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THE LEGAL AND ETHICAL IMPLICATIONS OF
IMPLEMENTING PARTIAL-BIRTH ABORTION IN
SOUTH AFRICA

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This research project is submitted in partial fulfilment of the regulations for the
LLM Degree at the University of KwaZulu-Natal

DECLARATION

I, FAADIELA JOGEE, hereby declare that:

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ACKNOWLEDGMENTS

This dissertation is dedicated to the following:

My parents, for their endless love, undying support and unwavering patience. Without you, I would not be where I am today. I am forever indebted to you and eternally grateful to have you as parents.

My family and friends, for their encouragement and kindness.

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ACRONYMS

ASA	Abortion and Sterilization Act
ATR	African Traditional Religion
BADRA	Birth and Deaths Registration Act
BAMP	British Association of Perinatal Medicine
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CLA	Christian Lawyers Association
CTOPA	Choice on Termination of Pregnancy Act
D&C	Dilation & Curettage
D&E	Dilation & Evacuation
D&X	Intact Dilation & Extraction
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IFPA	Irish Family Planning Association
IHRL	International Human Rights Law
IOL	Induction of Labor
LTOP	Late Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NAF	National Abortion Federation
NHA	National Health Act
NHS	National Health Services
PBA	Partial-birth Abortion
PBABA	Partial-Birth Abortion Ban Act
PLDPA	Protection of Life during Pregnancy Act
RCOG	Royal College of Obstetricians and Gynecologists
S&C	Suction & Curettage
TOP	Termination of Pregnancy
UN	United Nations
UNHRC	United Nations Human Rights Council
VALRA	Victoria's Abortion Law Reform Act
WHO	World Health Organisation

THE ETHICAL AND LEGAL IMPLICATIONS OF IMPLEMENTING PARTIAL-BIRTH ABORTION IN SOUTH AFRICA

PREFACE

Abortion is among the most morally contentious issues plaguing the fields of bioethics and law today. Recently, the subject of abortion was thrust back into the global spotlight when the controversy surrounding partial-birth abortion resurfaced.^{1,2} The term originated in the United States of America and is a colloquialism for intact dilation and extraction³, employed by PBA opponents.⁴ Parallels have been drawn between PBA and infanticide by pro-life advocates⁵ who describe PBA as the partial delivery of a full-term baby whose head is pierced and brain removed on the precipice of live birth.^{6, 7} However, physicians⁸ consider D&X to be a safer variant of dilation and evacuation.^{9,10} The latter procedure is deemed the safest late termination of pregnancy¹¹

¹ Prior to the federal ban on partial-birth abortion signed by President George W. Bush in 2003, the House of Representatives initially passed legislation banning the procedure in 1995. However, President William J. Clinton vetoed the bill in 1996 and a subsequent bill in 1997. See RS Conley *Historical Dictionary of the Clinton Era* (2012).

² BF Schaffner & PJ Sellers (eds) *Winning with Words: The Origins & Impact of Political Framing* (2010).

³ The terms partial-birth abortion (hereafter, referred to as “PBA”) and intact dilation and extraction (hereafter, referred to as “D&X”) will be used interchangeably throughout this paper.

⁴ NEH Hull & PC Hoffer *Roe v Wade: The Abortion Rights Controversy in American History* 2 ed (2010) 276.

⁵ JB Hames & Y Ekern *Constitutional Law: Principles and Practice* 2 ed (2013) 549.

⁶ W Saletan *Bearing Right: How Conservatives Won the Abortion War* (2004) 233.

⁷ ML White *Of Science and God* (2012) 133.

⁸ Hereafter, “physician” will be used interchangeably with “medical practitioner”.

⁹ PA Lohr & R Lyus ‘Dilation and Evacuation’ in S Rowlands (ed) *Abortion Care* (2014) 88.

¹⁰ SB Oswalt *Exploring the Dimensions of Human Sexuality* 5 ed (2014) 88, 278.

¹¹ Hereafter, referred to as “LTOP”.

procedure.^{12,13} In actuality, D&X is a LTOP¹⁴ procedure typically involving breech conversion and cephalocentesis¹⁵ to safely deliver the fetus intact.¹⁶ Since fetal dismemberment is a requisite for dilation and evacuation¹⁷, it may compromise the health and lives of patients requiring LTOP as D&E involves higher rates of mortality and morbidity during LTOP.^{18,19} Hence, D&X could provide additional health and safety benefits to women requiring D&E. Nevertheless, the procedure is federally banned in most states in the United States of America.²⁰

South Africa's Choice on Termination of Pregnancy Act 92 of 1996, is lauded as one of the most liberal pieces of legislation governing termination of pregnancy²¹ the world over.²² It safeguards and upholds several constitutional rights that women were previously denied during Apartheid, makes provision

¹² MI Middleberg *Promoting Reproductive Security in Developing Countries* (2004) 187.

¹³ MA Fritz & L Speroff *Clinical Gynecologic Endocrinology and Infertility* (2011) 945.

¹⁴ Refers abortions that normally occur during the latter half of the second trimester or in the third trimester. See JC Ahronheim, JD Moreno and C Zuckerman *Ethics in Clinical Practice* 2 ed (2005) 429.

¹⁵ Also referred to as intracranial decompression, this refers to the partial removal of the intracranial contents from the fetal skull via a suction device in order to reduce the diameter of the skull to prevent cervical injury. See MC Lu 'Induced Abortion' in JP Pregler & AH DeCherney *Women's Health: Principles and Clinical Practice* (2002) 228, 231.

¹⁶ A Von Hagel and D Mansbach *Reproductive Rights in the Age of Human Rights: Pro-life Politics from Roe to Hobby Lobby* (2016) 131.

¹⁷ Hereafter, referred to as "D&E"

¹⁸ MC Lu 'Induced Abortion' in JP Pregler & AH DeCherney *Women's Health: Principles and Clinical Practice* (2002) 228, 230 – 231.

¹⁹ N Ehrenreich *The Reproductive Rights Reader: Law, Medicine and the Construction of Motherhood* (2008) 177.

²⁰ Guttmacher Institute State Policies in Brief: Bans on "Partial-Birth" Abortion (2016) available at http://www.guttmacher.org/statecenter/spibs/spib_BPBA.pdf.

²¹ Hereafter, referred to as "TOP".

²² CL Morna and M Makaya-Magarangoma 'The Impact of Women's Political Leadership on Democracy and Development in South Africa' in Commonwealth Secretariat *The Impact of Women's Political Leadership on Democracy and Development Case Studies from the Commonwealth* (2013) 7, 28.

for safe and legal abortion services, and promotes women's reproductive health.²³ Nevertheless, it does not regulate feticide.²⁴ Consequently, the choice of TOP procedure is within the discretion of the physician. If PBA is medically superfluous and inhumane, proscription and criminalization should be considered. Conversely, if D&X is a medically necessary, advantageous and life-saving alternative to D&E, it should be implemented and performed without legal consequence. Nevertheless, neither action can be done without determining whether PBA is constitutionally and ethically admissible.

The object of this dissertation is to expound the legal and ethical implications of implementing PBA in South Africa. Accordingly, this paper will determine whether the use of PBA is constitutionally and ethically permissible. To do so it is necessary to first review the history of South African abortion laws and discuss TOP in the context of ethics. These discussions are necessary in order to gauge the legal and ethical implications of PBA. Furthermore, it will lay the foundation for the arguments raised in favor and against the implementation of PBA in South Africa. Moreover, it will influence the recommendations outlining the use of feticidal agents to induce painless and humane fetal demise prior to LTOP, and neonatal palliative care as an alternative to LTOP. Thereafter, the nature and methodology of surgical abortion procedures will be reviewed. Subsequently, a comprehensive account of the arguments advanced by opponents and exponents of PBA will be dissected in order to provide an objective view of the ethics and constitutionality of PBA. Once determining whether implementation of PBA is constitutionally and ethically justifiable, the aforesaid recommendations will be outlined.

Chapter I delivers an overview of the history of South African law governing TOP, focusing on its progression from strictly prohibitive to one of the most

²³ S Guttmacher ... et al 'Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act' (1998) 24(4) *International Family Planning Perspectives* 191.

²⁴ The term 'feticide' refers to the destruction or abortion of the fetus. See A Stevenson (ed) *Oxford Dictionary of English* 3 ed (2010) 645.

liberal and globally celebrated pieces of legislation. Emphasis is placed on the Choice on Termination of Pregnancy Act's²⁵ impact on women's rights and reproductive health. Next, a discussion on the constitutional right to conscientious objection and its effect on abortion services is offered. Subsequently, the constitutional challenges to the legislation and the manner in which the courts have dealt with the issue of abortion, will be outlined. Thereafter, this chapter will proceed to determine whether South African statutory law recognizes fetal interests. Finally, the chapter will conclude with a brief discussion on whether abortion procedures are regulated by South African law.

Chapter II explores the bioethical theories and principles relevant in determining whether the implementation of PBA is ethically justifiable. This discussion will shape the arguments raised in support of, and against the implementation of PBA. Moreover, these theories and principles will assist us in contemplating the existence of potential alternatives to fetal pain and LTOP. Thereafter, a discussion on religious bioethics and abortion is offered. This discussion is restricted to religions germane to South Africa. Finally, the chapter will conclude with a brief outline on secular morality and abortion, as well as the boni mores of abortion.

Chapter III examines the fetocidal abortion procedures employed during each trimester, induced fetal demise and neonatal palliative care. This chapter will outline what each procedure entails, including the differences and similarities among TOP procedures.

The Constitution of the Republic of South Africa²⁶ states: "when interpreting the Bill of Rights, a court, tribunal or forum must consider international law; and may consider foreign law."²⁷ Accordingly, Chapter IV proffers a discussion on

²⁵ Act 92 of 1996.

²⁶ The Constitution of the Republic of South Africa Act 108 of 1996. (Hereafter, referred to as the "1996 Constitution").

²⁷ *Ibid* Section 39(1).

the stance of international human rights law regarding TOP and reproductive rights. The discussion will include an overview of several international treaties and guidance documents germane to TOP. These documents will be used to assess whether proscription of PBA is justifiable from an international human rights law perspective. Thereafter, an examination of foreign law regulating abortion will follow. The discussion will be restricted to countries formerly belonging to the British Commonwealth, given their common legal heritage and the influence of English common law on the South African legal system.²⁸

Chapter V explores the normative arguments underpinning the proscription of PBA. This chapter will commence with an examination of the medical evidence fortifying the existence of fetal pain. Secondly, it will observe the effect of PBA on informed consent and patient-autonomy. Thereafter, a discussion on the wanton abuse of PBA will follow. Next, the similarities between infanticide, neonaticide and PBA will be contemplated. Subsequently, a brief discussion on religion, the right to conscientious objection, and its impact on PBA will be outlined. Lastly, this chapter will conclude with an analysis of why PBA is supposedly unsafe, unnecessary, and unsuitable in an emergency context.

Chapter VI examines the normative arguments fortifying implementation of PBA. This chapter will offer a response to each of the arguments raised in the previous chapter, proving that PBA is a medically necessary, salutary and life-saving procedure. Furthermore, it will demonstrate how the claims raised in the previous chapter cannot be restricted to PBA as it extends to all surgical abortion procedures. Thus, providing valid grounds for all surgical abortion procedures to be proscribed. In addition to disputing the claims posited by proponents of the ban on PBA, it will further illustrate how proscription of PBA undermines the rights of women, rendering it constitutionally and ethically unjustifiable.

