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ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Reproductive health information and abortion services: Standards developed by the European Court of Human Rights

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ABSTRACT

In 3 recent judgments, the European Court of Human Rights addressed the issue of access to abortion and related reproductive health services. In 2 of the judgments, the Court declared that the state violated women's rights by obstructing access to legal health services, including abortion. In so doing, it referred to the state's failure to implement domestic norms on prenatal testing and conscientious objection, and recognized the relevance of international medical guidelines. This illustrates that domestic and international medical standards can serve as critical guidance to human rights courts. In the third case, the Court showed its unwillingness to declare access to abortion a human right per se, which is troubling from the perspective of women's right to health and dignity. The present article outlines the relevance of these cases for the reproductive health profession and argues that medical professional societies can influence human rights courts by developing and enforcing medical standards, not only for the benefit of abortion rights domestically but also for the advancement of women's human rights worldwide.

1. Introduction

Since 2010, the European Court of Human Rights has issued 3 decisions with great relevance for understanding the human rights obligations of medical professionals in the field of abortion. In 2 of these cases—*A, B, and C v. Ireland* and *P and S v. Poland*—the Court discussed the right of women to access legal termination of pregnancy and elaborated in some detail on related state and medical service obligations. These 2 cases, while very different, both address the roles and responsibilities of health professionals where access to abortion is severely compromised owing to restrictive laws. The third case, *RR v. Poland*, is primarily about the right to access reproductive health information, in close connection with the right to lawful abortion.

The present article discusses these 3 cases and their relevance for standards of duty of care for health professionals in settings with restrictive laws in the reproductive healthcare field. It also briefly examines some of the shortcomings of the approach of the European Court of Human Rights and its unwillingness to address abortion as a rights issue per se. The article emphasizes that human rights standards and medical ethical obligations are closely intertwined and argues that clearly formulated medical guidelines are critical as human rights standards in the field of healthcare develop. Where domestic laws or medical guidelines exist, courts will be reluctant to decide against them. Therefore, medical professional societies have a key role in developing comprehensive and human rights-based guidelines that can influence the evolution of human rights norms, in Europe and beyond. Moreover, when courts cite these medical standards as a source of law, they also legitimate them, which in turn strengthens the authority of the standards themselves.

2. Access to information: *RR v. Poland*

The case of *RR v. Poland* [1] was brought by a woman who had an ultrasound scan during her pregnancy and was told that her fetus possibly had a genetic malformation. The woman told the doctor that she wished to have a termination if this proved to be true. Abortion is legal in Poland under certain, narrow circumstances, including severe fetal anomalies. However, when RR tried to access further genetic tests to determine the health status of her fetus, she was denied the examinations to which she was entitled under Polish law. She was referred to several hospitals, on 1 occasion hospitalized for 3 days, and traveled across the country to access the information but was repeatedly refused relevant tests. After 6 weeks of fruitless attempts, she reported at a hospital as an emergency patient, claiming that she was about to miscarry, and an amniocentesis was finally performed on her. She had to wait 2 weeks for the results and when she ultimately got them—confirming that her fetus had serious congenital defects—it was too late to obtain a legal abortion under Polish law. RR gave birth to a girl with Turner syndrome.

The European Court of Human Rights found that the suffering that RR experienced, before as well as after the diagnosis, and the deliberate denial of information critical for her to make an informed

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decision violated her rights in multiple ways. For the first time, the Court determined that denial of services critical for deciding whether to seek an abortion can violate the right to be free from inhuman and degrading treatment. It stressed that the relevant information services were legal under domestic law and clearly available, the knowledge of which increased RR's suffering, and that she—a pregnant woman deeply distressed that her fetus might have a serious abnormality—was greatly vulnerable.

This case does not primarily revolve around abortion, but centers on the *right to information in the reproductive healthcare context*. The option to have a legal abortion was directly related to the provision of accurate and timely information—which was in the hands of the state to provide or deny. The Court stressed that denial of health information related to pregnancy, regardless of what a woman chooses to do with the information, has repercussions on her most fundamental rights: "[I]n the context of pregnancy, the effective access to relevant information on the mother's and foetus' health, where legislation allows for abortion in certain situations, is directly relevant for the exercise of personal autonomy" [1] (para. 197).

Importantly, the Court relied in its judgment on existing medical standards in Poland relating to the right to access reproductive health information. It emphasized that "there was an array of unequivocal legal provisions in force at the relevant time specifying the State's positive obligations towards pregnant women regarding their access to information about their health and that of the foetus" [1] (para. 157). Polish doctors had a clear legal obligation to secure access to prenatal genetic testing when a suspicion of fetal malformation had arisen, and this obligation had been deliberately and systematically ignored. Thus, the Court concluded, Poland had failed to establish a system in which a woman's rights to timely information and services are guaranteed.

