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R.J. Cook, B.M. Dickens, M.F. Fathalla,
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Responding to a Request for Pregnancy Termination

Case Study

Mrs R, aged 36, has two children aged 10 and 3, and suffers from chronic active hepatitis that has persuaded her and Mr R, on her physician's advice, not to have another child. Mrs R's physician, Dr T, has now found her to be two months pregnant, and Mrs R has requested Dr T to terminate the pregnancy. The local legislation states only that 'Any person who unlawfully procures a woman's miscarriage commits an offence punishable with up to 14 years' imprisonment'. Taking account of medical, ethical, legal, and human rights considerations, how should Dr T respond?

1. *Background*

Women's ability to obtain abortion services is affected by the prevailing law in a particular country and how it is interpreted and applied. It is an oversimplification to classify abortion as legal or illegal. Many countries, even those that criminalize the procedure, permit abortion in some circumstances. However, the exceptions legally allowed to criminal prohibitions are frequently unwritten or ambiguously worded, and not easily understood by health care providers and women seeking services. As a result of this ambiguity, health care providers are reluctant to provide those services, even though women might be legally entitled to them.

A global trend towards liberalization of abortion laws has continued in recent years. Since 1985, nineteen nations have significantly liberalized their abortion laws; only one country has substantially curtailed legal access to abortion.[1] Currently, 61 per cent of the world's people live in countries where induced abortion is permitted either for a wide range of reasons or without

[1] A. Rahman, L. Katzive and S. K. Henshaw, 'A Global Review of Laws on Induced Abortion, 1985–1997', *International Family Planning Perspectives*, 24 (1998), 56–64.

restriction as to reason; in contrast, 25 per cent reside in nations where abortion is generally prohibited. However, even in countries with highly restrictive laws, induced abortion is usually permitted when the woman's life is endangered. In contrast, access is often limited in countries with liberal laws, because of lack of availability of reasonably priced services, limitations on the types of facilities that perform induced abortions, and, for example, third-party authorization requirements.[2]

Determining the legal status of abortion in any given country is a complex but necessary task. Laws regarding abortion are often addressed in multiple statutes, codes, and regulations, and often court decisions, all of which apply simultaneously. Where abortion is criminalized, it is addressed in the criminal code, usually in language that is understandable only to lawyers, and not easily operationalized by health care providers.

Countries agreed to address the public health consequences of unsafe abortion at two United Nations Conferences, one held in Cairo in 1994 on Population and Development, and the other held in Beijing in 1995 on women, and were further considered at their subsequent five-year reviews. Governments agreed at the 1994 Cairo Conference

> to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions.[3]

A year later at the 1995 Beijing Conference, governments agreed to 'consider reviewing laws containing punitive measures against women who have undergone illegal abortions'.[4]

[2] R. J. Cook, B. M. Dickens, and L. E. Bliss, 'International Developments in Abortion Law from 1988 to 1998', *American Journal of Public Health*, 89 (1999), 579–86.

[3] UN, *Population and Development*, i. *Programme of Action Adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994* (New York: UN, Department for Economic and Social Information and Policy Analysis, ST/ESA/SER.A/149, 1994), para. 8.25.

[4] UN, Department of Public Information, *Platform for Action and Beijing Declaration: Fourth World Conference on Women, Beijing, China, 4–15 September 1995* (New York: UN, 1995) (hereinafter Beijing Platform), para. 106(*k*).

At the twenty-first special session of the United Nations General Assembly in July 1999, in order to further the implementation of the Cairo Programme of Action, governments agreed that in circumstances where abortion is not against the law 'such abortion should be safe'[5] and that 'health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible'.[6] In order to train health service providers and take measures to ensure that abortion is safe and accessible, health ministries will need to clarify the situations in which abortion is not against the law, through, for example, the development of regulations or treatment protocols.

2. *Medical Aspects*

Hepatitis means, literally, inflammation of the liver. This can have a multiplicity of causes but the most frequent hepatitis is due to viruses. There are a number of these viruses. The acute manifestations are more or less the same, but they differ in their propensity to lead to chronic hepatitis and liver cancer.