²⁸ KK Mwenda *Comparing American and British Legal Education Systems: Lessons for Commonwealth African Law Schools* (2007) 3.

Chapter VII proffers recommendations on how physicians can induce fetal and neonatal demise humanely and painlessly when faced with LTOP. It will briefly detail the use of the fetocidal agent, potassium chloride and how it can be used in conjunction with any fetocidal abortion procedure to induce painless fetal demise. Thereafter, an overview of neonatal palliative care as a viable alternative to LTOP will be explored in greater detail. This discussion will include suggestions on when and why neonatal palliative care should be employed by physicians.

Chapter VIII concludes that implementation of PBA is constitutionally and ethically justifiable. Accordingly, PBA should be effected without legal consequence. It is submitted that the ethical arguments advanced by opponents of PBA are not limited to PBA and extend to all surgical abortion procedures. Consequently, the arguments advanced are not robust enough to constitutionally and ethically indorse proscription. Nevertheless, humane and painless methods of inducing fetal demise exist. Accordingly, when faced with LTOP, physicians should employ such methods to induce humane and painless fetal demise. Additionally, neonatal palliative care provides an alternative to LTOP and should be employed in situations where the latter it is not required.

METHODOLOGY

This dissertation constitutes the results of a desk review of publically accessible documents namely: national and foreign legislation and case law; academic textbooks; publications produced by international agencies; government and non-government publications; newspaper articles; journal articles and various websites.

CHAPTER ONE

1. A HISTORY OF SOUTH AFRICAN ABORTION LAW

This chapter delivers an outline of the history of South African abortion legislation, illustrating its progression from prohibitive and oppressive to liberal and dynamic. It will reveal the effect of the contemporary abortion legislation on abortion services and health care providers, as well as review the challenges to its constitutionality. Lastly, it will allow us to identify any shortfalls in the law as regards to feticide.

1.1. Common Law

South African common law criminalized TOP, strictly prohibiting its use except in life-threatening circumstances; consequently, anyone who procured or attempted to procure abortion was held criminally liable.²⁹

Abortion was a relatively minor crime as illustrated by the following cases:

In *Rev v Freestone*³⁰ the accused was found guilty of procuring five counts of TOP and one of attempting to procure TOP, the accused was sentenced to four years imprisonment with hard labour.³¹

In *Rex v Claasen*³² the accused was charged with attempting to procure TOP and unlawfully encouraging the use of abortifacients; the punishment for this crime was a three-month sentence, or payment of £15.³³

In *Rex v Guala*³⁴ the accused was charged with attempting to procure TOP and alternatively contravening S 165 of the "Criminal Code for these Territories", which prohibited unlawful provision and promotion of abortifacients.³⁵ This case

²⁹ SA Strauss 'Therapeutic Abortion and South African Law' (1968) 42(28) SAMJ 711-712.

³⁰ *Rev v Freestone* 1913 TPD 758.

³¹ *Ibid* 763.

³² *Rex v Claasen* 1936 CPD 28.

³³ *Ibid* 29.

³⁴ *Rex v Guala* 940 EDL 1.

³⁵ *Ibid* 2.

demonstrated how abortion was recognized as a common law crime and statutory crime.

In *R v Davies and Another*³⁶ the appellants were charged with culpable homicide and procuring TOP in the alternative.³⁷ The first appellant was fined £50 on each count and a six-month prison sentence, the second appellant was ordered to serve the same sentence and pay a fine of £25.³⁸

In *S v Collop*³⁹ it was alleged that according to Roman-Dutch law, TOP is a capital crime if the woman is 'quick' with the child.^{40,41}

Nevertheless, abortion was never a capital crime, presumably because of the difficulty in imposing harsh penalties for pervasive crimes; moreover, fetal personhood did not exist under the common law.⁴²

1.1.1. Legal personhood

Legal personhood begins at birth.⁴³

'Birth' in terms of legal subjectivity is entirely dependent on two common law requirements.⁴⁴

1. The child must be separated from the mother.⁴⁵

³⁶ *R v Davies and Another* 1956 (3) SA 52 (A).

³⁷ *Ibid* 55A.

³⁸ *Ibid* 55B.

³⁹ *S v Collop* 1981 (1) SA 150 (A).

⁴⁰ *Ibid* 153F.

⁴¹ *Ibid* 153E and 165. Quickening refers to the period in which the unborn child begins to move in the womb. However, there was uncertainty regarding the exact time at which the child begins to quicken as the Roman-Dutch writers did not specify a gestation period.

⁴² J McGill 'Abortion in South Africa: How We got Here, the Consequences, and What is Needed' (2006) 2 *Journal of Christian Scholarship* 197.

⁴³ T Boezaart *The Law of Persons* 5th ed (2010) 11.

⁴⁴ DSP Cronje & J Heaton *The South African Law of Persons* 3rd ed (2008) 7.

⁴⁵ *Ibid*.

2. The child must live independently from its mother, irrespective of how long it lives after birth; any sign of life can satisfy this requirement.⁴⁶

These two requirements are collectively known as the “born alive” rule.⁴⁷

1.1.2. Nasciturus fiction

Despite the lack of statutory recognition regarding fetal personhood, the common law recognizes and protects fetal interests via the nasciturus fiction.

According to nasciturus fiction, the unborn child is considered to be born alive when a benefit accrues to it; once the unborn child is born alive, it is entitled to the accrued benefit.⁴⁸

Three requirements must be satisfied regarding the nasciturus fiction:

1. A benefit must be accrued to the unborn child; the requirement will be satisfied if the benefit accrues jointly to the unborn child and a third party but it cannot be solely for the benefit of a third party.⁴⁹

2. The benefit must accrue after conception.⁵⁰

3. The unborn child must be born alive.⁵¹

1.2. The Abortion and Sterilization Act⁵²

⁴⁶ *Ibid.*

⁴⁷ R Pillay ‘The Beginning of Human Personhood: Is South African Law Outdated?’ (2010) 2 *Stellenbosch LR* 230 - 231.

⁴⁸ Boezaart (note 43 above) 13.

⁴⁹ CJ Davel & RA Jordaan *The Law of Persons* 4th ed (2005) 14.

⁵⁰ Boezaart (note 43 above) 14.

⁵¹ *Ibid.*

⁵² Abortion and Sterilization Act No. 2 of 1975. (Hereafter, referred to as “ASA”).

The ASA endeavored to extend the grounds under which abortion could be procured under common law.⁵³

According to the ASA, abortion could be performed by a physician if: (a) the patient's life or health was at serious risk⁵⁴; (b) there was “a serious threat to the mental health” of the patient, which could result in permanent damage⁵⁵; (c) there was “a serious risk that the child... will suffer from a physical or mental defect”, resulting in an irreparable and serious handicap⁵⁶; (d) the fetus was allegedly conceived out of rape or incest⁵⁷; or (e) the fetus was conceived in “unlawful carnal intercourse” with a woman afflicted with a long-lasting mental disability.⁵⁸

Moreover, two additional physicians had to verify the patient's need for TOP.⁵⁹ Further, the physician performing TOP required authorization to perform TOP at a relevant facility.⁶⁰

If pregnancy arose from a case of rape or incest, a police complaint had to be lodged; the local magistrate had to investigate the matter and issue a certificate.⁶¹ The certificate had to state that a complaint was lodged or that there was a valid reason for not doing so.⁶² In the latter case, the onus was on the complainant to prove the existence of a valid ground for not lodging the complaint.⁶³ Additionally, the certificate had to state that on a balance of

⁵³ R Hodes, ‘The Medical History of Abortion in South Africa, c 1970 – 2000’ (2015) 39(3) *J of Southern African Studies* 535.

⁵⁴ ASA (note 52 above) at S 3(1)(a).

⁵⁵ *Ibid* S 3(1)(b).

⁵⁶ *Ibid* S 3(1)(c).

⁵⁷ *Ibid* S 3(1)(d).

⁵⁸ *Ibid* S 3(1)(d)(bb).

⁵⁹ *Ibid* S 3(1)(a) – (d).

⁶⁰ *Ibid* S 6(1) - (2).

⁶¹ *Ibid* S 6(4).

⁶² *Ibid* S 6(4)(a)(i).

⁶³ *Ibid*.

probabilities the crime was committed.⁶⁴ Likewise, the alleged victim had to present an affidavit asserting that the pregnancy was a product of the alleged crime.⁶⁵ The superintendent of the relevant medical facility was obligated to provide the Director-General of Health with all of the information relevant to the procedure.⁶⁶ The ASA also contained a conscience clause stating that it was not mandatory for medical personnel to participate in or assist in TOP.⁶⁷

The ASA made it virtually impossible for women to safely and legally procure abortion, subsequently triggering an influx of illegal and unsafe abortions that needlessly endangered women lives.⁶⁸ The bureaucratic nature and processes of the ASA oppressed women, stripping them of their reproductive rights and infringing their constitutional rights to privacy, bodily integrity, dignity, health and life.

1.2. The Choice on Termination of Pregnancy Act⁶⁹

CTOPA repealed the ASA in 1996, delivering access to safe TOP⁷⁰ services to all women⁷¹ under the following grounds:

(a) “Pregnancy may be terminated upon request... during the first 12 weeks of the gestation period...”⁷²;

(b) TOP may occur between the 13th and “20th week of the gestation period... if a medical practitioner, after consultation with the pregnant woman” believes

⁶⁴ *Ibid* S 6(4)(a)(ii).

⁶⁵ *Ibid* S 6(4)(b).

⁶⁶ *Ibid* S 7(1).

⁶⁷ *Ibid* S 9.

⁶⁸ R Rebouche ‘Challenges for Contemporary Reproductive Rights Advocacy: the South African Example’ in B Baines, D Barak-Erez and T Kahana (eds) *Feminist Constitutionalism: Global Perspectives*. (2012) 298, 300.

⁶⁹ Choice on Termination of Pregnancy Act 92 of 1996. (Hereafter, referred to as “CTOPA”).

⁷⁰ *Ibid* S 1(x) "termination of a pregnancy means the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman."

⁷¹ *Ibid* S 1(xi) "woman" means any female person of any age."

⁷² *Ibid* S 2(1)(a).

that:⁷³ (i) “continued pregnancy would pose a risk of injury to the woman’s physical or mental health”;⁷⁴ (ii) there is a serious risk that “the fetus will suffer from a severe physical or mental abnormality”;⁷⁵ (iii) “the pregnancy resulted from rape or incest;”⁷⁶ (iv) or “continued pregnancy would significantly affect the social or economic circumstances of the woman.”⁷⁷

(c) Following “the 20th week of the gestation period” TOP is permitted if the medical practitioner having consulted with “another medical practitioner or registered midwife, is of the opinion that continued pregnancy”:⁷⁸ (i) is life-threatening;⁷⁹ (ii) will leave the fetus severely malformed;⁸⁰ or (iii) “pose a risk of injury to the fetus”.⁸¹

Furthermore, the State is obligated to promote “non-mandatory and non-directive counselling, before and after” TOP.⁸²

TOP will not be performed without the patient’s informed consent.^{83,84} If she is a minor, a physician or registered midwife must encourage her to seek guidance from her parents, guardians, family or friends before finalizing a decision.⁸⁵ TOP will be available to her regardless of whether she consults with the aforementioned parties.⁸⁶ Moreover, women seeking TOP services under CTOPA are legally authorized to be informed of all legal rights entitled to them

⁷³ *Ibid* S 2(1)(b).

