Termination of pregnancy as emergency obstetric care: 
the interpretation of Catholic health policy and the 
consequences for pregnant women

An analysis of the death of Savita Halappanavar in Ireland and similar cases

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Abstract: Issues arising from the death of Savita Halappanavar in Ireland in October 2012 include the question of whether it is unethical to refuse to terminate a non-viable pregnancy when the woman’s life may be at risk. In Catholic maternity services, this decision intersects with health professionals’ interpretation of Catholic health policy on treatment of miscarriage as well as the law on abortion. This paper explores how these issues came together around Savita’s death and the consequences for pregnant women and maternity services worldwide. It discusses cases not only in Ireland but also the Americas. Many of the events presented are recent, and most of the sources are media and individual reports. However, there is a very worrying common thread across countries and continents. If further research unearths more cases like Savita’s, any Catholic health professionals and/or hospitals refusing to terminate a pregnancy as emergency obstetric care should be stripped of their right to provide maternity services. In some countries these are the main or only existing maternity services. Even so, governments should refuse to fund these services, and either replace them with non-religious services or require that non-religious staff are available at all times specifically to take charge of such cases to prevent unnecessary deaths. At issue is whether a woman’s life comes first or not at all. © 2013 Reproductive Health Matters

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“There is only one way to be sure a woman’s life is at risk, that is, after she dies.” (Christian Fiala, 2012)

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.

Contrast this with the death of Savita Halappanavar on 28 October 2012, a dentist from India from a privileged background, who miscarried at 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. Savita’s death was anything but anonymous; her name and photograph circled the globe within days of her death and sparked street demonstrations and protests, not only across Ireland but also in many other countries, including India. Six months on, an inquest into her death has just taken place, articles and blogs about her death continue to be published in many places, demands by her husband for justice are still headline news in Ireland, and the Irish government has been forced to consider the effects of her death for the law on termination of pregnancy, which has resulted in a draft bill being released as we go to press (1 May 2013).

Savita’s death became iconic for a number of reasons. First, preventing maternal deaths has become a global priority. Since 2000, reducing maternal deaths by 75% by 2014 has been the main target of Millennium Development Goal No.5, and since 2010 one of five main goals in the UN Secretary-General’s Global Strategy on Women’s and Children’s Health. Moreover, maternal deaths have increasingly become news items in the global media, who are reporting both successes and failures to reduce deaths, and individual women’s stories regularly.
Secondly, holding governments accountable for their failure to provide the required services to prevent maternal deaths, from antenatal and delivery care to emergency obstetric care, has become the subject of court cases, including in India; public protests by women’s rights advocates; and hearings by human rights bodies, particularly CEDAW, who examine individual cases and make policy recommendations to governments.²

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

In the light of the findings of the inquest in Savita’s death, the Irish Medical Organisation’s rejection of a motion to support legislation for abortion where there is a real and substantial risk to the life of the woman,³ and the Irish government drafting of proposals on permitting extremely limited legal abortion in Ireland, this paper explores how so many issues came together around Savita’s death, including clinical interpretation of Catholic health policy, and the consequences for pregnant women worldwide.

Protesting maternal deaths

The Millennium Development Goals have made countries with continuing high maternal mortality ratios⁴ increasingly 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 and not having been offered contraception, she became pregnant again six months later, went into labour prematurely at seven months, delivered the baby at home without skilled attendance or 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.⁴

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, in May 2011, where hundreds of concerned citizens and health professionals stormed the Constitutional Court in Kampala in support of a coalition of activists who took out a landmark lawsuit against the government over two women who died giving birth unattended in hospital.⁵

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. Yet, ironically, India’s ambassador to Ireland was among the first to criticise those in Ireland who failed to prevent Savita’s death.⁶

Termination of a non-viable pregnancy as emergency obstetric care

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 it is indeed preventable. This is the basis on which the UK Confidential Enquiries into Maternal Deaths have been conducted and reported for decades,⁶ a process that 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 or negligence. In

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¹The latest report was published as a supplement to the BJOG at: http://onlinelibrary.wiley.com/doi/10.1111/bjo.2011.118.issue-s1/issuetoc. For a history of these reports, see: What has happened to the UK Confidential Enquiry into Maternal Deaths? BMJ 2012;344:e414 at: www.bmj.com/content/344/bmj.e4147.

