Feature Article

Abortion on Demand

Pointers from the American Freedom of Choice Act

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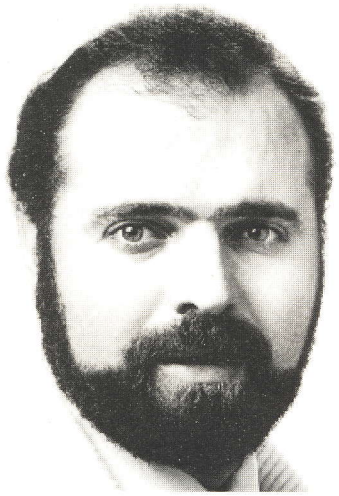

Curriculum vitae

Dr Angelo Grazioli graduated MBChB (UCT) in 1979 and B Theology (Hons), Summa Cum Laude (UWC) in 1990. He is a registered member of the; South African Medical and Dental Council, 1979; South African Academy of Family Practice/Primary Care, 1979; British Medical Association, 1980; American Association Sex Educators Counsellors and Therapists, 1983; Society for the Scientific Study of Sex (USA), 1983; A Family Practitioner from 1983 - 1988, he then founded the Sex Education and Dysfunction Unit of South Africa, and is currently providing professional sexological counselling at the rate of 25 to 35 hours per week. Widely published and a sought after public speaker, he currently accepts in excess of 100 engagements per annum addressing professional, paraprofessional and public bodies. Dr Grazioli conducts the graduate course in human sexuality for Masters Clinical Psychologists at the University of Stellenbosch. He is Southern Africa's Consulting Editor for the international circulation UK based journal "Carer and Counsellor".

Summary

We can expect new laws in the new South Africa. Abortion on Demand is one. It is a world-wide phenomenon and we should learn form the experiences of other countries where abortion on demand has been legalised. The situation in America (their Freedom of Choice Act) is described and analysed here to help South African doctors understand the practical implications for them and to help them respond wisely when it comes.

Introduction

In a 1986 letter to Arkansas Right to Life, then Governor Bill Clinton wrote: 'I am opposed to abortion and to government funding of abortions .... I do support the concept of the proposed Arkansas Constitutional Amendment 65 and agree with its stated purpose.' (That no public funds would be used to pay for any abortion, except to save the mother's life.)

In a dramatic about-face a few years later Clinton is thought to have won many votes in his presidential electoral campaign by promising to have all abortion restricting laws repealed.

To the great surprise of some the proposed laws facilitating abortion on demand have met with major opposition, not only from anti-abortion campaigners, but also from pro-abortion activists and abortion providers themselves.

FOCA tabled

In March 1993, the US Senate Labour and Human Resources Committee approved the so-called 'Freedom of Choice Act' (FOCA) (S.25), a proposed federal status that would allegedly 'facilitate abortion on demand' and 'codify the Supreme Court's Roe vs Wade ruling'.

But, as will be detailed later, the FOCA's impact would be much wider than that. Specific limitations to the provision of abortions were embodied in the Roe vs Wade ruling of 1973 and affirmed by the Supreme Court as late as in the 1992 Casey ruling. The FOCA proposed to do away with all these limitations.

GAG Rule

Recognising the controversial and far reaching implications of such legislation, House Speaker Tom Foley said that he would only bring the proposed FOCA to the House floor under a 'closed rule' procedure, which would prohibit consideration of amendments to it.

This proposed 'gag rule' sparked widespread opposition even amongst legislators and editorial boards that supported Roe vs Wade.

Virtually all agreed, that on issues of this magnitude, it is especially important that whatever law is enacted be the legitimate product of a truly democratic process.

Vocal pro-abortionists and abortion providers opposed both

(a) any federal statute that would dismiss the state regulatory authority recognised from Roe vs Wade to Casey, and

(b) any House consideration of a national abortion law under a 'gag rule' which would not permit amendments to be considered.

Statutory vs Constitutional Law

Consequently, in May 1993, the House Judiciary Committee approved a slightly different version of the FOCA bill (HR.25), but strong opposition from both pro-and anti-abortion campaigners, as well as many abortion providers, has not abated because to equate the FOCA with Roe vs Wade is to confuse statutory apples with constitutional oranges.

Sanctity of life is an outdated, naïve and impractical concept

The FOCA would create an entirely new statutory 'right to abortion' limiting laws that were explicitly tabled in Roe vs Wade and upheld by the US Supreme Court between 1973 and 1992.

If FOCA were accepted as statute, then any state's constitutional law or policy restricting access to abortion would have to be struck down by the Supreme Court for being in contravention of that stature.