⁷⁴ *Ibid* S 2(1)(b)(i).

⁷⁵ *Ibid* S 2(1)(b)(ii).

⁷⁶ *Ibid* 2(1)(b)(iii).

⁷⁷ *Ibid* S 2(1)(b)(iv).

⁷⁸ *Ibid* S 2(1)(c).

⁷⁹ *Ibid* S 2(1)(c)(i).

⁸⁰ *Ibid* S 2(1)(b)(ii).

⁸¹ *Ibid* S 2(1)(b)(iii).

⁸² *Ibid* S 4.

⁸³ *Ibid* S 5(1).

⁸⁴ *Ibid* S 5(2).

⁸⁵ *Ibid* S 5(3).

⁸⁶ *Ibid*.

within CTOPA.⁸⁷ Furthermore, the identity of women requesting TOP or have already procured TOP, cannot be divulged unless it is autonomously disclosed by the woman concerned.⁸⁸

1.4. Conscientious Objection and Abortion Services

In South Africa “everyone has the right to freedom of conscience, religion, thought, belief and opinion.”⁸⁹ What is more, one cannot be directly or indirectly unfairly discriminated against on the basis of their religion, conscience or belief.⁹⁰ Therefore, a physician can conscientiously object to TOP without unfair discrimination from his or her employer or coworkers.⁹¹ Nevertheless, the right to conscientious objection cannot be invoked in an emergency context since there is a constitutional⁹² and ethical duty to assist patients.⁹³ Furthermore, only the procedure itself can be conscientiously objected to.⁹⁴ CTOPA requires health care providers to notify patients of all legal rights entitled to them within CTOPA, irrespective of whether they conscientiously object to TOP.⁹⁵ Thereby, ensuring that patients are equipped with information that will continue to allow them to procure safe and legal TOP elsewhere. Nurses are permitted to conscientiously object to participating or assisting in TOP; should a nurse conscientiously object, he or she is required to timeously lodge a written refusal

⁸⁷ *Ibid* S 6.

⁸⁸ *Ibid* S 7(5).

⁸⁹ 1996 Constitution (note 26 above) S 15(1).

⁹⁰ *Ibid* S 9(3).

⁹¹ C Ngwenya ‘Conscientious objection and legal abortion in South Africa: delineating the paramiters.’ (2003) 28(1) *J of Juridical Science* 9 – 10.

⁹² 1996 Constitution (note 26 above) S 27(3) states: “no one shall be denied emergency medical treatment.”

⁹³ C Morroni, G Buga & L Myer ‘Understanding aspects of the termination of pregnancy legislation.’ (2006) 24(1) *Continuing Medical Education* 38.

⁹⁴ It does not apply to health care providers that do not actively participate in the procedure itself. For instance those who are required to provide abortion counselling or general medical care unrelated to the procedure, cannot raise their right to conscientious objection. See J Harries ... et al ‘Conscientious objection and its impact on abortion services in South Africa: a qualitative study.’ (2014) 11(16) *Reproductive Health* 2.

⁹⁵ COTPA (note 69 above) S 6.

to their employer.⁹⁶ Thereafter, a duplicate of the employee's refusal will be retained in their personnel record and a certified copy will be given to them as proof of refusal.⁹⁷ The Health Professions Council of South Africa deems TOP ethically permissible and necessary in emergency contexts to preserve the health and/or life of the patient.⁹⁸ Physicians can conscientiously object to performing TOP in non-emergency contexts without jeopardizing their careers; however, he or she is required to refer the patient to a colleague willing to perform TOP.⁹⁹ Furthermore, physicians cannot impose their subjective religious or cultural views regarding TOP onto patients.¹⁰⁰ In addition, physicians are required to counsel the patient objectively.¹⁰¹

Conscientious objection regarding PBA will be discussed in Chapters 5 and 6.

1.5. Challenges to CTOPA

The constitutionality of CTOPA was questioned in two cases.

In *Christian Lawyers Association v Minister of Health and Others*¹⁰² an order was sought declaring Sections 5(2) and 5(3), read in conjunction with term 'woman' under Sections 1 and 5(1) of CTOPA, unconstitutional; and an order striking down Sections 5(2) and 5(3) in addition to the term 'woman' under Section 1.¹⁰³ It was alleged that pregnant minors were incapable of making

⁹⁶ South African Nursing Council *Charter of Nursing Practice – Draft 1* (2004) 24 – 25 available at <http://www.sanc.co.za/pdf/Charter%20Draft.pdf>.

⁹⁷ *Ibid.*

⁹⁸ Health Professions Council of South Africa *Health Professions Council of South Africa Guidelines for Good Practice in Health Care Professions - General Ethical Guidelines for Reproductive Health Booklet 13* (2008) 8 – 9 available at <http://juta.co.za/academic/support-material/resource/277>.

⁹⁹ *Ibid.*

¹⁰⁰ *Ibid.*

¹⁰¹ *Ibid.*

¹⁰² *Christian Lawyers Association v Minister of Health and Others* (Reproductive Health Alliance as Amicus Curiae) 2005 (1) SA 509 (T). (Hereafter, referred to as “CLA 2005 case”).

¹⁰³ *Ibid* 512B – C.

autonomous reproductive health decisions.¹⁰⁴ Consequently, it was argued that minors are unable to provide informed consent as required by S 5(1).¹⁰⁵ Further, it was claimed that the relevant provisions were unconstitutional because it permits pregnant minors to autonomously consent to TOP without the permission of their parents or guardians.¹⁰⁶

The court held that CTOPA was constitutional because the right to choice is enshrined in Sections 12(2)(a) and (b), 27(1)(a), 10 and 14 of the 1996 Constitution, which are accorded to everyone.¹⁰⁷ Further, discrimination of women on the grounds of age violates their rights under Sections 9(1) and 9(3).¹⁰⁸ The limitation of the right to freedom of women, including minors wishing to procure TOP, is only warranted by S 36(1) of the 1996 Constitution.¹⁰⁹ Furthermore, it was held that the relevant provisions were constitutional since CTOPA caters to the best interest of pregnant minors since it appreciates and accommodates their positions by acknowledging their emotional, intellectual and psychological dispositions.¹¹⁰

In *Christian Lawyers Association of SA and Others v Minister of Health and Others*¹¹¹ an order was sought declaring CTOPA unconstitutional, contending that the right to life engaged at conception.¹¹²

The court held that the terms "everyone" and "every person" are synonymous; therefore, the plaintiffs' cause of action depended on whether these terms were

¹⁰⁴ *Ibid* 512E.

¹⁰⁵ *Ibid* 514.

¹⁰⁶ *Ibid* 513B – C.

¹⁰⁷ *Ibid* 528 D – E.

¹⁰⁸ *Ibid* 528E/F – G.

¹⁰⁹ *Ibid*.

¹¹⁰ *Ibid* 528H/I – J.

¹¹¹ *Christian Lawyers Association of SA and Others v Minister of Health and Others* 1998 (4) SA 1113 (T). (Hereafter, referred to as "CLA 1998 case").

¹¹² *Ibid* 1116.

inclusive of the fetus.¹¹³ Referring to the term "everyone", the court found that the plaintiff's claim that the fetus becomes a person at conception, is unreasonable.¹¹⁴ The court held that the 1996 Constitution did not include any provisions granting fetal personhood; hence, the right under S 12(2) is not qualified for the protection of the fetus.¹¹⁵

The court reasoned that if there was any intention to include fetal interest the fetus would have been mention under S 28, which concerned children who are defined as persons aged 18 years and under.¹¹⁶ However, age originates at birth; thus, the fetus cannot be a 'child' since it is without age.¹¹⁷ If S 28 is inclusive of fetal protection, then the same can be said for all provisions contained within the Bill of Rights, including S 11.¹¹⁸ Furthermore, all provisions within the Bill of Rights, save for those addressing particular classes of people, confer rights to 'everyone'.¹¹⁹ If the definition of the word 'everyone' included the fetus it will alter the meaning of the word throughout the 1996 Constitution.¹²⁰ Besides, conferring the right to life to the fetus indicates that both mother and fetus would be constitutionally protected; consequently, abortion will be prohibited in all circumstances.¹²¹ Surely, this could not be the intention of the drafters of the 1996 Constitution.¹²² The court held that the law does not recognize the fetus as a person.¹²³

1.6. Fetal Recognition and the Law

Statutory law acknowledges and protects fetal interests.

¹¹³ *Ibid* 1118A/B – C.

¹¹⁴ *Ibid* 1120H – J.

¹¹⁵ *Ibid* 1121F/G - J.

¹¹⁶ *Ibid* 1122B – F.

¹¹⁷ *Ibid*.

¹¹⁸ *Ibid*.

¹¹⁹ *Ibid* 1122F – I.

¹²⁰ *Ibid*.

¹²¹ *Ibid* 1122I – 1123B/C.

¹²² *Ibid*.

¹²³ *Ibid* 1123B/C.

It is trite that COTPA preserves fetal interests by implementing restrictions on TOP as pregnancy progresses; once the fetus reaches viability, TOP is permitted in rare circumstances.¹²⁴

The National Health Act¹²⁵ prohibits experimentation on embryos¹²⁶ after 14 days unless written permission is granted under certain conditions.¹²⁷ The Birth and Deaths Registration Act¹²⁸ defines a “stillborn” as a child with a gestational age of at least 26 weeks.¹²⁹ Once declared a stillborn the physician will provide a prescribed certificate or declaration, and a burial order will be drawn up for the child.¹³⁰ The gestational period specified coincides with fetal viability.¹³¹ Ergo, fetal viability determines the registration of child’s death and its burial. Therefore, the fetus is assigned some legal rights as a potential person.

Evidently South Africa has attempted to balance women’s reproductive rights with fetal interests.

1.7. COTPA and Abortion Procedures

COTPA does not regulate abortion procedures nor does it govern laws relating to feticide. Ergo, all feticidal TOP methods are permissible until laws regulating feticide are implemented. Consequently, the choice of TOP procedure is within the discretion of the physician.

1.8. Conclusion

¹²⁴ COTPA (note 69 above) S 2(1)(a)-(c).

¹²⁵ National Health Act 63 of 2003. (Hereafter, referred to as “NHA”)

¹²⁶ *Ibid* S1 defines embryo as “human offspring in the first eight weeks of conception”.

¹²⁷ *Ibid* S 57.

¹²⁸ Birth and Deaths Registration Act 51 of 1992. (Hereafter, referred to as “BADRA”).

¹²⁹ *Ibid* S 1.

¹³⁰ *Ibid* S 18.

¹³¹ Fetus becomes viable at 24 weeks. WHO recommends that in developing countries a birth weight of 500g to measure viability. See EC van Niekerk; I Siebert & TF Kruger ‘An evidence-based approach to recurrent pregnancy loss.’ (2013) 19(3) SAJOG 61.