The main reason doctors refused RR prenatal examinations was clearly that she was considering abortion. The Court addressed this fact, for the first time discussing conscientious objection in the abortion context. It emphasized that the state must put procedures in place so that services are available and accessible regardless of whether individual doctors refuse to perform them. While acknowledging the right to conscience of physicians, the Court emphasized that the state has responsibilities to balance this right with women's right to access legal services. This important finding was further elaborated in the case of *P and S v. Poland*, approximately 1 year after the *RR v. Poland* judgment (see below).

It is worth noting that, as background to the decision, the Court quoted various international medical standards. In a section named "[r]elevant non-Convention material," it included both Council of Europe standards [2,3] and FIGO statements on ethical issues of prenatal genetic testing and termination of pregnancy [4–6]. The Court did not cite these documents directly in its reasoning, but the fact that it included them in the text, referred to them as relevant, and included strong language in its reasoning that closely resonates with them indicates that the Court considers international medical standards an authoritative point of reference.

3. Access to reproductive health services for adolescents: *P and S v. Poland*

In *P and S v. Poland* [7], a 14-year-old girl, pregnant following rape, sought to access an abortion that was lawful in Poland and should have been easily accessible to her. However, the adolescent encountered multiple barriers in her quest for a termination. She was subjected to harassment, coercion, and humiliating treatment from health professionals, church officials, the police, and the judiciary, and she repeatedly received confusing or deliberately misleading information. One hospital, declaring that the whole institution invoked conscientious objection, leaked information about her predicament to the press. Hospital staff and a priest sought to manipulate the relationship between the adolescent and her mother, who supported her, resulting in the girl being taken from her mother's custody and locked up in a youth center. Finally, the girl obtained an abortion, 500 km from her home, in a hospital where she was not registered as a patient and where no postabortion care was offered.

The European Court of Human Rights found multiple violations of the human rights of both the adolescent and her mother, including the right not to suffer inhuman and degrading treatment and the right to respect for private life. Several aspects of this judgment are worth highlighting. In regard to conscientious objection, the Court noted that Polish law provides for some safeguards—for example, health professionals who object must make their refusals in writing and refer their patients to non-objecting providers—but found these requirements to have been blatantly ignored. The Court sharply reproached the health providers involved [7] (para. 108):

> On the whole, the Court finds that the staff involved in the applicants' case did not consider themselves obliged to carry out the abortion expressly requested by the applicants on the strength of the certificate issued by the prosecutor. The applicants were given misleading and contradictory information. They did not receive appropriate and objective medical counseling which would have due regard to their own views and wishes. No set procedure was available to them under which they could have their views heard and properly taken into consideration with a modicum of procedural fairness.

This demonstrates how several of the most basic obligations of health providers had been violated. By concluding that these serious breaches together constituted a violation of the adolescent's right to respect for her private life, the judgment illustrates how closely interconnected medical ethics and human rights standards are. The Court noted that the right to religion, protected under the European Convention on Human Rights, "does not denote each and every act or form of behaviour motivated or inspired by a religion or a belief," and reiterated its statement in the case of *RR v. Poland* that states are obliged to organize their health services in a way that balances health professionals' exercise of freedom of conscience with patients' access to legal health services [7] (para. 106). Moreover, by finding specifically that the health professionals' failure to abide by the *existing provisions* on conscientious objection in Polish law constituted a violation of rights, the Court established a Europe-wide minimum standard on this issue. At the least, refusals must be in writing and referrals must be secured. This minimum standard falls short of being as comprehensive as the ethical guidelines on conscientious objection established by FIGO [8], for example, but it is a step in the right direction. That the Court established this rule through referral to existing Polish regulations illustrates how important domestic medical standards and laws can be for the development of international human rights norms.

Furthermore, the *P and S v. Poland* judgment clarifies adolescents' rights in the reproductive health context. In many parts of the world, the rights of adolescents to make decisions regarding their reproductive health—in particular relating to contraception and abortion—are severely circumscribed by barriers such as parental consent laws, lacking information, and/or financial constraints. In this case, there was no conflict between the teenager and her mother that a termination of pregnancy was in the girl's best interest. The Court nevertheless identified some key principles of autonomy and dignity of youth in regard to accessing abortion services [7] (para. 109, emphasis added):

> [The Court] is of the view that legal guardianship cannot be considered to automatically confer on the parents of a minor the right to take decisions concerning the minor's reproductive choices, because proper regard must be had to the *minor's personal autonomy* in this sphere. This consideration applies also in a situation where abortion is envisaged as a possible option.