A new wave of litigation would be launched in the US by FOCA with lawsuits being based on the statute not on Roe vs Wade.

There would be only 2 ways for states opposed to FOCA to bypass the new statute:

1) the state would have to prove that it's proposed law is 'medically necessary' to protect the health of women. In other words: it would then no longer be the task of the woman to show reason why she should have an abortion. The onus would be on the state itself to prove to the Supreme Court, beyond doubt, that it is unhealthy for the woman concerned to have an abortion in the face of the statutory total freedom granted her by FOCA to demand one.

Often the legal burden falls on the doctor to obtain consent

2) the state would have to invoke an explicit exception to the 'no one may restrict access to abortion'

rule in the text of FOCA. While the original S.25 version of FOCA does contain one such exception in the form of the statement that the bill does not 'prevent a State from declining to pay for the performance of abortions", the revised HR.25 version of FOCA has dropped that exception. In HR.25 the statute's 'may not restrict' rule is an all encompassing absolute, which gives no escape clause for states which do not wish to use tax and rate-payer's money to fund all and any abortions on demand.

What are the implications of these legal developments in the USA for the South African public?

What do we need to consider as we attempt to establish a Bill of Human Rights?

Should we:
(a) also push for a statute to entrench the right to abortion on demand or
(b) settle for the constitutional freedoms of the type granted by Roe vs Wade, or
(c) identify the pertinent questions which arise.

Personal Remarks

I have my own views about abortion, which are based on my own chosen value system and experiences. I have not been shy to air my views on television, radio and printed media.

My goal in presenting this article is not to highlight any particular perspective or to justify any particular conclusions. My goal is to document the reaction to the FOCA, thereby tabling the controversies and dilemmas presently exercising countries which are attempting to enact legislation facilitating abortion on demand. In so doing I hope to stimulate serious and focused local debate, particularly in legal, political and medical circles. I do not for a moment expect to escape the usual kneejerk suspicion of my motives, personal vilification and misinterpretation of what I write, which will inevitably follow from both the extreme pro- and anti-campaigners. I do sincerely hope fair-minded, influential, courageous and compassionate individuals will find these gleanings from human rights agencies, professional and popular literature, and pro- and anti-abortion lobbies useful in their consideration and response to the ANC's proposed revision of existing South African law.

Unlimited abortions for sex preference ...

Pro-Abortion Apologetics

Pro-abortion activists offer ultimate justification for their stance under one of three axiomatic beliefs:

a) 'Abortion is not a problem because it is not destroying human life'. Some maintain the foetus is to be regarded as fully human only when capable of life independent of mother, while others would consider the foetus human only after spontaneous labour and birth.

b) 'Abortion is not a problem because taking a life is not a problem'. Some maintain that the concept of sanctity of life as enshrined in ethical codes such as the Medical Association of South Africa's credo, is an outdated, naive and impractical concept.

Abortion is merely the end symptom. It never solves the problem

c) "Abortion may or may not be the taking of human life, but is not a problem because under certain circumstances it is right to do so'. Some maintain that the lack of resources, circumstances, freedom of choice and/or expediency make abortion the lesser evil faced by hard pressed individuals and/or society.

Because no human being is ultimately capable of survival apart from competent care until several years of age, and because of the obvious

ethical, social and legal implications of abandoning an overriding defense of the sanctity of life, the first two axioms seem to enjoy relatively little support worldwide.

The third axiom, whilst the most commonly held one, is nevertheless fraught with assumptions and implications which regularly spawn heated debate.

As declared, it is not the purpose of this article to enter into such debate. Suffice it for now to note these three axiomatic viewpoints.

1. The Third Trimester

The first problem highlighted by the FOCA has to do with abortion in the third term of pregnancy.

The FOCA allows abortions for any reason whatsoever through the second and third trimester of pregnancy to 'preserve a woman's health including physical, emotional psychological or familial'. The psychological and familial clauses are obviously broad catch-all provisions.

Concern and opposition has been raised by some doctors and nursing staff expected to be instrumental either in the deliberate quest for life or the deliberate quest for death of pre-born individuals of the same gestational age, depending on whether labelled 'for abortion' or 'for pre-term care'.

Viability as ground for abortion is widely recognised as a purely legal means to escape culpability.

Expediency overrules, in the eyes of some, the reality that viability of preterm infants is largely dependent on the quality of medical care and technology available. The less sophisticated the facilities available the higher the gestational viability. Not much one can do about that in the case of pre-term birth.