²India’s is 200 deaths per 100,000 live births compared to only 6 per 100,000 live births in Ireland in 2010.
my opinion, not only in Savita’s case but also in the others summarised below, which are similar, the question of whether there was indeed 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 treatment or way 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 and one reason given was that there was still a fetal heartbeat.*

But why if the fetus was non-viable?? What appears to be part of the answer arises from the statement by one of the nurses involved in Savita’s care, in reply to Savita asking why she could not have a termination, that “this is a Catholic country”. This also came out at the inquest, and was accepted by the coroner as a matter of law, that because it was apparently not recognised how at risk Savita’s life was, a termination would have been illegal and open to prosecution.1 However, what has come out in other cases where a termination was required to save the pregnant woman’s life was direct reference to professional or hospital-wide interpretation of what doctors and nurses believed to be Roman Catholic health policy, as regards treatment of miscarriage by Catholic health professionals.

“Termination of pregnancy” may become a necessary emergency obstetric response, even with a wanted pregnancy, and this is where the problem lies. Termination of pregnancy to save the 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. “To save the woman’s life” should be understood to mean to prevent a pregnancy from becoming life-threatening, not just when it is already life-threatening, by which time it may be too late. One would have thought that includes termination to complete an inevitable miscarriage, or end an unviable pregnancy, or when a woman has or develops a life-threatening illness while pregnant. Yet, there is nothing in writing that specifies what “termination of pregnancy to save a woman’s life” actually means, nor when it applies.

This is even more complicated in Ireland due to a 1983 Constitutional amendment, whose aim was to prevent termination of pregnancy ever becoming legal — or indeed ever being 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)8

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, a year after having breast cancer surgery 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 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.9

In 2007, a 17-year-old known as Miss D had anencephalic (non-viable) pregnancy and went to the Irish High Court to stop the Health Service Executive from preventing her from travelling outside the country to obtain an abortion. The High Court ruled that she had a right to travel.10 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

*Savita was also at high risk for a serious pelvic infection, due to her dilated cervix, and indeed developed sepsis, for which treatment was also delayed, which also contributed to her death.7 This is another reason why a timely termination was crucial, to prevent infection entering and taking hold. This paper is not about what caused her death, however, which the inquest revealed in great detail, but rather about why there was an unconscionable delay in one aspect of her treatment, i.e. termination of the pregnancy.
protect her health but argued that she should have had the right to an abortion in Ireland. The European 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 when abortion is lawful in Ireland had long been an issue by the time Savita died. Her death became the subject of enormous public protest against Ireland’s failure to act on the European Court’s directive, and especially on the part of those supporting women’s right to abortion. The failure to carry out an abortion as a life-saving emergency obstetric procedure was not a focus of those protests. Yet the two are intimately linked.

In January 2013, in evidence to the government committee considering what to do about the law in Ireland, three experts – Dr Jennifer Scheppe from the University of Limerick, Ciara Staunton from NUI Galway, and Dr Simon Mills of the Law Library – gave evidence to the committee 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 of Ireland, 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”. Did the doctors at Savita’s hospital not know about this ruling? It would have protected them if they had agreed to terminate her pregnancy in time. Or was there something else stopping them?

What is Roman Catholic policy on emergency termination of pregnancy in the case of risk to the woman’s life?

Ireland

Savita’s death led other women in Ireland, who had 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 had faced similar situations to Savita’s. All five had been 15–20 weeks pregnant when the incidents occurred from 1997 to 2004 in Irish hospitals. 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 stand 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].’”

A statement issued in November 2012 by the Standing Committee of the Irish Catholic Bishops’ Conference, presumably in response to Savita’s death, appears not to contradict the “equal right to life” interpretation of Irish law quoted 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 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 signal fails to acknowledge this, to women’s great detriment. While this text appears to support treating the woman to save her life, it is highly equivocal, precisely because it still insists on opposition to all abortions.

