, it says only that:

“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.”
On the basis of this statement, there would appear to have been no need to delay the evacuation of the uterus in Savita’s case because the fetus was not viable. However, a fetal heartbeat, indicating the fetus was alive, appears to have made all the difference – because it forced the individual medical professionals to decide, from a Catholic policy perspective, whether the death of the fetus was “directly intended” or not. This uncertainty, a direct result of this policy, was fatal for Savita and is potentially fatal for other women.

The authors of a 2008 study of provision of treatment for miscarriage by obstetrician–gynaecologists in Catholic-owned hospitals in the USA, describing best medical practice, state:

“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. Such cases include first-trimester septic or inevitable miscarriage, pre-viable premature rupture of membranes and chorioamnionitis, and situations in which continuation of the pregnancy significantly threatens the life or health of the woman. In each instance, the physician must weigh the health impact to the woman of continuing the pregnancy against the potential viability of the fetus.”

The authors go on to say, however, that the manual of Catholic hospital ethics committees, which the doctors use to help them interpret and apply the 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.” Because the manual of Catholic hospital ethics committees is probably considered the more authoritative source by these doctors, uterine evacuation may be carried out only after a woman becomes ill. Thus, the authors state:

“Our data indicate 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.”

Their interviews with six US obstetrician-gynaecologists working in Catholic-owned hospitals found that in spite of the Bishops’ guidance, there were cases where, in managing miscarriages, Catholic-owned hospital ethics committees had denied approval of uterine evacuation while a fetal heartbeat was still present, forcing the physicians to delay care or refer the woman elsewhere. Some physicians intentionally violated this restriction because they felt patient safety was compromised. Here is what they write about three of their reports:

• One reported that at her Catholic-owned hospital, “approval for termination of pregnancy was rare if a fetal heartbeat was present (even in “people who are bleeding, they’re all the way dilated, and they’re only 17 weeks”) unless “it looks like she’s going to die if we don’t do it.”

• Another reported: “She was very early, 14 weeks. She came in… and there was a hand sticking out of the cervix. Clearly the membranes had ruptured and she was trying to deliver… There was a heart rate, and [we called] the ethics committee, and they [said], “Nope, can’t do anything.” The woman was then sent 90 miles away to another hospital for treatment.”

• Still another reported: “I’ll never forget this; it was awful – I had one of my partners accept this patient at 19 weeks. The pregnancy was in the vagina. It was over… And so he takes this patient and transferred her to [our] tertiary medical center, which I was just livid about, and, you know, “we’re going to save the pregnancy”. So of course, I’m on call when she gets septic, and she’s septic to the point that I’m pushing pressors on labor and delivery trying to keep her blood pressure up, and I have her on a cooling blanket because she’s 106 degrees. And I needed to get everything out. And so I put the ultrasound machine on and there was still a heartbeat, and [the ethics committee] wouldn’t let me because there was still a heartbeat. This woman is dying before our eyes. I went in to examine her, and I was able to find the umbilical cord through the membranes and just snapped the umbilical cord and so that I could put the ultrasound – “Oh look. No heartbeat. Let’s go.”

The authors conclude that:

“…although Catholic doctrine officially deems abortion permissible to preserve the life of the woman, Catholic-owned hospital ethics committees differ in their interpretation of how much health risk constitutes a threat to a woman’s life and therefore how much risk must be present before they approve the intervention.”

These interpretations appear to be operative in
other countries with Roman Catholic influence as well. The Dominican Republic is one of the five countries globally where abortion is not permitted legally on any grounds, even to save the life of the woman. Although this should not apply in cases of emergency obstetric care, it did apply in August 2012 in the case of a 16-year-old Dominican girl with leukaemia who died of complications caused by a miscarriage. She had been diagnosed as suffering from leukaemia in early July that year, when she was only a few weeks pregnant. At that time, she was prevented from having a therapeutic abortion – as recommended by health professionals – because it was believed to be against the law. Chemotherapy was also delayed as doctors were concerned it would harm the fetus.19