Not so easily sidestepped, however, the issue of volitional and premeditated action versus natural event or act of God. Any pre-birth human is perfectly viable in its intrauterine environment and, in the absence of disease, likely to proceed to full development and natural birth if not forcibly removed from that environment (eg into an atmospheric one). Any post-birth human is similarly perfectly viable in its atmospheric environment and likely to proceed, in the absence of disease, to full development and natural death if not forcibly removed from that environment (eg into a liquid one). To forcibly and deliberately remove either the pre- or post-birth human from his or her natural age appropriate environment and then disown responsibility for his or her death on the grounds that he or she is not viable in the new environment is legally condemned as homicide in the post-birth case, but condoned as abortion in the pre-birth case. Dismemberment, burning or other deliberately inflicted injury associated with such forceful lethal environmental change would severely aggravate the legal culpability of the one responsible in the post-birth case but is again legally ignored in the pre-birth case. The only escape from this legal inconsistency is to invoke either the 'it is not human' or the 'life is not sacrosanct' anxioms. But then one faces the impossible task of logically and incontrovertibly proving that it is not human, or that life should indeed cease to be regarded as sacrosanct.

'I'm a pragmatist, not a philosopher' has been the escape clause for those expediently favouring abortion but wishing to escape the task of justifying it.
However, many who manage to thus escape personal responsibility when aborting in the first two trimesters of life, find it impossible to do so in the case of a healthy third trimester pregnancy. Reality is that if lethal dismemberment, burning, decompression or other injury is not inflicted in the process of forcefully removing the third term human from the natural age appropriate environment, then that human can survive given appropriate and readily available care. While many refuse to term such an event abortion, and prefer to call it 'third trimester induction of labour", it is impossible to escape the fact that whether such induction will result in a live or dead infant will depend on whether someone is willing to provide the basic suction, umbilical cord care, warmth, feeding etc necessary for survival.

In the face of a discipline at fetology so advanced as to be able to provide life support for pre-term infants, not to speak of intrauterine diagnostics or even intrauterine corrective surgery, many abortion clinics refuse to provide third trimester abortions, and personnel worldwide, willing to provide first and second trimester abortions, have refused to do so in the third trimester.

Controversies and dilemmas in the countries where abortion on demand is legal

The questions arising are:

- If abortion is to be provided on demand, up to what gestational age is dismemberment, burning, cranial decompression or infliction of other lethal injury legally acceptable? Why?
- And if abortion on demand is to be provided, is the third trimester to be excluded? Why?
- Should there be any exceptions to the first two questions above, placing the pre-born human outside all and any constitutional protection?

2. Parental Consent

The second problem highlighted by FOCA has to do with parental notification or consent laws.

Under the amended FOCA, a state must give every pregnant minor the

option of consulting with any 'responsible adult' of her choosing, rather than a parent or a judge.

Concern and opposition has been raised by several parent bodies and by the legal profession.

Parents object because 'responsible adult' can mean an older boyfriend, an abortion clinic staff person, or any other adult, even the abortionist him/herself.

In the Netherlands and other nordic countries, the abortion clinic buses which 'do the rounds' of towns and villages transporting candidates for abortion have frequently been the focus of media attention. The prospect of such facilities being available to minors without parental consent has elicited the deep concern of the 32 USA states which presently enforce such requirements.

Legal professionals object because the Supreme Court presently enacts an expeditious judicial bypass for all parental consent laws in cases worthy of such bypass.

The proposed FOCA 'other responsible adult' clause renders the Supreme Court's judicial bypass meaningless, since few minors will approach a court when they have the expeditious option of consulting any non-legal adult of their choice.

Moreover, most current laws place the legal burden on the doctor to notify or obtain consent. Such a requirement can be enforced by license penalties, civil remedies, and/or criminal penalties. All such provisions would be invalidated by the FOCA, which effectively places the burden for obtaining consent only on the minor concerned.

The questions arising are:

- Does a minor's right to abortion on demand supercede the parental right to protect and nurture?

- Does the minor's right to abortion on demand supercede the independent judicialy's right to protect and nurture when parents are incapable/unwilling to do so?

- Should the ultimate legal burden of obtaining consent be shifted *de facto* from doctors to pregnant minors?

3. Waiting Period

The third problem highlighted by FOCA has to do with 'right-to-know' laws and waiting periods.

In the 1992 Casey decision, the Supreme Court upheld the law requiring a 24 hour waiting period prior to an abortion, as well as the 'right-to-know' or 'informed consent' law. The FOCA would invalidate both these laws in all states.

Concern and opposition has been raised by some feminists, civil rights bodies, and mental health professionals.