The significance of each virus is determined by two factors: the mode of transmission and the persistence of the infection. In public health terms, the viruses can be regarded as falling into two groups: (1) the viruses transmitted by the faecal-oral route, which cause acute hepatitis and no persistent infection; (2) the sexually and parenterally transmitted viruses, which lead to persistence and chronic liver disease. These two groups also have different geographical distributions. Hepatitis A and E are transmitted by a faecal-oral route and are common in developing countries with poor sanitary conditions. They can assume epidemic dimensions. Hepatitis B, C, and D are transmitted by the sexual route and parenteral routes, for instance by injection or blood transfusion. While Hepatitis B is quite rare in developed countries and most of Latin America, rates of infection are much higher in China and sub-Saharan Africa. Hepatitis B is particularly a problem for intravenous drug users. The Amazon basin is the area in which it represents the largest public health problem. Hepatitis C infection occurs in both developed and developing countries primarily in adult life.[7]

Pregnant women seem to be particularly vulnerable to hepatitis. Incidence rates as well as case fatality rates are higher than in non-pregnant women.

[5] UN, General Assembly, *Report of the Ad Hoc Committee of the Whole of the Twenty-First Special Session of the General Assembly: Overall Review and Appraisal of the Implementation of the Programme of Action of the International Conference on Population and Development*, A/S-21/5/Add.1 (New York: UN, 1999), para. 63(i).

[6] Ibid., para. 63(iii).

[7] A. J. Hall, 'Viral Hepatitis', in K. S. Lankinen, S. Bergstrom, P. H. Makela, and M. Peltomaa (eds.), *Health and Disease in Developing Countries* (London: Macmillan, 1994), 239–46.

Pregnant women are particularly susceptible to acute Hepatitis E infection. In some epidemics, the case fatality rate in pregnant women has been as high as 25 per cent.[8] The outcome of pregnancy in women with chronic active hepatitis is related to the extent of the disease. In some countries, viral hepatitis ranks among the most important causes of maternal death. There is no effective treatment for the pregnant woman with chronic active hepatitis. Cure can occur only after acute hepatitis, if it does not turn chronic. The woman with chronic active hepatitis runs the risk of deterioration of the liver function, which can lead ultimately to death.

Perinatal loss rates are usually high in pregnant women with poor liver function. Premature birth is common. Foetal infection *in utero* is rare, but the neonate may be exposed to the virus at delivery and the virus may be transmitted by breastfeeding. Babies born to mothers with the disease may be saved if immunization is available and undertaken. Hepatitis virus immunoglobulin should be given to a baby within twelve hours after birth, and the hepatitis virus vaccine should be given in three doses: after birth, at one to two months, and at six months.

3. *Ethical Aspects*

The ethical challenge is aggravated by uncertainty in the meaning of the law, which is expressed in ambiguous yet commonly used language. Mrs R's life may not necessarily be endangered by continuation of her pregnancy, but it is likely that her health would be, including her ability to care for her growing children. Her interests and theirs would be served by pregnancy termination, which for her health should preferably be undertaken as soon as possible and preferably within the first trimester.

An obvious ethical issue in abortion concerns the moral status of the embryo/foetus. This is often a contentious issue. Some think that the ethical principle to do no harm requires that the interest of the embryo should prevail over the interest of the woman. Others think that the ethical principle of respect for persons requires that there is consideration and regard for women's autonomous choices. That is, respect for persons requires that we treat women not as instruments of governmental birth control policies, whether pro- or anti-natalist, but as their own moral agents. Moreover, the ethical principle of beneficence might well favour the woman taking critical decisions on behalf of her family and dependent children.