USA

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.”16 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.”16

On the basis of this statement, again, there would appear to have been no need to delay termination in Savita’s case because the fetus was not viable. However, a fetal heartbeat, indicating the fetus was still alive, may have made all the difference, as has happened in other cases – because it may have forced the medical professionals to worry whether the death of the fetus would be seen as “directly intended” or not.

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.”17

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.”18 Because, according to these authors, 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.”17

“…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.”17

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 the woman’s 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.”

Another case reported in 2010 involving a Catholic-run hospital in the US state of Arizona 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.’”

However, as a result 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”. The Bishop was also reported to have procured the removal of [a Sister] from the ethics committee of the hospital for approving the decision and declared that she had “automatically excommunicated” herself, saying: “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.”

Dominican Republic, Costa Rica and El Salvador

These interpretations appear to be operative in other Roman Catholic countries as well. The Dominican Republic is one of the five countries globally where abortion is not permitted 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. Both she and the baby died.

In December 2012, the International Campaign for Women’s Right to Safe Abortion published a solidarity request in support of a Costa Rican woman who was carrying a non-viable pregnancy with multiple, severe fetal malformations. For almost five months, the report said, she suffered from severe back and abdominal pain and was unable to work. The baby’s survival outside the womb would have been brief at most. Yet no one in the country could be found to 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 national women’s rights group, Ms 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 (E-mail communication, 4 January 2013).

In April 2013, Amnesty International publicised the case of “Beatriz”, a 22-year-old woman from El Salvador, another of the five countries where abortion is criminalised in all circumstances. Under Article No. 133 of their Penal Code, anyone who provides, or tries to access, abortion services can face lengthy prison sentences. Beatriz has a history of lupus, an autoimmune disease, kidney disease related to the lupus and other medical
conditions. Beatriz has a one-year-old son. She suffered serious complications during her previous pregnancy, and this time she has been diagnosed as at high risk of pregnancy-related death if the pregnancy continues. Three scans have confirmed that the fetus is anencephalic, i.e. highly likely to die before or soon after birth. Beatriz was four and a half months pregnant and had been requesting a termination for over a month without success when this request was publicised. Her doctors have not (yet) acted on her wishes; they feel unable to terminate her pregnancy without express assurance from the Salvadoran government that they will not be prosecuted for administering this life-saving treatment. As yet, there has been no response from the authorities to their request for permission to proceed.23

This silence must be understood in all of these cases as prioritising the life of the fetus over and above the life of the pregnant women, even though the fetus has no chance of survival. According to Catholics for Choice,24 Bishop Olmsted made an error of interpretation of Catholic health policy in the Arizona US case. However, on the evidence gathered for this paper, which is far from comprehensive and has mostly emerged through media reports since November 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 for women of termination of pregnancy, wanted or unwanted

Countries where abortion remains legally restricted and unsafe are almost always countries where maternal deaths in wanted pregnancies are also still high. In those countries in other words, 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, the interpretation of Catholic health policy that the woman must be sacrificed 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.25 Unfortunately, it is not possible to have it both ways.

Is this the norm in Catholic maternity services?

“… 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?”26

This is a question that must be asked not only in Ireland but also other countries. Savita had all those symptoms. The refusal to terminate the pregnancies described in this paper, killing some of the women and putting the lives of the others seriously at risk, 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 still has a heartbeat? Are these exceptions – or is this the norm across Catholic health services, and if so, in how many countries? The governments of Ireland and every other country with Catholic maternity services need to answer these questions urgently.

The ethical imperative to save pregnant women’s lives

The individual reports presented in this paper point to a very worrying common thread across three continents. They invite rigorous investigation of treatment provided and outcomes for women with inevitable miscarriage, severe fetal anomalies and other non-viable pregnancies, and pregnancies affected by serious illness that require a termination in Catholic-controlled maternity services.