Pro-abortion polemicists sometimes refer to this law as requiring that women 'listen to a state-sponsored anti-abortion lecture', or words to that effect. This is inaccurate.

The Pennsylvania law, for example, requires only that the doctor inform the woman, in his own words, of 'the risks of abortion, the medical risks of carrying the child to term, and the probable gestational age of the unborn child'. The woman must also be offered, although not necessarily by the doctor, printed material prepared by the state health department containing 'objective, non-judgemental ... accurate scientific information' about fetal development, and information on agencies and public assistance programmes that would help the woman carry her child to term.

Feminists and civil rights bodies have objected to HR.25's effective invalidation of fully informed consent requirements.

Mental health professionals have objected because it is universal experience that most women presenting themselves for abortion have already made up their mind to proceed, but many have done so out of ignorance of implications, risks, alternatives and of support available, in the absence of informed, non-judgemental and empathetic professional support.

The questions arising are:

- Does the right to abortion on demand imply the right to refuse to consider all aspects of the decision as well as possible alternatives available?
- Who would compile the pertinent information, and who should present it?
- Exactly what should the minimum information package include?

Is abortion on demand true empowerment of women?

4. Reasons for Abortion

The fourth problem highlighted by the FOCA has to do with the reasons which can be offered to demand an abortion.

The FOCA allows for physical, emotional, psychological or familial reasons to be proferred.

Concern and opposition have been raised by some family planning agencies and sociologists.

The family planners see their primary task usurped by a law which would allow women unlimited abortions in the face of readily available contraception, as well as allow for abortions to be performed for sex selection purposes as is common practice in several Eastern countries.

Sociologists point out that any

abortion is merely dealing with the end symptom of several underlying problems, and does absolutely nothing towards solving those root problems.

It was not abortion on demand that dramatically dropped the birthrate in several selected provinces of India these past few years. It was a well documented four pronged aggressive and imaginative programme of education, social upliftment and redistribution of national resources, consisting of:

1. Commitment to read and write (with female literacy number one priority).
2. Improved health care (when fewer children die, families are smaller).
3. Subsidised feeding schemes.
4. Land ownership and economic growth through private enterprise.

Back home, through a similar approach, Minister Chris April succeeded in reducing the birth rate in the George coloured community from 46% to 15% in 5 years.

The questions arising are:

- Should women be allowed to undergo multiple abortions? If so, how many?
- Should sex selection abortions be allowed?
- Should abortion on demand be considered in the absence of programme designed to truly empower women and reduce the birth rate?

5. Public Hospitals

The fifth problem highlighted by the FOCA has to do with the obligation it places on public hospitals to provide abortions.

Both HR.25 and S.25 currently permit, not require, states to protect 'private agents' from being sued if they refuse to provide abortions. The word

'private' is not defined. However, both bills clearly would require that all public hospitals provide abortions, obviously at tax and ratepayers expense.

Concern and opposition have been raised by some public hospital administrative boards and local authorities.

The Supreme Court dealt with this issue under Roe vs Wade. The city of St Louis adopted a policy of no abortions in its two city hospitals except in cases of risk of grave physiological injury or death. In its 1977 ruling in Poelker vs Doe, the Supreme court subsequently ruled that 'We find no constitutional violation by the city of St Louis in electing, as a policy of choice, to provide publicly financed hospital services for childbirth without providing corresponding services for non-therapeutic abortions'.

An amendment to the FOCA to allow states to maintain such freedom of choice was defeated in the House Judiciary Committee on the 19th May 1993. Another amendment was accepted in spite of its proposer, FOCA sponsor Rep Barney Frank, candidly admitting to it being purely cosmetic and ultimately ineffective since the operative language of FOCA 'in its own explicit terms overturns any restrictions on access to abortion, including those upheld by the Supreme Court during the 1973-1988 period'.

While administrators in large city and liberal town environments are not unduly affected, their counterparts in less liberal environments see this aspect of the FOCA as an infringement of their own freedom of choice and that of their tax and ratepayers.

This must be viewed in the context of the February 1992 report in Contemporary Sexuality (newsletter of the American Association of Sex Educators, Counsellors and Therapists) of the NARAL (National Abortion Rights Action League) survey of the 50 USA states which found 32 states 'highly to very highly likely to eliminate access to abortion on demand altogether'. Of the remaining 18 states 11 are split, with only 7 out of the 50 states found to be unlikely to tighten rather than relax their abortion laws.