This chapter traced the development of South Africa's abortion laws. Initially TOP was criminalized by the common law and reserved for life-threatening situations.¹³² The ASA extended the grounds to procure TOP but implemented rigorous administrative and procedural measures, which prevented women from procuring safe TOP.¹³³ CTOPA usurped the ASA, providing access to safe and legal abortion services on personal, socio-economic and medical grounds within a gestational framework that promotes women's reproductive rights and protects fetal interests.¹³⁴ Despite the recognition of fetal interest in common law and statute, maternal interest takes precedent. The law does not recognize fetal personhood or afford the fetus constitutional protection¹³⁵ and the decision to procure TOP lies solely with the woman concerned, regardless of her age.¹³⁶ Physicians can conscientiously object to performing TOP without being unfairly discriminated against.¹³⁷ However, this right is not applicable in emergency contexts as there is an ethical and constitutional duty to perform TOP.¹³⁸ Since CTOPA only regulates access to abortion services, feticidal TOP methods are permissible until the law states otherwise. Feticidal TOP procedures will be discussed in Chapters 3. Chapters 4 and 6 will center on PBA's impact on women's rights. Chapter 5 and 6 will address the issue of conscientious objection in the context of PBA and the physician.

¹³² Strauss (note 29 above) 711 – 712.

¹³³ Rebouche (note 68 above) 300.

¹³⁴ COTPA (note 69 above) S 2(1).

¹³⁵ CLA 1998 (note 111 above) 1122B – F.

¹³⁶ CLA 2005 (note 102 above) 528E/F – G.

¹³⁷ Ngwena (note 91 above) 9 – 10.

¹³⁸ 1996 Constitution (note 26 above) S 27(3).

CHAPTER TWO

2. ETHICS AND ABORTION

2.1. Bioethics

2.1.1. Ethical theories

The purpose of an ethical theory is to assist decision-makers in analyzing and resolving moral dilemmas.¹³⁹ The subsequent ethical theories were selected out of relevance in determining whether or not the implementation of PBA is morally and ethically permissible.

2.1.1.1. Consequentialism

Consequentialism states that an action will be determined solely by its consequences; thus, requiring the actor to assess all possible consequences of each option.¹⁴⁰ The action providing the best overall consequence would be the most appropriate action.^{141,142,143}

2.1.1.2. Utilitarianism

Utilitarianism is an extension of consequentialism, it states that the action producing the “greatest happiness” for the greatest amount of people is most appropriate; if harm is inevitable, the action producing the least harm is the best option.^{144,145,146}

¹³⁹ TL Beauchamp ... et al *Contemporary Issues in Bioethics* 7 ed (2008) 12.

¹⁴⁰ J Herring *Medical Law and Ethics* 3 ed (2010) 12.

¹⁴¹ RM Hare 'A Utilitarian Approach' in H Kuhse & P Singer (eds) *A Companion To Bioethics* 2 ed (2009) 85, 85.

¹⁴² N Taylor 'Consequentialism and the Ethics of Planning Research' in FL Piccolo & H Thomas (eds) *Ethics and Planning Research* (2009) 13.

¹⁴³ K McShane 'The Bearers of Value in Environmental Ethics' in A Hiller, R Ilea & L Kahn (eds) *Consequentialism and Environmental Ethics* (2014) 17, 21.

¹⁴⁴ S Wilkens *Beyond Bumper Sticker Ethics: An Introduction to Theories of Right and Wrong* 2 ed (2011) 100.

¹⁴⁵ G Varner 'Animals in Agriculture' in GL Comstock (ed) *Life Science Ethics* 2 ed (2010) 239, 245.

¹⁴⁶ T Tannsjo *Understanding Ethics* 3 ed (2013) 18.

Regarding PBA, consequentialism aids us in analyzing the positive and negative consequences of legally implementing and proscribing PBA. Subsequently, utilitarianism allow us to determine which action (proscription or implementation) will produce the most benefit or the least harm to the greatest number of people. Hence, both theories are relevant in assisting us in examining whether or not PBA is ethically permissible. This issue will be explored in Chapters 5 and 6.

2.1.1.3. Deontology

Deontology centers on the moral characteristics of the action; irrespective of the consequences, an action will either be right or wrong^{147,148} For instance the act of harm or killing is unacceptable regardless of the consequences¹⁴⁹. Deontology is synonymous with Kantianism since it stems from the theories of Immanuel Kant.¹⁵⁰

Deontology is germane to the issue of fetal pain. Deontology asserts that harm and killing defies the dictates of morality, similarly encourages us to consider if there are ways to avert fetal pain in the context of LTOP or whether there is an alternative to LTOP. These issue will be covered in Chapters 5, 6 and 7.

2.1.1.4. Virtue Ethics

Virtue ethics places emphasis on the actor's character.¹⁵¹ Virtue ethicists believe that an actor equipped with the necessary skills, experience, virtuous character and good intention, will produce morally good actions.^{152,153}

¹⁴⁷J Mizzoni *Ethics: The Basics* (2010) 104.

¹⁴⁸ M Johnstone *Bioethics: A Nursing Perspective* 5 ed (2009) 63.

¹⁴⁹ J Mandal, DK Ponnambath and SC Parija 'Utilitarian and deontological ethics in medicine' (2016) 6(1) *Tropical Parasitology* 5 – 7.

¹⁵⁰ E Cherkasova *Dostoevsky and Kant: Dialogues on Ethics* (2009) 7.

¹⁵¹ J Jackson *Ethics in Medicine* (2006) 25.

¹⁵² D Birsch *Introduction to Ethical Theories: A Procedural Approach* (2014) 162.

¹⁵³ R Loudon 'On Some Vices of Virtue Ethics' in H Geirsson & MR Holmgren (eds) *Ethical Theory: A Concise Anthology* (2001) 231, 231.

Thus, in determining whether or not an action is morally correct, consideration is given to the actor's character and intention.¹⁵⁴ Accordingly, an action is morally correct only if an actor possessing virtuous character performs it.¹⁵⁵

This theory is problematic. Although the physician may possess the necessary skill and experience, intention is subjective. Virtue ethics is relevant in determining why physicians are performing PBA. The motive of the physicians is indicative of whether PBA is unethically abused by physicians. This issue will be discussed in Chapters 5 and 6.

2.1.1.5. Feminist Bioethics

Feminist bioethics identifies, criticizes and subjugates the oppression of women; promotes equal rights; and strives to ensure equitable distribution of scarce resources.^{156,157} Feminist ethics places emphasis women's interests and issues exclusive to women, including TOP.^{158,159,160}

Feminists view TOP broadly and, their arguments focus on overcoming the injustices women are subjected to regarding abortion; thus, availability and accessibility of abortion services is of vital concern.¹⁶¹ Feminist ethics appreciates that women procure abortions for a number of reasons.¹⁶² Consequently, creating a need for safe and legal abortion services without

¹⁵⁴ Birsch (note 151) 162 – 163.

¹⁵⁵ J Oakley 'A Virtue Ethics Approach' in H Kuhse & P Singer (eds) *A Companion To Bioethics* 2 ed (2009) 91, 92 – 93.

¹⁵⁶ S Loue 'Feminist Ethics' in S Loue & M Sajatovic (eds) *Encyclopedia of Women's Health* (2004) 265, 265.

¹⁵⁷ MA Grodin 'Introduction: The Historical and Philosophical Roots of Bioethics' in MA Grodin (ed) *Meta Medical Ethics: The Philosophical Foundations of Bioethics* (2001) 1, 21.

¹⁵⁸A Donchin 'Bioethics: Feminist' in C Kramarae & D Spender *Routledge International Encyclopedia of Women: Global Women's Issue and Knowledge* (2000) 105, 106.

¹⁵⁹ Loue (note 155 above) 265.

¹⁶⁰ Grodin (note 156 above) 21.

¹⁶¹ S Sherwin 'Abortion Through A Feminist Ethics Lens' in L Gruen & GE Panichas (ed) *Sex, Morality and the Law* (1997) 318, 318 – 319.

¹⁶² *Ibid.*

restrictive policies that exacerbate maternal morbidity and mortality rates, this is paramount to feminist ethics.¹⁶³

Feminist ethics is relevant to PBA because it questions how implementation and proscription impacts the accessibility and availability of safe and legal TOP services. Additionally, it questions whether proscription constitutes a restrictive policy that unduly burdens access to TOP? More importantly, will proscription needlessly endanger women's lives? These issues will be addressed in Chapters 4 and 6.

2.1.2. Ethical principles¹⁶⁴

Principlism identifies and comprehends moral issues by applying each principle to a given issue, where principles conflict the significance of each one must be evaluated.¹⁶⁵ This will assist the decision-maker in finding a solution.

2.1.2.1. Respect for autonomy

Autonomy is founded on individual freedom and the right of choice, personal autonomy refers to self-governance.¹⁶⁶ Patients are entitled to make autonomous health care decisions; ergo, physicians are obligated to disclose relevant information unambiguously to patients before patients make their decisions.^{167,168}

Respecting patient autonomy requires physicians to recognize that patients are entitled to their opinions and beliefs, which influence their decisions; irrespective of whether the physician disagrees with the patient, autonomy must

¹⁶³ *Ibid.*

¹⁶⁴ Hereafter, referred to as "Principlism".

¹⁶⁵ Beauchamp (note 139 above) 22.

¹⁶⁶ TL Beauchamp & JF Childress *Principles of Biomedical Ethics* 6 ed (2009) 38 – 39.

¹⁶⁷ TK Svensson *A Bioethical Analysis of Sexual Reorientation Interventions: The Ethics of Conversion Therapy* (2003) 44.

¹⁶⁸ C Collier & RFC Haliburton *Bioethics in Canada: A Philosophical Introduction* (2011) 76.

be upheld.^{169,170} However, repudiation of patient-autonomy is justifiable if moral violations eventuate from the patient's actions.¹⁷¹

Informed consent is predicated on autonomy. Physicians are ethically obligated to solicit informed consent before provision of medical treatment, including TOP.¹⁷² In determining whether implementation and proscription of PBA is ethical we have to consider its effect on patient-autonomy. This matter will be addressed in Chapters 5 and 6.

2.1.2.2. Beneficence

Beneficence encompasses a range of duties providing assistance and abstention from harm; it has several meanings but it typically connotes the promotion of good deeds, kindness and charity.^{173,174,175}

Subsequently, beneficence can be narrowly defined as preventing harm and aiding others in promoting their significant and lawful interests, which can be obtained by abstention or prevention of possible harms.¹⁷⁶

2.1.2.3. Non-maleficence

¹⁶⁹ AE Hinkley 'Two Rival Understanding of Autonomy, Paternalism, and Bioethical Principlism' in HT Engelhardt (ed) *Bioethics Critically Reconsidered: Having Second Thoughts* (2012) 85, 85.

¹⁷⁰ B Maier & WA Shibles *Philosophy and Practice of Medicine and Bioethics: A Naturalistic-Humanistic Approach* (2011) 281.

¹⁷¹ Collier & Haliburton (note 168 above) 75.

¹⁷² JA Singh 'Law and the Health Professional in South Africa' in K Moodley (ed) *Medical Ethics, Law and Human Rights: a South African Perspective*. (2011) 109, 117.

¹⁷³ Beauchamp & Childress (note 165 above) 38 – 39, 151.

¹⁷⁴ D Dickenson, R Huxtable, & M Parker *The Cambridge Medical Ethics Workbook 2 ed* (2010) 195.

¹⁷⁵ RJ Devettere *Practical Decision Making in Health Care Ethics: Cases and Concepts 3 ed* (2010) 52.

¹⁷⁶ JE Snyder & CC Gauthier *Evidence-Based Medical Ethics: Cases for Practice-Based Learning* (2008) 11.