The ethical principle of justice would require an exploration of why women are being treated differently from men by the law with respect to their health

[8] A. J. Hall, 'Viral Hepatitis', in K. S. Lankinen, S. Bergstrom, P. H. Makela, and M. Peltomaa (eds.), *Health and Disease in Developing Countries* (London: Macmillan, 1994).

needs, the health system, and the larger society. Men can serve their health needs, regarding treatment for hepatitis and other health conditions, without fear of committing a criminal offence. Further, justice would require consideration of whether compelling women, such as Mrs R, to serve their unborn against their will is discriminatory on grounds of sex, reflecting a disrespectful attitude towards women. Neither women nor their husbands can be legally compelled to afford their born children necessary blood or, for instance, bone marrow transfusions or other resources available from their bodies.[9] Justice might also require accommodating the plurality of views on this issue by ensuring that the law respects those who conscientiously object to the procedure by not requiring their involvement, but also allows for the provision of services for those who have conscientiously decided that they need such services.

There are also microethical and macroethical perspectives that need exploration. Interests in prenatal life might best be respected in ways that are consistent with the interests of the woman. That is, a microethical approach is to look at the woman and her foetus as an interdependent unit, and not in adversarial terms where the interests of the woman are pitted against the interests of the foetus.[10] From a macro perspective, the ethical principle of beneficence requires an examination of what else needs to be done to ensure healthy pregnancies and childbirth for women whose pregnancies are wanted. This principle requires, for example, ensuring the provision of appropriate preventive care for women who might be at risk of hepatitis, such as hepatitis B vaccination, or appropriate treatment for excessive drug use to reduce the risk of contracting hepatitis. The American College of Obstetricians and Gynecologists (ACOG) has recommended universal vaccination against hepatitis B for all adolescents, to be given at age 11–12, with immunization for older adolescents based on risk status. ACOG notes that hepatitis B is the only sexually transmitted disease for which effective vaccination is now available.[11]

The ethical principle of respect for persons requires respect for Mrs R's religious convictions. In this case, her request for abortion indicates how she has resolved her responsibilities to her existing children, her family, her religious conscience, and to herself. Accordingly, if the doctor has no conscientious objections, there may be few ethical barriers to complying with the woman's request. If the doctor has conscientious objections, then the ethical duty would be for Dr T to refer her directly to an appropriate facility willing to end her pregnancy on health grounds.

[9] J. J. Thompson, 'A Defense of Abortion', *Philosophy and Public Affairs*, 1 (1971), 47–66.

[10] P. King, 'Helping Women Helping Children: Drug Policy and Future Generations', *Milbank Quarterly*, 69 (1991), 595–621.

[11] American College of Obstetricians and Gynecologists, *Hepatitis B Immunization for Adolescents. Committee Opinion Number 184, June 1997* (Washington, DC: ACOG, 1993); repr. in *Int. J. Gynecol. Obstet.* 58 (1997), 341.

The procedures the clinic has conducted, however, have been to preserve women's lives endangered by pregnancy. Many clinics do not characterize life-saving procedures that terminate pregnancies as constituting abortions. Under the concept of 'double effect', pursuit of a legitimate goal is not prohibited when a relatively minor result not permissible in itself is unavoidable. For instance, hospitals that decline to perform abortions as such will remove ectopic pregnancies or treat pregnant women with cervical cancer in order to save their lives. Treating a pregnant woman with cervical cancer may be incompatible with the continuation of pregnancy since removal of the uterus and radiation both require ending foetal life.

4. *Legal Aspects*

Critical to legality is the meaning of the language in the local legislation. This makes a person punishable who 'unlawfully' procures miscarriage. Widely followed court judgments have interpreted this language to show that there are circumstances in which the procedure may be undertaken lawfully. It is widely accepted that abortion is lawful when undertaken to save a pregnant woman's life. A leading judgment has further explained that saving 'life' includes not simply the fact of life, but also the quality of life, meaning physical and mental health, when pregnancy would cause it to be seriously and enduringly impaired.[12] Accordingly, courts interpreting this legislation may consider abortion lawful when undertaken to preserve a woman's health from prolonged, serious impairment.