Thus, the Court appears to suggest that, in cases of conflict between an underage girl and a parent in the context of abortion, the adolescent's wishes should prevail. This finding, the first of its kind from a human rights court, complies with recommendations from UN human rights treaty-monitoring bodies. For example, the Committee on the Rights of the Child has recommended that, in line with the principles of the best interest of the child and the evolving capacities of youth, parental consent laws to reproductive health services should be abolished [9,10]. This finding harmonizes perfectly with well-established medical ethics [11,12] (p. 95) [13].

The applicants in the case of *P and S v. Poland* also claimed that the failure to provide emergency contraception upon reporting of rape amounted to a human rights violation. The Court opted not to address this claim. As highlighted by WHO [14] and the Inter-American Commission [15], access to emergency contraception for rape victims is an indispensable part of emergency care. Similarly, in its 2012 Safe Abortion Guidelines, WHO establishes that standards for provision of safe abortion following rape should be part of a comprehensive package for the overall management of rape survivors, covering, inter alia, physical and psychological care and access to emergency contraception [12] (p. 69). Providing such access can, thus, reasonably be argued to constitute part of the state's positive obligations to protect the individual's rights to health, dignity, privacy, and bodily integrity under human rights law. It is unfortunate that the Court chose not to comment on this matter. However, given how confidently it referred to domestic standards on conscientious objection, it might well have addressed emergency contraception had there been clearer domestic policies and medical guidelines on this issue in Poland. International and domestic medical societies can have an important role in developing such standards, in Poland and other parts of the world. As highlighted elsewhere in the present article, if the medical community establishes guidelines or advocates laws at the domestic level—in line, for example, with the international standards set out by WHO—human rights courts will be more likely to endorse them than if there is a regulatory vacuum domestically. In this way, the medical community can directly advance human rights norms on key reproductive health issues such as the absolute obligation to provide emergency contraception to rape victims.

4. Health and/or life exceptions to abortion bans: *A, B, and C v. Ireland*

In 2010, the European Court of Human Rights issued a judgment in the case *A, B, and C v. Ireland* [16]. It involved 3 women residing in Ireland who had abortions in the UK. The women had different motives: A was living in poverty and recovering from substance abuse; B was single, young, and not ready to care for a child; and C was suffering from a rare cancer, treatment of which was contraindicated during pregnancy. Abortion is banned in Ireland, with 1 narrow exception: when the pregnant woman's life, as distinct from her health, is in danger. Even this exception, established 20 years ago by an Irish Supreme Court judgment, has not yet been codified into written law; furthermore, there are no guidelines interpreting the exception.

Given this lack of guidelines, an Irish doctor often cannot know whether a particular case qualifies for a legal termination, and a provider who thinks that an abortion is indicated takes a legal risk by providing one. In all other circumstances—including rape, physical and/or mental health problems, or serious fetal abnormalities—abortion is prohibited under harsh criminal punishments for women and providers. Each year, more than 4000 women residing in Ireland travel to the UK for abortions—and these are only the official UK statistics [17]. Traveling and services offered in the UK and other European countries are expensive, and costs are an obvious barrier for many poor or otherwise marginalized women. Moreover, having to leave the country for a fundamental health service—feeling "like criminals," according to some women—can result in deep psychological trauma [18,19].

These were some of the hardships that the applicants in the case of *A, B, and C v. Ireland* raised, claiming that the consequences of the Irish abortion ban amounted to violations of their right to life, freedom from degrading treatment, and private life. The Court found that C's inability to assess whether her condition was sufficiently life-threatening to qualify for abortion under the narrow exception in Irish law violated her right to private life. This finding is consistent with the Polish decisions discussed earlier: if abortion is legal in a country, it should also be accessible there through adequate and speedy procedures. Three years later, as a result of the Court's judgment, the Irish government has introduced legislation that seeks to make enforceable the exception to the abortion ban when the woman's life is in danger [20,21].

The situation of applicants A and B was very different. Their claim was not of uncertainty under the existing legal regime but that the regime as such was unjust and in violation of international human rights standards. The fact that Irish law does not allow abortion on the basis of health and wellbeing, they claimed, led to a violation of their fundamental rights. The European Court did not agree. Through complex and somewhat inconsistent reasoning, it concluded that, while the abortion ban interfered with women's right to private life, this interference could be justified. The Court referred in particular to the "profound moral views of the Irish people as to the nature of life" and the "consequent protection to be accorded to the right to life of the unborn," particularly bearing in mind "the right to lawfully travel abroad for an abortion with access to appropriate information and medical care in Ireland" [16] (para. 241). Thus, the Court did not find the Irish ban on abortion in cases of risk to health and/or wellbeing to be in violation of the European Convention of Human Rights.