Non-maleficence translates to "do no harm".^{177,178} It requires the physician to avert harm to patients.¹⁷⁹

Yet, it is inevitable that the patient will be harmed for the purposes of their health. For instance, if the patient requires surgery and has provided informed consent, then operating on the patient will not constitute maleficence.¹⁸⁰

Ergo, non-maleficence could similarly mean that physicians should refrain from wantonly inflicting harm when alleviating pain and promoting well-being.¹⁸¹

In determining whether PBA is ethical, consideration must be given to whether it is beneficial or harmful to the patient's health. Beneficence and non-maleficence are relevant to the question of harm. Beneficence questions whether PBA benefits health and prevents harm. Non-maleficence questions whether PBA inflicts wanton harm to the fetus. These issues will be addressed in Chapters 5 and 6.

2.1.2.4. Justice

Justice usually connotes fairness, equity, and reason; an injustice occurs if someone is awarded more than what is deserve, or is unduly burdened.¹⁸²

In determining whether proscription of PBA is ethical, consideration must be given to whether it is just or oppressive? This principle is significant in determining whether proscription of PBA is equitable or a restrictive policy that

¹⁷⁷ FA Paola, R Walker & LL Nixon *Medical Ethics and Humanities* (2010) 180.

¹⁷⁸ JL Bernat *Ethical Issues in Neurology* 3 ed (2008) 11.

¹⁷⁹ RC O'Neill 'Ethics - the theory' in JA Rees, I Smith & J Watson (eds) *Pharmaceutical Practice* 5 ed (2014) 65, 69.

¹⁸⁰ KK Porter & GS Rai 'Principles of medical ethics' in GS Rai (ed) *Medical Ethics and the Elderly* (2009) 1, 5.

¹⁸¹ S Mehring *First Do No Harm: Medical Ethics in International Humanitarian Law* (2015) 38 - 39.

¹⁸² C Carr *Unlocking Medical Law and Ethics* 2 ed (2015) 15.

unduly burdens access to TOP services? These questions will be addressed in Chapters 4 and 6.

2.2. Religious Bioethics

A discussion on the ethics of TOP is incomplete without exploring religious ethics. Religious ethics often influence the choices of adherents of religions. Therefore, it is necessary to conduct a brief overview of religious views on abortion.¹⁸³

2.2.1. Abrahamic religions

2.2.1.1. Judaism

Halacha¹⁸⁴ places great emphasis on the infinite value of human life.^{185,186} Since the fetus is potential life, it does not enjoy the rights of adults; nevertheless, specific rights allocated to the fetus cannot be violated.^{187,188}

Although, abortion is not overtly mentioned in the Torah, Halacha condemns it; this is largely owed to the verse, "Whosoever sheddeth the blood of man in

¹⁸³ This discussion will be restricted to religions pertaining to South Africa and were selected as per national census. It will not provide an in-depth discussion on religious bioethics, as it is not the subject of this paper. See Statistics South Africa *Statistical Release P0138 Household Survey* (2014) available at <http://www.statssa.gov.za/publications/P0318/P03182014.pdf>.

¹⁸⁴ Refers to Jewish law.

¹⁸⁵ G Goldsand, ZRS Rosenberg & M Gordon 'Bioethics for clinicians: 22. Jewish bioethics' (2001) 164 (2) *Canadian Medical Association J* 220.

¹⁸⁶ RM Green 'The Jewish Perspective on GenEthics' in G Pfeleiderer, G Brahier & K Lindpaintner (eds) *GenEthics and Religion* (2010) 119.

¹⁸⁷ JR Baskin 'Abortion' in JR Baskin (ed) *The Cambridge Dictionary of Judaism and Jewish Culture* (2011) 1, 1.

¹⁸⁸ S Falk & D Judson *The Jewish Pregnancy Book: A resource for the Soul, Body & Mind during Pregnancy, Birth & the First Three Months* (2004) 34.

man, his blood shall be shed" - Genesis 9:6. This verse is interpreted to include the fetus; hence, feticide constitutes murder.^{189,190}

Necessity is the only exception to the prohibition on TOP and is founded on Halachic understanding of the concept of the 'rodef', whereby a believer is permitted to kill whoever threatens his or her life.^{191,192,193} Thus, if the fetus threatens the life of the woman and LTOP becomes necessary, the prohibition will be overturned.

In order to distinguish between the levels of necessity, Jewish bioethicists developed four categories of illness.¹⁹⁴ The first category, "discomfort" includes minor indispositions; the second, "minor illness" excludes illnesses requiring bed rest.¹⁹⁵ The third concerns severe but non-fatal illnesses requiring preventative treatment and/or bed rest; and the fourth concerns potentially fatal conditions.¹⁹⁶ Particular normative rules can be relaxed under certain circumstances depending on each category.¹⁹⁷ This ranges from strict adherence to normative rules (first category), to completely over turning any rule to avert death (fourth category).¹⁹⁸

¹⁸⁹ F Rosner *Biomedical Ethics and Jewish Law* (2001) 184-185.

¹⁹⁰ HT Engelhardt Jr. 'The Euthyphro's Dilemma Reconsidered: Variation on a Theme from Brody on Halakhic Method' in MJ Cherry & AS Ittis (eds) *Pluralistic Casuistry: Moral Arguments, Economic Realities, and Political Theory* (2007) 109, 118-119.

¹⁹¹ D Schiff *Abortion in Judaism* (2002) 87.

¹⁹² D Kohn 'Judaism' in S Sorajjakool, MF Carr & JJ Nam (eds) *World Religions for Health Professionals* (2010) 113, 123-124.

¹⁹³ GD Chryssides 'Abortion' in D Cohn-Sherbok, GD Chryssides & D El-Alami *Love, Sex and Marriage: Insights from Judaism, Christianity and Islam* (2013) 219, 222.

¹⁹⁴ JD Bleich 'The Obligation to Heal in the Judaic Tradition' in F Rosner & JD Bleich (eds) *Jewish Bioethics* (2000) 3, 31-32.

¹⁹⁵ *Ibid.*

¹⁹⁶ *Ibid.*

¹⁹⁷ *Ibid.*

¹⁹⁸ *Ibid.*

If continued pregnancy is potentially life-threatening it falls within the fourth category, necessitating TOP and failure to perform TOP in this instance constitutes murder.

2.2.1.2. Christianity

Catholicism

In Catholicism, the right to life reigns supreme; hence, it is used as the guiding principle for issues on abortion.¹⁹⁹ Catholic teachings state that life originates at conception, therefore, TOP is strictly prohibited.^{200,201} The fetus holds the same status and enjoys the same rights as its mother.²⁰²

Even though an emergency may necessitate TOP, the fetus must not be directly harmed. This belief is based on the “principle of double effect”, which states that if an act can produce consequences that could be both good or bad, the act will only be permitted if the good prevails.^{203, 204, 205} Consequently, if continued pregnancy is life-threatening, TOP remains prohibited unless the fetus is not harmed directly.²⁰⁶ Therefore, feticide is strictly prohibited, irrespective of the circumstances.

Protestantism

¹⁹⁹ HJ Markwell & BF Brown ‘Roman Catholic bioethics’ in PA Singer & AM Viens (eds) *The Cambridge Textbook of Bioethics* (2008) 436, 436.

²⁰⁰ MF Kohmescher *Catholicism Today: A Survey of Catholic Belief and Practice* 3 ed (1999) 139.

²⁰¹ GD O'Brien *The Church and Abortion: A Catholic Dissent* (2010) 15-16.

²⁰² J Trigilio & K Brighenti *Catholicism for Dummies* 2 ed (2013) 229.

²⁰³ E Gregory ‘Religion and Bioethics’ in H Kuhse & P Singer (eds) *A Companion To Bioethics* 2 ed (2009) 46, 50.

²⁰⁴ K Cassidy ‘A Convenient Untruth: The Pro-Choice Invention of an Era of Abortion Freedom’ in K Schmiesing (ed) *Catholicism and Historical Narrative: A Catholic Engagement with Historical Scholarship* (2014) 73, 76.

²⁰⁵ DF Kelly, G Magill & HT Have *Contemporary Catholic Health Care Ethics* 2 ed (2013) 108-109.

²⁰⁶ *Ibid.*

There is a myriad of Protestant beliefs and practices regarding abortion. Conservative groups prohibit TOP, believing that life begins at conception; others say that women's right of choice should be evaluated against the fetus' right to life; whilst some groups believe TOP is within the discretion of mother and physician in the first trimester.^{207, 208} Protestantism is considerably less restrictive than Catholicism, centering on maternal interests as opposed to fetal interests; thus, TOP is not restricted to necessity.^{209,210}

2.2.1.3. Islam

According to Islamic scholars there are five essential objectives of Sharia law: preserving religion, life, intellect, genealogy and property.²¹¹ Should an emergency arise directly threatening any of these values, it is permissible to overturn any normative prohibitions to eradicate it.²¹² Thus, if continued pregnancy directly threatens the life of the woman, TOP is permitted.

The Prophet Muhammad stated that the fetus undergoes three stages of fetal development consisting of 40 days, ensoulment of the fetus occurs at the end

²⁰⁷ M Pauls and RC Hutchinson 'Protestant Bioethics' in PA Singer & AM Viens (eds) *The Cambridge Textbook of Bioethics* 2008 430, 434.

²⁰⁸ SF Brown *Protestantism* 3 ed (2009) 131. See JP Wogaman 'Protestantism, Politics, Economics and Sociology' in AE McGrath & DC Marks (eds) *The Blackwell Companion to Protestantism* (2004) 287, 294.

²⁰⁹ TD Davis *Contemporary Moral and Social Issues: An Introduction through Original Fiction, Discussion, and Readings* (2014) 240.

²¹⁰ C Wilcox 'Evangelicals and Abortion' in M Cromartie (ed) *A Public Faith: Evangelicals and Civic Engagement* (2003) 101, 106.

²¹¹ RM Olwan *Intellectual Property and Development: Theory and Practice* (2013) 175; MO Farooq *Toward Our Reformation: From Legalism to Value Oriented Islamic Law and Jurisprudence* (2012) 90-91.

²¹² M Keshavjee *Islam, Sharia and Alternative Dispute Resolution: Mechanisms for Legal Redress in the Muslim Community* (2013) 9-10.

of 120 days.^{213,214,215} Upon ensoulment, the fetus is acknowledged as a person with most accompanying rights, and TOP is prohibited.^{216,217,218} The only exception that will override the 120-day restriction is necessity.^{219,220}

Post-ensoulment, TOP is permitted if the woman's health is at stake or the fetus suffers from an abnormality that could result in severe deformity.^{221, 222} TOP is similarly permissible if pregnancy arose from rape or incest, in which case two options are available to the woman: she can either keep the child or abort it before ensoulment.²²³ Failure to abort within the prescribed period obligates her

²¹³ DL Bowen 'Reproduction: Abortion and Islam' in S Joseph & A Nagmabadi *Encyclopedia of Women & Islamic Cultures Volume 3: Family, Body, Sexuality* (2006) 313, 313.

²¹⁴ S White & MU Anshor 'Islam and Gender in Contemporary Indonesia: Public Discourses on Duties, Rights and Morality' in G Fealy & S White (eds) *Expressing Islam: Religious Life and Politics in Indonesia* (2008) 137, 143.

²¹⁵ A Helie 'The Politics of Abortion Policy in the Heterogeneous "Muslim World" ' in C Raghavan & JP Levine (eds) *Self-determination and Women's Rights in Muslim Societies* (2012) 3, 13-14.

²¹⁶ R Khorfan & A Padela 'The Bioethical Concept of Life for L in Judaism, Catholicism, and Islam: Abortion when the Mother's Life is in Danger' (2010) 42 *J of the Islamic Medical Association of North America* 104.