Similarly, the International Campaign for Women’s Right to Safe Abortion published a solidarity request in December 2012 in support of a Costa Rican woman called Aurora who was carrying a non-viable pregnancy with multiple, severe fetal malformations, which were identified in the first trimester.20 For almost five months, the report said, she suffered from severe back and abdominal pain and was unable to work. A live birth was impossible. Yet no one in the country could be found who would induce labour to bring the pregnancy and her suffering to an end. Only when she was 29 weeks pregnant did her waters break, and a caesarean section was carried out. In response to protests by a women’s rights group, Ileana Balmaceda, described as the highest authority in Costa Rica’s public health system, said that the country’s laws did not allow abortion in this kind of case (Personal communication, 4 January 2013).

Savita’s case has also led women in Ireland who survived similar experiences to speak out. The Irish Examiner reported on 16 November 2012 that on RTÉ Radio’s Liveline, five women phoned in who faced similar situations to Savita Halappanavar. All five were 15–20 weeks’ pregnant when the incidents occurred in hospitals from 1997 to 2004. Here is what one was reported as saying:

“Jennifer said that in 2003 when she was 16 weeks’ pregnant, she started bleeding and went to her local hospital. ‘All the nurses inside [the unit] just started crying uncontrollably. They said there was no hope for the baby and they couldn’t understand why I hadn’t miscarried. There was no … fluid [around the fetus], he had one kidney, fluid on his brain. But there was a heartbeat. They kept listening,’ Jennifer said GPs and four consultants met her separately after work in their own time for scans, only to tell her “you need to make a decision immediately” due to the impact on her health. She said one said to her mother: ‘I know what I would do if it was my daughter, you need to read between the lines. You need to do it urgently.’ ‘I went to see my GP at 11pm at night.’ Her mother travelled with her to Britain [for a termination].”21

Another case reported in 2010 regarding a Catholic-run hospital in the state of Arizona in the US led the head of the hospital and of the hospital ethics committee to reach exactly the same conclusion:

“…The case involved a woman in her 20s with a history of abnormally high blood pressure that was under control before she became pregnant. Doctors were concerned about the extra burden that pregnancy would place on her heart. She was constantly monitored during the early stages of pregnancy when tests showed that her condition was deteriorating rapidly… Before long her pulmonary hypertension had begun to seriously threaten her life. The woman was informed by doctors that the ‘risk of death’ was high if she continued with the pregnancy. After consultations with the patient, her family, her doctors and the hospital’s ethics team the decision was made to go ahead with an abortion in order to save the mother’s life. Hospital president Linda Hunt said: “The hospital’s actions were consistent with our values of dignity and justice. If we are presented with a situation in which a pregnancy threatens a woman’s life, our first priority is to save both patients. “If that is not possible we will always save the life we can save, and that is what we did in this case. Morally, ethically, and legally we simply cannot stand by and let someone die whose life we might be able to save.”22

However, because of this decision, the hospital was officially stripped of its Catholic affiliation by Bishop Thomas J Olmsted because it “did not faithfully adhere to the ethical and religious directives for Catholic health-care services”.22 The Bishop was also reported to have procured the sacking [of Sister Margaret McBride] from the ethics committee of the hospital for approving the decision and declared that she had “automatically excommunicated” herself because:
“While medical professionals should certainly try to save a pregnant mother’s life, the means by which they do it can never be by directly killing her unborn child. The end does not justify the means.”

In both these cases, as in Savita's case, a decision to refuse treatment would have led to the death of the woman. This refusal must therefore be understood as prioritising the life of the fetus over and above the life of the pregnant women, even though the fetus had no chance of surviving to become a live baby.

According to Catholics for Choice, Bishop Olmsted made an error of interpretation of Catholic health policy in the Arizona case. However, their interpretation of what Catholic policy should be does not appear to be reflected in existing texts and statements made. Even on the evidence gathered for this paper, which is far from comprehensive and has mostly emerged through media reports since October 2012 and only because of Savita Halappanavar’s death, the refusal to terminate a pregnancy even when the woman’s life is at risk appears to be happening on three continents.