The questions arising are:

- Does the individual's right to abortion on demand supercede the public's right to democratically determine, by majority vote, whether a local authority's ratepayers' funds or state tax funds be employed for the purpose?
- If private health-care providers are to be granted freedom from prosecution for refusing to provide abortion, what exactly does the term 'private' mean? ie Where do fund-raising organisation, health-care conglomerates, companies for profit, etc fit in?
- If a public institution is to be legally bound to provide abortions on demand, should the public service personnel employed there have a legal right to refuse to take part?

6. Paraprofessionals

The sixth problem highlighted by the FOCA has to do with the licensing of personnel other than doctors for the performance of abortions.

Concern and opposition have been raised by some abortion providers.

The Supreme Court ruled explicitly in Roe vs Wade that states 'may proscribe any abortion by a person who is not a physician'. The Court reaffirmed that position in Menillo 1975.

Forty-seven out of 50 USA states currently ban abortion by non-physicians, regardless of training. The

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exceptions are Oregon and Washington which have restrictions, and Vermont, the only state where non-physician abortions are routinely performed.

These 'doctors-only' laws indisputably 'restrict' access to abortion. Moreover, the abortion industry (represented, for example, by the National Abortion Federation) and various medical societies that seek to 'expand access' to abortion (such as the American College of Obstetricians and Gynaecologists), have already taken formal position that these laws are not 'medically necessary'.

But if they are not 'medically necessary", then they are invalid under the FOCA.

The House Judiciary Committee rejected an amendment by Rep Henry Hyse (R.11) to allow (not require) states to bar abortions by non-doctors.

Abortion providers have expressed dismay that the same bill would allow for abortions to be performed by non-physicians, even in the third trimester, for any reason.
Abortion providers have also expressed concern that such a lucrative industry might attract abuse if not strictly limited and controlled particularly in terms of surgical technique, diagnosis of complications, and immediate aftercare.

The questions arising are:

- Should fully trained doctors only be allowed to perform abortions? If not why not, and when not?
- If non-physicians are to be allowed to perform abortions, who will be screened and licenced by which recognised authority?
- If non-physicians are to be allowed to perform abortions, what changes need to be made to laws pertaining to consent, litigation, and funding?

Reactions to the FOCA

While anti-abortion campaigners have been only too keen to see legislation postponed until a measure of consensus is reached on the above key questions, pro-abortion activists have been understandably upset to see Clinton thus raise their hopes and then fail to deliver. The third pro-abortion axiom has again been invoked with the claim that while everybody irons out the major difficulties inherent in the FOCA, women are dying in backstreet abortions.

A factual perspective, however, needs to be maintained.

A report by The American Association Council on Scientific affairs released 5th June 1992 showed that abortion related deaths dropped from 3,3 per 100,000 in 1973 (the year Roe vs Wade style of abortion on demand was introduced), to 0,4 deaths per 100,000 in 1985. In other words, mortality rate dropped to 1/8th. However, the same period of time also saw the number of abortions performed rise eight fold. In other words, while the mortality rate has dropped, the same actual number of women is losing their life.

Obviously the procedure is fatal to each pre-born human involved.

Furthermore, the sharp rise in the number of abortions since abortion on demand was partially facilitated in 1973 does not reflect any such sharp rise in the number of women falling pregnant, far exceeds the number of women who were aborting before, and dwarfs the number of women aborting for reasons of rape or congenital abnormality. The sharp rise indisputably reflects a new clientele. In other words, tens of thousands of women will avail themselves of abortion when its provision is liberalised rather than seek assistance in keeping or giving up the child to adoptive parents, seek better contraception or sterilisation to avoid recurrence, etc.

This is a worldwide phenomenon.

Painful as the decision undoubtedly is, it is ultimately not the quality of the child's life that motivates the majority of women to seek abortion, but the perceived immediate and long term disruption to their own life were they to see through the pregnancy. With much agony and trauma, without perceived hope or alternative, without personal or state support, death of the pre-born or even the risk of backstreet abortion is preferred to owning the costlier responsibility for one's mistakes. The burden of such a desperate decision is carried by the woman for the rest of her life, and frequently resurfaces painfully as her life circumstances improve.

How are we to respond to this in the new South Africa?

Do we allow these unfortunate women to face the worst consequences of their predicament, or do we drastically review our distribution of resources, not only providing immediate assistance to pregnant mother and child, but also imaginatively, aggressively and courageously tackling the root causes of the problem?

Is abortion on demand true empowerment of women or a cheap, expedient and cowardly avoidance of proven effective remedies? Is it truly granting women basic human rights, or denying them those rights, thus perpetuating their suffering at a bloody price?

What is to be the relationship between women's rights, the pre-born's rights, health carer's rights, parental rights and the state's rights?

Whatever the course of action chosen, the questions raised by the FOCA will have to be answered.