A governing principle of criminal law is that, when the meaning or scope of the law is uncertain, it is to be interpreted in favour of a defendant. If the assessment of the woman's health condition and prognosis is made in good faith, confirmed perhaps by a concurrent second opinion, and acted upon non-secretively, the latitude of the law should protect the woman's request and the doctor's compliance. This might be equally so even if the word 'unlawfully' was not explicit in the legislation, because a court would be likely to find it implicit. Courts occasionally read legislation restrictively so as to minimize protections it affords criminal suspects, but are disinclined to do so when there is liability to heavy punishment.

Many court systems decline to give rulings on hypothetical facts, but require an actual dispute, so that it may not be possible to find in advance whether abortion governed by law of uncertain effect would be lawful in the circumstances of a certain case. It may be possible to initiate a dispute by seeking

[12] *R. v. Bourne*, [1939] 1 KB 687 (Central Criminal Court, London, England).

a judicial declaration, in an action against a government officer such as a Minister of Justice, or of Health, that the procedure requested would be lawful. However, it may be impossible to obtain such a ruling to accommodate Mrs R's request within the first trimester of her pregnancy. Prevailing uncertainty of the law's meaning therefore presents the doctor with the dilemma of either refusing a woman's legitimate request, and thereby risking her health, or complying with it and risking prosecution and conviction. That is, the doctor's legal, and ethical, choice is between serving this patient's needs or the physician's interests in remaining available for serving future patients.

5. *Human Rights Aspects*

National courts and international human rights tribunals considering women's claims to safe abortion have increasingly applied certain human rights provisions. International tribunals draw on an expanding body of decisions based on international human rights conventions, and national courts also draw on these, often to reinforce provisions in their own national laws, including constitutional laws. In addition, agencies that monitor international human rights conventions have become increasingly critical of countries whose restrictive laws, and restrictive enforcement of laws that could be interpreted more generously to women's interests, result in women's deaths and injuries to health resulting from unsafe pregnancies or abortions. The common theme in these human rights applications is that women's decisions to terminate unplanned and otherwise inappropriate pregnancies are not to be regarded as criminal defiance of laws, but as conscientious decisions made in the best interests of their own lives and health, and those of their families, that women should be allowed to make.

The human rights involved include women's rights to life not only against the significant threat of maternal mortality, but against conscientious resort to unskilled means of reproductive self-determination, and related rights to security and liberty of their persons. Depending on the level of state repression of women's choice, rights to be free from inhuman and degrading treatment may be involved, and even without repression, women's rights to private life and family life are necessarily implicated. Further, since men are free to have recourse to medical means to advance important interests in their lives, but women are denied this right to terminate inappropriate pregnancies, rights to sexual non-discrimination in access to health care are implicated. The human rights movement has been inspired by recognition that individuals should be free to make critical decisions in their lives by their own choice, and are not involuntarily at the disposal of governmental or religious policies or purposes. Nevertheless, human rights outrages are amplified when state laws and

governments deny women safe abortion services when they are victims of rape and comparable sexual abuse.

As against the trend in favour of women's rights to free choice of maternity are constitutional court decisions and amendments to national constitutions that protect life from the moment of conception. These provisions are rarely written in absolute terms, since the same constitutions also claim to protect the lives, health, and dignity of all persons, including women. As a result, it is not clear whether these provisions prevail over women's rights to life, security, and liberty of the person, rights to private and family life, and to sexual non-discrimination in access to health services. It is also not clear whether provisions on respect for prenatal interests are intended only to prohibit abortions or would be applied consistently with women's rights to give birth to wanted children by requiring governments to provide more adequate prenatal services or emergency obstetric care to ensure safe delivery. Some governments invoking constitutional provisions to deny lawful abortion fail to provide women with prenatal care that evidences the entitlement to protection that governments claim to attribute to foetal life.