²¹⁷ H Ziebertz & M Reindl 'Religion and Attitudes towards Euthanasia and Abortion' in JA van der Ven & H Ziebertz (eds) *Human Rights and the Impact of Religion* (2013) 119, 129-130.

²¹⁸ T Fischmann 'Distress and Ethical Dilemmas Due to Prenatal and Genetic Diagnostics' in T Fischmann & E Hildt (eds) *Ethical Dilemmas in Prenatal Diagnosis* (2011) 51, 60.

²¹⁹ M Saniei 'Human Embryonic Stem Cell Research in Iran: The Significance and Islamic Context' in MC Inhorn & S Tremayne (eds) *Islam and Assisted Reproductive Technologies: Sunni and Shia Perspectives* (2012) 194, 202.

²²⁰ H Shanawani & MH Khalil 'Reporting on "Islamic Bioethics" in the Medical Literature: Where Are the Experts?' in JE Brockopp & T Eich (eds) *Muslim Medical Ethics: From Theory to Practice* (2008) 213, 222.

²²¹ YA Alamri, 'Islam and Abortion' (2011) 43(1) *J of the Islamic Medical Association of North America* 40.

²²² AS Daar & AB Al Khitamy 'Bioethics for clinicians: 21. Islamic Bioethics' (2001) 164(1) *Canadian Medical Association J* 63.

²²³ *Ibid.*

to carry the fetus to term and raise it as her own; should she require assistance in raising the child, it will be granted to her.²²⁴

2.2.2. Eastern religions

2.2.2.1. Hinduism

Abortion is outlawed in Hindu scripture and defies the concept of 'ahimsa' or 'nonviolence' as it completely disregards the life of the developing fetus.²²⁵

There is evidence of Hinduism pro-life advocacy dating back to ancient times; during the Vedic period religious scripture permitted men to leave their wives for procuring TOP.²²⁶ The Dharma literature strictly prohibits abortion, so much so that the punishment for a woman procuring abortion is to lose her position in the caste system.²²⁷

The concept of karma and rebirth is relevant to TOP since the fetus is acknowledged as person from conception.^{228, 229, 230} Therefore, abortion is strictly banned unless an overriding circumstance presents itself requiring abortion out of necessity.^{231, 232} Furthermore, abortion violently halts the karmic

²²⁴ *Ibid.*

²²⁵ J Mayled and L Ahluwalia *Philosophy and Ethics for OCR GCSE Religious Studies* (2002) 128.

²²⁶ J Renard *Responses to 101 Questions on Hinduism* (1999) 66.

²²⁷ JG Lochtefeld *The Illustrated Encyclopedia of Hinduism Vol One: A-M* (2002) 3.

²²⁸ H Coward & T Sidhu 'Bioethics for Clinicians: 19. Hindu and Sikh Bioethics' (2000) 169(3) *Canadian Medical Association J* 1167 – 1168.

²²⁹ DC Maguire *Sacred Choices: The Right to Contraception and Abortion in Ten World Religions* (2001) 50.

²³⁰ Mayled & Ahluwalia (note 225 above) 128.

²³¹ A Faúndes & JS Barzelatto *The Human Drama of Abortion: A Global Search for Consensus* (2006) 88.

²³² J Bailey *Abortion* (2012) 33.

manifestation of the fetus' past lives. Therefore disrupting the destiny of the atman^{233,234}

2.2.3. African traditional religions

The fundamental belief of all African Traditional Religions²³⁵ is monotheism. God created the universe and mankind, the highest form of creation.^{236,237,238} Human life has infinite value and is a fundamental aspect of ATR as faith and life are intertwined.^{239,240,241}

African cultures place emphasis on procreation and child protection, irrespective of how the child was conceived.²⁴² Procreation is thought to be the sole purpose of marriage.²⁴³ According to African traditional culture, children belong to the community at large.²⁴⁴

²³³ Union of body and spirit.

²³⁴ C Damian 'Abortion from the Perspective of Eastern Religions: Hinduism and Buddhism' (2010) 8 (1) *Romanian Journal of Bioethics* 128.

²³⁵ Hereafter, referred to as "ATR".

²³⁶ F Nwaigbo 'Faith in the One God in Christian and African Traditional Religions: A Theological Appraisal (2010) 7 *African J Online* 60 – 61.

²³⁷ TO Aderibigbe 'Broken Calabashes: Yoruba Traditional Faith' in R Landau & E Blyth (eds) *Faith and Fertility: Attitudes Towards Reproductive Practices in Different Religions from Ancient and Modern Times* (2009) 179, 179.

²³⁸ R Ramakrishnan *Many Paths, One Destination: Love, Peace, Compassion, Tolerance and Understanding through World Religions* (2009) 312.

²³⁹ Nwaigbo (note 236 above) 63.

²⁴⁰ ES Mlingo *Elements of African Traditional Religion: A Textbook for Students of Comparative Religion* (2013) 55.

²⁴¹ NL Erskine *Plantation Church: How African American Religion Was Born In Caribbean Slavery* (2014) 60.

²⁴² F Tanju 'Multicultural/Multiethnic Divide: Interrogation of Politics, identity and Culture towards Transcending the Multiculturalism Conundrum' in MJ Tosam and P Takov (eds) *Philosophy in Culture: A Cross-Cultural Perspective* (2016) 87, 101.

²⁴³ GB, Tangwa 'Some African Reflections on Biomedical and Environmental Ethics' in K Wiredu (ed) *A Companion to African Philosophy* (2004) 387, 391.

²⁴⁴ W Lajul *African Philosophy: Critical Dimension* (2013) 111.

African traditionalists believe that abortion is equivalent to the murder of a child.^{245,246,247,248} The status of a fetus is equivalent to a child; ergo, the fetus possesses the right to life upon conception.²⁴⁹ Abortion is strictly prohibited, but permissible only if the pregnancy arose out of rape or incest.²⁵⁰ Poverty is not a valid ground for TOP.²⁵¹

2.3. Secular Morality & Abortion

Secular morality and secular ethics are necessary in order for heterogeneous societies to co-exist harmoniously, undeterred by religious dissimilarity.²⁵² Secular morality is void of religion;²⁵³ logic facilitates its moral understandings, which is reinforced by evidence.²⁵⁴ It concerns itself with what is right and good for humanity instead of what is sacred.²⁵⁵ Ergo, it can justify women's right to TOP for reasons²⁵⁶ consistent with their legal rights that are often incompatible religious beliefs²⁵⁷ such as career objectives and socio-economic position.²⁵⁸ Secular morality does not acknowledge the fetus as a person and moral agent,

²⁴⁵ AM Lugira *African Traditional Religion* (2009) 66.

²⁴⁶ H Kalu *Together as One: Interfaith Relationships Between African Traditional Religion, Islam and Christianity in Nigeria* (2011) 27.

²⁴⁷ OA Onwubiko *African Thought, Religion and Culture: Christian Mission and Culture in Africa, vol 1* (1991) 22-23.

²⁴⁸ RJ Gehman *African Traditional Religion in Biblical Perspective* (2005) 64.

²⁴⁹ MA Rakhudu ... et al 'Exploration of the views of traditional healers regarding the Termination of Pregnancy (TOP) law' (2006) 29(3) *Curationis* 56, 58-59.

²⁵⁰ *Ibid.*

²⁵¹ *Ibid.*

²⁵² B MacKinnon & A Fiala *Ethics: Theory and Contemporary Issues* 8th ed (2015) 30-31.

²⁵³ *Ibid.*

²⁵⁴ P Kurtz *Multi-secularism: A New Agenda* (2014) 106.

²⁵⁵ HT Engelhardt 'Abortion and the Culture Wars: Competing Moral Geographies and Their Implications for Bioethics' in A Caplan. ... et al *The Fulbright Brainstorms on Bioethics - Bioethics Frontiers and New Challenges* (2006) 27, 35.

²⁵⁶ See HT Engelhardt Jr 'Abortion and the Culture Wars: Competing Moral Geographies and Their Implications for Bioethics' in A Caplan ... et al *The Fulbright Brainstorms on Bioethics - Bioethics Frontiers and New Challenges* (2006) 33-34.

²⁵⁷ T Tomlinson *Methods in Medical Ethics: Critical Perspectives* (2012) 37.

²⁵⁸ Engelhardt (note 255 above) 33.

therefore abortion does not amount to murder; subsequently, legal personhood along with its corresponding rights are acquired after birth.²⁵⁹

Secular morality relies on medical evidence and reasoning to determine whether PBA is ethical. It questions the practicality of PBA and whether it is medically beneficial. The answers to these questions will then determine if PBA is medically necessary. These questions will be addressed in Chapter 6.

2.4. Boni Mores & Abortion

Boni mores refers to public policy or good morals.^{260, 261} It is an objective reasonableness criterion used to determine wrongful or unlawful conduct, and is linked to the legal convictions of society and the general standard of reasonableness.²⁶² It is used when common law issues lack authority or precedent, and when the court is requested to depart from precedent and strike new ground.²⁶³ It gives regard to "the prevailing values of society"²⁶⁴ and "society's perception of justice, equity, good faith and reasonableness."²⁶⁵ As South Africa evolved and developed different values and needs, so too did the boni mores to accommodate the country's new needs and values.²⁶⁶ Public reaction is not suggestive of the legal convictions of society and perception of reasonableness. Therefore, no consideration is given to the public's opinion on what is morally, ethically or religiously reprehensible when applying the boni mores test.²⁶⁷ Further, the legal convictions of the community include the

²⁵⁹ HT Engelhardt *The Foundations of Bioethics* 2 ed (1996) 271.

²⁶⁰ *Sasfin v Beukes* 1989 (1) SA 1 A at 8.

²⁶¹ C Rautenbach 'Deep Legal Pluralism in South Africa' in GR Woodman and Y Sezgin (eds) *The Journal of Legal Pluralism and Unofficial Law: Human Rights and Legal Pluralism* (2011) 143, 155.

²⁶² K Malan *Politocracy- An assessment of the coercive logic of territorial state and ideas around a response to it* (2012) 163-164.

²⁶³ *Compass Motors Industries (Pty) Ltd v Callguard (Pty) Ltd* 1990 (2) SA 520 (W) 527 H.

²⁶⁴ *Clark v Hurst NO. and Others* 1992 (4) SA 630 (D) 652 H.

²⁶⁵ *Compass Motors Industries (Pty) Ltd v Callguard (Pty) Ltd* 1990 (2) SA 520 (W) 528 I.

²⁶⁶ *Amod v Multilateral Motor Vehicle Accidents Fund* 1999 (4) SA 1319 (SCA), 1330 A.

²⁶⁷ *Van Eeden v The Minister of Safety and Security* 2003 (1) SA 386 (SCA), 396 C.

legislature and judiciary.²⁶⁸ Moreover, public policy must be consistent with the 1996 Constitution.²⁶⁹ Furthermore, Ngwena insists that a law is *contra boni mores* if it completely excludes fetal interests.²⁷⁰

We know from the previous chapter that the judiciary and legislature prioritize women's rights and interest regarding TOP. However, both statutory and common law recognize fetal interest, providing some form of fetal protection. Moreover, it is apparent that public policy acknowledges fetal interests. In determining whether PBA is unlawful, one must consider whether a TOP procedure exists that promotes women's interests but refrains from needlessly killing the fetus. Can PBA satisfy these requirements? Is there a method that does not employ feticide? These questions will be addressed in Chapter 7.