If further research unearths more cases like Savita’s, any Catholic health professionals and/or hospitals refusing to terminate a pregnancy as emergency obstetric care should be stripped of their right to provide maternity services. Religious institutions contribute massively to the provision of health care in many countries. In Ireland, about 40% of all hospitals are owned and run by Catholic institutions27 and in the USA about 30%.17 In some countries, e.g. much of Latin America and sub-Saharan Africa, Catholic-run hospitals provide the main or only existing
maternity services. Even so, governments should refuse to fund these services, and either replace them with non-religious services or require that non-religious staff are available at all times specifically to take charge of such cases to prevent unnecessary deaths among pregnant women.\textsuperscript{28*}

\*The Obama government in the US has set a precedent for this in withdrawing a multi-million dollar contract from the US Conference of Catholic Bishops for refusing to provide contraception in a government-funded service to women who have been trafficked and who require a range of urgent treatments. This decision was upheld by a US federal court in 2012. \textsuperscript{28}

In all conscience, no government that takes maternal mortality seriously can support the withholding of emergency obstetric care when a pregnant woman’s life and health may be at risk. By definition, termination of pregnancy will end fetal life — whether pregnancy is wanted or unwanted. At issue is whether the woman’s life comes first or not at all.

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Résumé
Parmi les enjeux soulevés par la mort de Savita Halappanavar en Irlande en octobre 2012 figure la question de savoir s’il est contraire à l’éthique de refuser d’interrompre une grossesse non viable quand la vie de la femme est menacée. Dans les maternités catholiques, cette décision est liée à l’interprétation que font les professionnels de la santé de la politique de santé catholique sur le traitement des fausses couches ainsi que la loi sur l’avortement. L’article étudie comment ces questions sont apparues autour du décès de Savita et les conséquences pour les femmes enceintes et les services de maternité dans le monde. Il examine des cas en Irlande, mais aussi aux Amériques. Beaucoup d’événements présentés sont récents et la plupart des sources sont des reportages ou des récits individuels. Néanmoins, il existe un dénominateur commun très inquiétant entre pays et continents. Si de nouvelles recherches mettent à jour d’autres cas comme celui de Savita, les professionnels de la santé et/ou hôpitaux catholiques refusant d’interrompre une grossesse comme soin obstétrical d’urgence devrait être privés de leur droit d’offrir des services de maternité. Dans certains pays, ils représentent les principaux ou les seuls services de maternité. Malgré cela, les autorités devraient refuser de financer ces services et les remplacer par des services non religieux ou exiger que du personnel non religieux soit disponible à tout moment, spécifiquement pour prendre en charge ces cas et prévenir tout décès prématuré. La question est ici de savoir si la vie d’une femme passe ou non avant tout.

Resumen
Entre los temas examinados tras la muerte de Savita Halappanavar en Irlanda, en octubre de 2012, figura la interrogante si es poco ético negarse a interrumpir un embarazo no viable cuando la vida de la mujer podría correr peligro. En servicios de maternidad católicos, esta decisión cruza la interpretación de profesionales de la salud de la política católica en cuanto al tratamiento del aborto espontáneo, así como la ley referente al aborto. En este artículo se explora la interrelación de estos asuntos a raíz de la muerte de Savita y las consecuencias para las mujeres embarazadas y los servicios de maternidad mundialmente. Se analizan casos no solo en Irlanda sino también en las Américas. Muchos de los sucesos expuestos son recientes y la mayoría de las fuentes son medios de comunicación e informes individuales. Sin embargo, hay un hilo común muy preocupante entre países y continentes. Si en futuras investigaciones se descubren más casos como el de Savita, a todo profesional de la salud y/u hospital católico que rehuse interrumpir un embarazo como cuidados obstétricos de emergencia se le debe despojar de su derecho a ofrecer servicios de maternidad. En algunos países estos son los principales o únicos servicios de maternidad. Aun así, los gobiernos deberían rehusar financiar estos servicios y sustituirlos con servicios no religiosos o exigir que haya personal no religioso disponible en todo momento específicamente para encargarse de tales casos para evitar muertes innecesarias. La interrogante es si la vida de la mujer es o no lo primordial.