Human rights treaty bodies are increasingly concerned with high rates of preventable maternal death, and are characterizing governmental failures to address pregnancy related death as violations of women's rights to life.[13] Such bodies are additionally critical of national laws that are interpreted and applied to deny lawful abortion in cases of rape and sexual violence, finding that they amount to inhuman and degrading treatment of women.[14] The term 'forced pregnancy' has emerged as a way of describing how women view the denial of abortion services, equating such denial to the outrage of rape. Forced pregnancy was condemned by governments at the Beijing Fourth World Conference on Women as a violation of women's rights.[15] The Committee on the Elimination of Discrimination against Women (CEDAW) has issued a General Recommendation on Women and Health that addresses the discriminatory dimensions of denial of abortion by observing that: 'It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women' (see Pt. III, Ch. 6, Sect. 2, para. 11) and that the obligation to respect women's right to health requires that States

[13] UN, Report of the Committee on the Elimination of Discrimination against Women, 16th Session, Concluding Observations on the Report of Morocco (New York: UN, 1997), paras. 68 and 78, Doc A/52/38/Rev 0.1. Available at http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/17345aada861de818025649d00322a05?Opendocument, last accessed 2 May 2002.

[14] UN, *High Commission for Human Rights, Concluding Observations on the Report of Peru* (New York: UN, 1995), paras. 15 and 22, CCPR/C/79/Add 0.72, available at http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/6f1b83cb65d8071cc12563f400376673?Opendocument, last accessed 2 May 2002.

[15] UN, Department of Public Information, *Platform for Action and Beijing Declaration. Fourth World Conference on Women, Beijing, China, 4–15 September 1995* (New York: UN, 1995), paras. 114, 132, 135.

parties remove barriers to women's access to appropriate health care, which include laws that criminalize medical procedures only needed by women (see Pt. III, Ch. 6, Sect. 2, para. 14).

6. *Approaches*

6.1. *Clinical duty*

If Dr T determines that termination of pregnancy is in the patient's best health interests, and the best interests of her family, the law presents the challenge to conscience and courage of deciding whether to undertake the procedure. If Dr T conscientiously finds that continuation of pregnancy would endanger the patient's life, termination of her pregnancy would be non-contentious. However, if it is determined that the patient would most probably survive pregnancy but suffer seriously diminished health, Dr T must consider whether compliance with the law requires her to bear that consequence.

Codes of professional ethics usually provide that a conscientious physician will put the interests of a patient above those of the attending physician. However, other patients in addition to Mrs R may depend on Dr T's availability for their care. Dr T may legitimately consider that their interests also weigh in the balance, and would be prejudiced by Dr T's involvement in legal proceedings and imprisonment. Accordingly, the clinical response to Mrs R's request could be governed by non-clinical considerations unrelated to her care, including Dr T's confidence in legal advice on how broadly the local legislation is interpreted.

If Dr T decides to proceed with the termination of pregnancy, clinical guidelines on care of women requesting abortion might be useful in determining pre-abortion management and which procedures are appropriate for a woman in Mrs R's circumstances.[16] If no clinical guidelines exist in Dr T's country, Dr T might want to work with his or her professional colleagues on steps to develop them.

6.2. *Health care systems obligations*

Dr T may legitimately protest that uncertainty in the law should not distort professional capacity to exercise conscientious medical judgement in patients' health interests. Dr T might collaborate with professional, governmental, and

[16] See e.g. Royal College of Obstetrics and Gynaecologists (RCOG), *The Care of Women Requesting Induced Abortion: Evidence-Based Guideline No. 7* (London: RCOG, 2000). Available at http://www.rcog.org.uk/guidelines.asp?PageID=108&GuidelineID=31, last accessed 6 May 2002. National Abortion Federation, *Clinical Policy Guidelines* (Washington, DC: National Abortion Federation, 2002). Available at http://www.guidelines.gov, last accessed 7 Aug. 2002.

non-governmental agencies to provide technical and policy guidance for health systems.[17]

Clarification of the law might be needed to ensure that health care professionals can readily respond to the needs of patients, such as Mrs R, in accordance with the ethics of medical and related care. Dr T should face no conflict between serving the needs of one patient, such as Mrs R, and remaining at liberty to serve the interests of other patients. Similarly, Dr T should be free to render conscientious services to all patients without distraction by fear of legal proceedings or detention.