2.5. Conclusion

TOP is as much an ethical issue as it is a legal one. Bioethical theories and principlism are used to interpret, analyze, comprehend and resolve ethical dilemmas.²⁷¹ Ethical theories and principlism facilitate arguments for and against the use of PBA, and assists us in considering whether alternatives to LTOP exist. Therefore, bioethics is essential in determining whether the implementation of PBA is ethical. TOP is as much a religious and moral issue as it is a legal and ethical one. Thus, consideration must be given to religious bioethics. The ethics of the religions surveyed, unanimously permit TOP in cases of necessity. Catholicism is the only religion that prohibits feticidal TOP in life-threatening situations.²⁷² Islam and ATR make exceptions for cases of

²⁶⁸ *Ibid.*

²⁶⁹ *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC), para 56.

²⁷⁰ C Ngwena 'The history and transformation of abortion law in South Africa.' (1998) 30(3) *Acta Academia* 61. Ngwena states: "it would be *contra boni mores* to ignore the fact that, whether on account of religion, humanitarianism or science, the majority of people would be uncomfortable with a law that only concerned itself with the interests of the woman to the total exclusions of the foetus."

²⁷¹ Beauchamp (note 139 above) 12 & 22.

²⁷² Kelly (note 205 above) 108.

rape and incest.^{273,274} The religious differences regarding TOP necessitate the use of secular morality. Since it is completely divorced of religion,²⁷⁵ secular morality determines the ethical permissibility of PBA through reason and medical evidence.²⁷⁶ Furthermore, consideration must be given to the boni mores or prevailing values of society.²⁷⁷ The boni mores test which has to be amplified by the values in the Constitution, will help us determine whether PBA is unlawful and should be proscribed according to the legal convictions of society.²⁷⁸ Secular and religious bioethics, secular morality and the boni mores will be used to develop arguments in support of and against PBA, as well as to consider alternative methods to fetidical LTOP procedures in Chapters 5, 6 and 7 respectively.

²⁷³ Alamri (note 221 above) 40.

²⁷⁴ Rakhudu (note 249 above) 56.

²⁷⁵ MacKinnon & Fiala (note 252 above) 30 – 31.

²⁷⁶ Kurtz (note 254 above) 106.

²⁷⁷ Clark (note 264 above) 652 H.

²⁷⁸ Van Eeden (note 267 above) 396 C.

CHAPTER 3

3. ABORTION PROCEDURES, INDUCED FETAL DEMISE & NEONATAL PALLIATIVE CARE

This chapter examine various surgical abortion procedures, induced fetal demise and neonatal palliative care. It is necessary to familiarize ourselves with these procedures because they will be frequently discussed and compared in subsequent chapters.

3.1. First Trimester

3.1.1. Manual vacuum aspiration²⁷⁹

MVA is used between seven and ten²⁸⁰ weeks of pregnancy.

MVA involves the insertion of a 4 to 16 mm metal rod called a cannula to dilate the cervix.²⁸¹ Upon cervical dilation, a 50 - 60 ml self-locking vacuum syringe is used to clear the uterus by continuously moving the cannula in and out of the uterus whilst simultaneously rotating the unit to ensure the complete removal of uterine wall.²⁸²

MVA is an outpatient procedure and the most cost effective surgical TOP procedure with an exceptional success rate and minimal risk of complications.²⁸³

3.1.2. Suction & curettage²⁸⁴

²⁷⁹ Hereafter, referred to as "MVA".

²⁸⁰ TL Callahan & AB Caughey *Blueprints in Obstetrics & Gynecology* 6 ed (2013) 339.

²⁸¹ World Health Organization *Safe Abortion: Technical and Policy Guidance for Healthy Systems* 2 ed (2012) 41.

²⁸² H Hamoda ... et al 'Surgical abortion using manual vacuum aspiration under local anesthesia: a pilot study of feasibility and women's acceptability' (2005) 31(3) *J Family Planning and Reproductive Health Care* 185 – 187.

²⁸³ Manual Vacuum Aspiration (MVA) *A Quick Reference Guide for Clinician*, Association of Reproductive Professionals (2004) 2-3.

²⁸⁴ Hereafter, referred to as "S&C".

S&C is used in 97 per cent of abortions, it is one of the most effective and safest procedures; it is used between seven and 13 weeks of pregnancy.^{285,286}

This procedure usually involves the mechanical dilation of the cervix, thereafter a suction cannula is used to remove the contents of the uterus and sharp curettage may be required to ensure that no fetal tissue remains behind.^{287,288}

This is done by using a para-cervical or uterosacral block with a local anesthetic and IV conscious sedation; general anesthesia is rarely administered to the patient, who is given antibiotic prophylaxis on the day of the procedure to prevent post abortion endometriosis.²⁸⁹

S&C has proven to be the safest of all surgical termination procedures, with exceptional success rates and minimal risks; the maternal mortality rate is rare at 0.1 in 100 00.²⁹⁰

3.1.3. Dilation & curettage²⁹¹

D&C is performed within the first 12 weeks of gestation.²⁹²

²⁸⁵ S Alters & W Schiff *Essential Concepts for Healthy Living Update* 5 ed (2011) 124.

²⁸⁶ L Impey & T Child *Obstetrics and Gynecology* 4 ed (2012) 122.

²⁸⁷ S Gupta *A Comprehensive Textbook of Obstetrics and Gynecology* (2011) 365.

²⁸⁸ RS Berkowitz & DP Goldstein 'Gestational Trophoblastic Neoplasia' in JS Berek & NF Hacker (eds) *Berek and Hacker's Gynecologic Oncology* 5 ed (2010) 593, 597-598. See SA Vasilev 'Perioperative Care' in PJ DiSaia ... et al (eds) *Women's Health Review: A Clinical Update in Obstetrics-Gynecology* (2012) 361.

²⁸⁹ Callahan (note 280 above) 338 – 339.

²⁹⁰ *Ibid* 339.

²⁹¹ Hereafter, be referred to as "D&C".

²⁹² R Sharma & Z Mohsin 'Surgical Methods of Abortion - Dilation and Curettage or Evacuation' in N Malhotra ... et al (eds) *Operative Obstetrics & Gynecology* (2014) 478, 478. See NT Hatfield *Introductory Maternity and Pediatric Nursing* 3 ed (2013) 87.

Cervical dilations transpire via a series of dilators and sharp metal curettes that scrape the inside of the uterine walls.^{293,294} It is not as safe as MVA and it is considerably more painful, the complication rates are much higher than with vacuum aspiration.^{295,296} Hence, MVA is preferable to D&C given the minimal complications and the general comfort of the procedure in comparison to D&C; the latter is scarce due to the availability of newer and safer procedures.²⁹⁷

3.2. Second Trimester

3.2.1. Dilation & evacuation

D&E is employed between 13^{298,299} and 22 weeks of pregnancy.³⁰⁰ As you will note D&E is quite similar to D&C, the only difference being that there needs to be wider cervical dilation; this is trite given the development fetus during the second semester.

D&E involves a combination of extraction forceps and suction, as well as sharp curettage to ensure complete removal of the uterine contents, especially if the fetus is has a gestational age of more than 16 weeks.^{301,302} Since the uterine content is greater, the cervix is dilated gradually using osmotic dilators that will be placed into the cervix a day before surgery and expand between 12 to 18

²⁹³ CRB Beckmann ... et al *Obstetrics and Gynecology* 6 ed (2010) 298.

²⁹⁴ LY Littleton-Gibbs & J Engebretson *Maternity Nursing Care* 2 ed (2012) 235.

²⁹⁵ LL Alexander ... et al *New Dimensions in Women's Health* 6 ed (2014) 129.

²⁹⁶ MS Rosenthal *Human Sexuality: From Cells to Society* (2013) 312.

²⁹⁷ Beckmann (note 293 above) 298.

²⁹⁸ DG Chambers 'Medical and Surgical Induced Abortion' in S Sifakis & N Vrachnis (eds) *From Preconception to Postpartum* (2012) 114.

²⁹⁹ R Crooks & K Baur *Our Sexuality* 12 ed (2014) 322.

³⁰⁰ Chambers (note 298 above) 118.

³⁰¹ D Chou & S Ural 'Operative Obstetrics' in M Morgan & S Siddighi (eds) *Obstetrics and Gynecology* 5 ed (2005) 130, 139.

³⁰² Alexander (note 295 above) at 129-130.

hours, dilating the cervix.³⁰³ Thereafter, a suction cannula is used to remove the uterine contents.^{304,305}

If the fetus is older than 16 weeks, forceps will be used in conjunction with S&C to clear the uterus.^{306,307,308} Subsequently, requiring the physician to ensure that the major fetal parts are present, in which case ultrasound can be used to guarantee complete removal.³⁰⁹ D&E has exceptional success rates, yet involves a higher risk of complication and maternal mortality than MVA and S&C, however, D&E is safer than induced abortion when the fetus has a gestational age exceeding 16 weeks.³¹⁰

3.2.2. Induction of labor³¹¹

IOL induces TOP through natural delivery by stimulating cervical dilation and contractions through the administration of mifepristone and misoprostol, which

³⁰³ These will be placed into the cervix a day before surgery and expand between 12 to 18 hours dilating the cervix.

³⁰⁴ A Bolin & P Whelehan *Human Sexuality: Biological, Psychological, and Cultural Perspectives* (2009) 323.

³⁰⁵ JT Jenson & DR Mishell Jr. 'Family Planning: Contraception, Sterilization, and Pregnancy Termination' in GM Lentz, RA Lobo, DM Gershenson ... et al *Comprehensive Gynecology* 6 ed (2012) 215, 268.

³⁰⁶ L Garcia *The Least of These: Calling on America's Youth to Defend the Unborn* (2010) 32.

³⁰⁷ A Kuebelbeck & DL Davis *A Gift of Time: Continuing Your Pregnancy When Your Baby's Life is Expected to be Brief* (2011) 33.

³⁰⁸ N Phillips *Berry & Kohn's Operating Room Technique* 12 ed (2013) 710.

³⁰⁹ Callahan (note 280 above) 341.

³¹⁰ *Ibid.*

³¹¹ Hereafter, referred to as "IOL". Previously installation of intrauterine abortifacient agents including hypertonic saline and prostaglandin as well as hyperosmolar urea was used to induce labor during the second semester. However, these methods were not safe and were discontinued in favor of safer methods. See L Freedman *Willing and Unable: Doctors' Constraints in Abortion Care* (2010) 154.

will induce abortion usually 24 hours after ingestion, or insertion of osmotic dilators into the cervix.³¹²

Thereafter, fetocidal agents including intra-amniotic saline, in combination with the prostaglandin to prevent live birth.^{313, 314, 315} These solutions usually asphyxiate and incinerate the fetus before delivering it intact.^{316,317}

3.2.3. Hysterotomy & hysterectomy

Hysterotomy is usually performed after the 18th week of pregnancy, it can result in live birth and deemed premature birth if the child survives.^{318,319}

The fetus is removed via abdominal incision of the uterus, similar to caesarean section³²⁰ but it requires a substantially smaller incision.³²¹ It is performed under general anesthetic and considered major abdominal surgery. Hysterotomy is performed when the fetus is too large³²² or when alternative TOP procedures are not feasible, for instance the patient has a large tumor or cervical cancer.³²³

³¹² L Borgatta & N Kapp 'Clinical guidelines. Labor induction in the second trimester. (2011) 84(1) *Contraception* 4.