The findings in relation to A and B raise several points of concern. The main troubling aspect is that the Court refused to approach abortion as such—in relation to women's right to health, dignity, and self-determination—as a human right [22]. It also failed to address that risks to *life* (which can justify a legal abortion in Ireland) are closely intertwined with risks to *health* (which cannot) and that there is a human right to life *and* health. This issue was brought to the fore in the October 2012 case of Savita Halappanavar—the woman in Galway, Ireland, who suffered a late spontaneous abortion but was denied appropriate emergency treatment because doctors could detect a fetal heartbeat and who died as a result of the maltreatment [23,24]. For many health conditions, the only way to know whether it "really" also threatens life is to postpone treatment unless and until it has become sufficiently critical. This corresponds poorly with medical ethics of rendering patients indicated care.

On a more practical level, in the case of *A, B, and C v. Ireland*, the Court failed to acknowledge that the option to travel abroad for abortion is not open to everybody and that being forced to travel to another country for a critical health service can entail suffering that rises to the level of cruel and inhuman treatment. Some have called the Irish abortion ban a ban for the poor, specifically hindering "those women who do not possess sufficient private economic resources" from terminating a pregnancy, resulting in injustice, discrimination, and health inequities [25]. Others have cautioned against the danger of deferring to the right to travel for abortion, as this "harm reduction approach" creates an illusion that reforms of an unjust law are not necessary [26].

5. Conclusion

The present article discusses 3 recent cases from the European Court of Human Rights bearing on human rights related to abortion services and services critical for effective exercise of abortion rights. Why the different conclusions in the different cases? Why such a rights-embracing approach in the 2 Polish cases, and a failure to acknowledge some basic elements of women's rights in relation to women A and B in the Irish case? One answer is that, in Poland,

both prenatal genetic testing and abortion in cases of rape are legal, but not accessible, whereas abortion for reasons of health and wellbeing is clearly illegal in Ireland. Thus, in the Polish cases, the Court could rely on decisions that had been made by the Polish parliament—to allow reproductive health services, albeit in narrow circumstances—and did not have to address whether abortion as such, regardless of domestic legislation, is a human right. Assessing whether laws are complied with, legal certainty is guaranteed, and theoretical rights can be accessed in practice is much closer to the Court's traditional "comfort zone" than taking a stand on general issues related to women's health and dignity. Thus, in the case of *A, B, and C v. Ireland*, the Court shied away from the burning issue at stake and opted to hide behind reasoning about "profound moral views of the Irish people" and a (supposedly unlimited) right to travel.

These disconcerting aspects of the Court's judgment in *A, B, and C v. Ireland* remind us of the artificial nature of the Irish abortion ban. The existing exception to the ban—for the life, but not the health, of the pregnant woman—is fictional. In practice, it is often impossible to address threats to life and health as separate interests. In its 2012 Safe Abortion Guidelines, WHO confirms that "[s]aving a woman's life might be necessary at any point in the pregnancy and, when required, abortion should be undertaken as promptly as possible to minimize risks to a woman's health" [12] (p. 92) and that, in general, abortion policies should "promote and protect the health of women, as a state of complete physical, mental and social well-being" [12] (p. 98). Given the authoritative nature of WHO recommendations, and the willingness of the European Court of Human Rights to rely on medical standards in other cases, the Court might have been less reluctant to acknowledge the rights issues at stake if these WHO guidelines had been available when it ruled on *A, B, and C v. Ireland*.

What is certain is that, in the debate in Ireland on how to implement the *A, B, and C v. Ireland* judgment, the relevance of international medical standards such as the WHO Safe Abortion Guidelines cannot be overstated. Here, the medical community has a crucial role. Irish health professionals could insist on the importance of these standards, which clarify that life and health can hardly be distinguished in the abortion context, to the effect that international principles would gain recognition domestically and eventually enter into the legal domain. Indeed, medical professionals and societies around the world should push for recognition of progressive international medical guidelines in the field of reproductive health care, as a way to legitimate and normalize these standards in the domestic sphere. Once these standards have become part of the domestic legal order, human rights courts may follow suit. In this way, medical professionals can also contribute to the evolution of human rights norms related to abortion and, thereby, advance women's rights.

Conflict of interest

The Center for Reproductive Rights provided legal advice to the representatives of R.R. v. Poland.

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