Through collective professional action, Dr T might join with colleagues to seek clarification of the law so as to enable health care providers to serve the health care needs of their community. A collective request may be made, perhaps through a general or specialized medical body, to the government's Minister of Justice, Attorney-General, or for instance Minister of Health, for clarification of the scope of the law. If the need for greater clarity remains unsatisfied, the medical body itself may set a protocol governing conditions in which abortion will be undertaken, and ask for a response from the government's chief legal officer.

If there is no adequate response within a predetermined time, the medical body, or an individual physician such as Dr T, may seek to initiate judicial proceedings against the government. These proceedings might seek a declaration that the legislation allows termination of pregnancy for preservation of women's lives, or of their health when medically considered to be in danger. Alternatively, a declaration might be sought that the legislation is void for vagueness, thus infringing upon the doctor's duty to provide necessary health services. They might also seek a declaration that the legislation violates women's human rights, including their right to life, their right to security and liberty of their person, their right to be free from inhuman and degrading treatment, and their right to sexual non-discrimination in access to health care.

6.3. *Social action for underlying conditions*

Abortion laws have historically been expressed only in prohibitive terms because they were designed against a background of unskilled and harmful practice, and were often reinforced by a religiously inspired moral agenda. Politicians, courts of law, social leaders, journalists, and others can be given case studies, perhaps modelled on the circumstances of Mrs R related anonymously, to demonstrate the need for clarification of laws in order to ensure access to services to which women are legally entitled.

There is a need for doctors, perhaps through their societies of obstetricians/gynaecologists, to enter into a constructive dialogue with the legal profession

[17] WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems* (Geneva: WHO, 2002).

and other groups, including women's health advocates, to clarify the circumstances when abortion may not be against the law. This might include outlining the kinds of conditions that put a pregnant woman's life in danger or would damage her health. The indications for therapeutic abortion constitute a long list in textbooks of obstetrics and gynaecology and include certain diseases of almost all body systems, which may be aggravated by the pregnant condition and put the health or life of the pregnant woman at risk. They also include certain congenital anomalies of the foetus. Such conditions might vary in prevalence from country to country, and some may need to be clarified in a dialogue between the medical and legal professions. Some societies, for example, have been able to reach agreements with governments to clarify the fact that the life-saving indication for abortion would permit providing abortions to women with HIV/AIDS.

The World Health Organization/International Federation of Gynecology and Obstetrics (WHO/FIGO) Task Force, in collaboration with Centro de Pesquisas das Doencas Materno-Infantis de Campinas/Universidade Estadual de Campinas, convened a workshop in Campinas, São Paulo, Brazil, on the topic of 'Abortion—a Professional Responsibility for Obstetricians and Gynecologists'. The workshop highlighted that, although laws may differ, medical communities and societies in general in countries share a common handicap: lack of knowledge of the legislation. As a consequence, laws are not being applied to the extent they could be to benefit the health of women. The workshop recommended that societies of gynaecology and obstetrics

> inform professionals on the legal status of abortion in the country, the procedures to be followed for a legal abortion, the interpretation of the laws being applied, and also on appropriate international legislation, and the impact of these legal contexts on maternal morbidity and mortality;
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> establish norms for performing abortions permitted by law, so that health care providers feel supported and authorized to carry out the procedure within the law. These norms should be the result of informed discussions of multidisciplinary teams including lawyers;
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> stimulate the establishment of legal abortion care services in university hospitals and other centers of excellence, as many of them have adequate technical-professional capacity and are responsible for training the new generation of health professionals; [and]
>
> lead in the implementation of legal abortion care services in each hospital, and stimulate a wide discussion, including all the professionals who will be directly or indirectly involved in the legal abortion care process. Social scientists and representatives of women's groups should also participate in this process to present the user's point of view.[18]

[18] WHO/FIGO Task Force, *Abortion—A Professional Responsibility for Obstetricians and Gynecologists. Report of the WHO/FIGO Task Force, Campinas (Brazil) Workshop, 2–5 March 1997* (London: FIGO, 1997).