The life-saving value of termination of pregnancy in both wanted and unwanted pregnancies

Countries where abortion remains legally restricted and unsafe are almost always also countries where maternal deaths in wanted pregnancies are also still high. In other words, in those countries, the value of a pregnant woman’s life is low no matter whether the pregnancy is viable or not, or wanted or not. In the five Catholic countries where termination of pregnancy is not permitted even to save the life of the woman, this error of interpretation of Catholic health policy is even more likely to be a risk.

Member of the Irish parliament, John O'Mahony, who is said to have strong anti-abortion views, described Savita Halappanavar’s death as “a terrible tragedy” and said he thought it should not have happened even with existing legislation. “I am totally against abortion but also totally for protecting the mother’s life,” he said. Unfortunately, it is not possible to have it both ways, as all the cases reported in this paper show.

In response to a letter protesting Savita’s death from the International Campaign for Women’s Right to Safe Abortion, Eamon Gilmore, the Deputy Prime Minister of Ireland, went further:

“I do not think we, as a country, should allow a situation where women’s lives are put at risk in this way. We must deal with the issue and bring legal clarity to it... Six Governments in this State since the Supreme Court judgment in 1992...have not dealt with it. This will not be the seventh.” (16 November 2012)

As one doctor said in a November 2012 blog:

“... I can easily argue that Savita’s life was at risk the moment her membranes ruptured at 17 weeks. However, does Irish law mean a different kind of risk? And if so, how would doctors judge that risk to be present? Ruptured membranes and fever? Shaking chills? Bacteria in the amniotic fluid? Positive blood cultures? Sepsis? Cardiovascular collapse? How sick must a pregnant woman be in Ireland for a doctor to state that her life is at risk?”

This is a question that must be asked in more countries than just Ireland.

Is this the norm in Catholic maternity services?

The refusal to terminate the pregnancies of Savita Halappanavar and others described in this paper appears to have contributed to Savita’s death and put the lives of other pregnant women seriously at risk. If so, this is unethical and violates the Hippocratic oath to do no harm.

How many other health professionals who believe they are adhering to Catholic health policy are refusing to terminate such pregnancies or have been refused permission to do so because the fetus is still alive? Is this the norm across Catholic health services, and if so, in which countries, or are these exceptions? The governments of Ireland and of every other country with Catholic-run maternity services need to answer these questions urgently.

The ethical imperative to save pregnant women’s lives

Many of the events presented in this paper are recent or have only just taken place, and most of the sources are media and individual reports. However, there is a very worrying common thread across countries and continents. These reports invite rigorous investigation of treatment provided and outcomes for women of inevitable miscarriage, severe fetal anomalies and other
non-viable pregnancies, and pregnancies affected by serious illness that require a termination in at least a sample of Catholic maternity services and by Catholic health professionals in the countries where they work.

If research unearths more histories of failure to treat and save women’s lives, as in the cases reported in this paper, any such health professionals and/or hospitals should be stripped of their right to provide maternity services and emergency obstetric care. In countries where these are the only existing maternity services locally or nationally, governments should either: 1) refuse to fund these services, 2) take over these services, 3) make every effort to replace them with non-religious services, and/or 4) at the very least, require that non-religious staff are available at all times specifically to take charge of such cases to prevent morbidity and deaths.27*

Finally, governments of countries with Roman Catholic-run maternity services should join with Catholic religious representatives to state categorically that neither the law nor Catholic health policy support the withholding of emergency obstetric care where a pregnant woman’s life and health may be at risk. Termination of pregnancy will end fetal life — whether done as emergency obstetric care, for an inevitable miscarriage or non-viable pregnancy, on grounds of severe fetal anomalies, when the continuation of the pregnancy presents a risk to the woman’s life or health, or when pregnancy is unwanted. By definition, it is always deliberate. At issue is whether the woman’s life comes first or not. This is the crux of what abortion — as well as emergency obstetric care — is all about.

Acknowledgements

Thanks to Goretti Horgan, Lisa Hallgarten, Toni Belfield and Pathika Martin for very helpful comments on the text.

References


21 Ó Cionnaith F. Miscarrying women told to ‘read between lines’ and go to UK. Irish Examiner. 16 November 2012.