³¹³ R Alcorn *Pro-Life Answers to Pro-Choice Arguments – Expanded & Updated* (2000) 185.

³¹⁴ C Kaczor *The Ethics of Abortion: Women's Rights, Human Life and the Question of Justice* 2 ed (2015) 159.

³¹⁵ H Konar *DC Dutta's Textbook of Obstetrics and Perinatology and Contraception* 7 ed (2014) 175-176.

³¹⁶ FD Cox & K Demmit *Human Intimacy: Marriage, the Family, and Its Meaning* 11 ed (2014) 250.

³¹⁷ S Martinelli-Fernandez, L Baker-Sperry & H McIlvaine-Newsad (eds) *Interdisciplinary Views on Abortion: Essays from Philosophical, Sociological, Anthropological, Political, Health and Other Perspectives* (2009) 38 - 39

³¹⁸ SC Butkus (ed) *Maternal-Neonatal Nursing Made Incredibly Easy!* 3 ed (2015) 94.

³¹⁹ A Pillitteri *Maternal & Child Health Nursing: Care of the Childbearing & Childbearing Family* 6 ed (2010) 142.

³²⁰ M Potts, P Diggory & J Peel *Abortion* (1977) 199-200.

³²¹ RE Jones & KH Lopez *Human Reproductive Biology* 4 ed (2014) 281.

³²² LW Sumner *Abortion and Moral Theory* (1981) 7.

³²³ Lohr & Lyus (note 9 above) 88.

Previously if born alive, physicians would smother the neonate with its own placenta or drown it in a bucket of water.³²⁴ Contemporary practice involves a fetocidal injection to ensure feticide.^{325,326,327}

Hysterectomy entails the complete removal of the uterus, fetus included; both procedures are used in 0.7 per cent of second trimester abortions.^{328,329,330}

3.2.4 Intact dilation & extraction

D&X is a variation of D&E.³³¹ It is usually performed between 20 and 24 weeks³³² and possibly in the third trimester³³³

D&X typically consists of four elements.³³⁴

1. Deliberate cervical dilation using several serial osmotic dilators for two days or more;
2. conversion into breech position;
3. breech extraction of the fetus excluding the head;

³²⁴ SD Schwarz & K Latimer *Understanding Abortion: From Mixed Feelings to Rational Thought* (2012) 62.

³²⁵ P Sharma *Midwifery and Obstetrical Nursing* (2010) 341.

³²⁶ The maternal mortality rate is incredibly high at 60 in 100 000 deaths. See Lohr & Lyus (note 9 above) 89.

³²⁷ W Cates Jr. & DA Grimes 'Morbidity & Mortality' in JE Hodgson (ed) *Abortion and Sterilization: Medical and Social Aspects* (1981) 155, 174.

³²⁸ JB Teitelbaum & S Wilensky (eds) *Essential Readings in Health Policy Law* (2008) 206.

³²⁹ NL Stotland *Abortion: Facts and Feelings: A Handbook for Women and the People who Care for Them* (1998) 49.

³³⁰ B Winikoff & S Wymelenberg *The Whole Truth About Contraception: A Guide to Safe and Effective Choices* (1997) 247.

³³¹ ST Chasen ... et al. 'Dilation and evacuation at ≥ 20 weeks: Comparison of operative techniques (2004) 190 *American J of Obstetrics and Gynecology* 1181.

³³² J Leo *Two Steps Ahead of the Thought Police* 2 ed (1998) 336.

³³³ V Tepe 'Abortion by Any Other Name' in Krista Jacob (ed) *Abortion Under Attack: Women on the Challenges Facing Choice* (2006) 129, 129.

³³⁴ D James ... et al. (eds) *High Risk Pregnancy Management Options* 4 ed (2010) 1161.

4. followed by cephalocentesis to induce vaginal delivery of the deceased intact fetus.³³⁵

3.3. Induced Fetal Demise

It is trite that fetocidal solutions have been used in conjunction with TOP to induced fetal demise prior to expulsion.

Intracardiac potassium chloride “and intra-fetal intra-amniotic digoxin injections” are the most common fetocidal solutions employed to induce fetal demise, yet they are rarely used for second-trimester TOP and LTOP.³³⁶ Both procedures are usually reserved for “selective termination” and “multifetal pregnancy reduction” that have resulted from fertility treatments.³³⁷

It is trite that saline solutions have been used to induce fetal demise along with LTOP procedures such as IOL. However neither saline nor intra-amniotic digoxin injections can ensure fetal demise; conversely intracardiac potassium chloride can regularly and effectively induce fetal demise through cardiac asystole via injection to the fetal heart.³³⁸ This begs the question, why has it yet to be incorporated in LTOP procedures? It is trite that failure to ensure fetal demise within the womb may have legal, ethical and medical consequences for the physician and patient.

Accordingly, it should be considered as a tool to be utilized in conjunction with fetocidal surgical TOP, particularly when the fetus approaches viability, to ensure fetal demise within the womb, especially if it is less destructive and traumatic than alternative fetocidal solutions.

3.4 Neonatal Palliative Care

³³⁵ *Ibid.*

³³⁶ J Diedrich & E Drey ‘Clinical Guideline – Induction of fetal demise before abortion.’ (2010) 81(6) *Contraception* 462 – 465.

³³⁷ *Ibid.*

³³⁸ Royal College of Obstetricians and Gynaecologists *the Care of Women Requesting Induced Abortion – Evidence-based Clinical Guideline Number 7* (2011) 57.

The principal objective of neonatal palliative care is to enhance the quality of life of those neonates afflicted with conditions that are life-limiting and life-threatening; it endeavors to assuage their suffering and ease their pain.³³⁹

Neonatal palliative care is generally aimed towards the following neonates:

- Extremely premature neonates requiring neonatal intensive care.³⁴⁰
- Neonates diagnosed with lethal conditions.³⁴¹
- Neonates in unbearable pain, thus rendering treatment is futile.³⁴²

Neonatal palliative care could present as a viable option to patients that do not wish to undergo LTOP in cases where the fetus is suffering from a life-threatening or life-limiting condition. On condition that TOP is not required and it is safe for the patient to deliver the fetus.

3.5. Conclusion

This chapter revealed that inevitably, all surgical abortion procedures are fetocidal, some of which are more destructive than the other. Nevertheless, all of abortion procedure fulfil the same purpose and which is TOP. It is important for the reader to familiarize themselves with these procedures as they will be frequently referred to in Chapters 5 and 6. This chapter further briefly touched upon induced fetal demise as a method that could potentially prevent legal, ethical and medical implications that may arise in the event that fetal demise is not achieved in the womb. Neonatal palliative was also discussed as a possible alternative to LTOP. Both procedures will be discussed further in Chapter 7.

³³⁹ National Association of Neonatal Nurses *Palliative and End-of-Life Care for Newborns and Infants – Position Statement #3063 February 2015* (2015) available at

http://nann.org/uploads/About/PositionPDFS/1.4.5_Palliative%20and%20End%20of%20Life%20Care%20for%20Newborns%20and%20Infants.pdf.

³⁴⁰ A Mancini ... et al. *Practical guidance for the management of palliative care on neonatal unit 1* ed (2014) 4 – 5 available at

<http://www.bamp.org/publications/documents/guidelines/NICU-Palliative-Care-Feb-2014.pdf>.

³⁴¹ *Ibid.*

³⁴² *Ibid.*

CHAPTER FOUR

INTERNATIONAL & FOREIGN LAW

Section 39(1) of the 1996 Constitution states: “When interpreting the Bill of Rights, a court, tribunal or forum must consider international law; and may consider foreign law.” Accordingly, an overview of international human rights law³⁴³ international guidance documents, and foreign law regarding abortion is offered. The following rights, particularly Right to Life applies to the mother – not the fetus which has no rights under the Bill of Rights.³⁴⁴

4.1. International Law

IHRL is authoritatively interpreted by United Nations treaty bodies³⁴⁵, which support women's right to autonomous reproductive health choices, including TOP.³⁴⁶ Although, most international treaties do not explicitly address TOP, it is evident from the interpretation of the following rights that IHRL promotes women's right to access TOP without State interference.³⁴⁷

Right to Life – The International Covenant on Civil and Political Rights,³⁴⁸ Article 6(1); African Charter on Human and Peoples Rights,³⁴⁹ Article 4; and Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa,³⁵⁰ Article 4(1), unanimously recognize everyone's inherent and inviolable right to life, which must be respected, legally protected and must not be arbitrarily deprived. We are aware that continued pregnancy may be life-

³⁴³ Hereafter, referred to as “IHRL”.

³⁴⁴ CLA 1998 (note 111 above) 1122I – 1123B/C.

³⁴⁵ Hereafter, referred to as “UN”.

³⁴⁶ I Bantekas & L Oette *International Human Rights Law and Practice* (2013) 63.

³⁴⁷ *Ibid.*

³⁴⁸ International Covenant on Civil and Political Rights 999 UNTS 171. (Hereafter, referred to as “ICCPR”).

³⁴⁹ African [Banjul] Charter on Human and Peoples' Rights, (1982) 121 *ILM* 58.

(1982) entered into force Oct. 21, 1986. (Hereafter, referred to as the “African Charter”).

³⁵⁰ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa CAB/LEG/66.6 (Sept. 13, 2000); 1 *Afr. Hum. Rts. L.J.* 40 (2001). (Hereafter, referred to as the “Maputo Protocol”).

threatening; thus, preventing TOP in such cases directly compromises the right to life.

Rights to Health & Equality – The International Covenant on Economic, Social and Cultural Rights,³⁵¹ Article 12(1) requires member States to acknowledge everyone's right to health.

The Committee on Economic Social and Cultural Rights, General Comment 14 on the right to the highest attainable standard of health, explains that the right to health and health care includes women's reproductive health care.³⁵² It suggests that States provide high quality reproductive services, prevent health risks and reduce maternal mortality; stating that the realization of the right to health "requires the removal all barriers interfering with access to health services... including... reproductive health."³⁵³

The Maputo Protocol, Article 14(1) says: "State Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted". Article 14(2)(c) compels State Parties to implement suitable measures to ensure the protection of women's reproductive rights by providing TOP in instances of rape and incest, as well as in life-threatening circumstances.

ICCPR, Articles 2(1) and 3 along with ICESCR, Articles 2(2) and 3, recognizes everyone's right to equality and non-discrimination. The Convention on the Elimination of All Forms of Discrimination against Women³⁵⁴ Article 1 defines discrimination against women as:

³⁵¹ International Covenant on Economic, Social and Cultural Rights G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No.16) at 49, U.N. Doc. A/6316 (1966). (Hereafter, referred to as the "ICESCR").

³⁵² ESCR, General Comment 14, The Right to the Highest Attainable Standard of Health, U.N. Doc. E/C.12/2000/4 (2000), para 8. (Hereafter, referred to as "General Comment 14").

³⁵³ *Ibid*, para 21.

³⁵⁴ Convention on the Elimination of All Forms of Discrimination Against Women GA res. 34/180, 34 UN GAOR Supp. (No. 46) at 193, UN Doc.

[A]ny distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women... of human rights and fundamental freedoms...

Article 12(1) of CEDAW states that:

State parties shall take all appropriate measures to eliminate discrimination against women... to ensure... access to health care services, including those related to family planning.

Access to safe TOP is essential, especially since abortion exclusively effects women.

CEDAW Committee General Recommendation 24 on women and health, advises States to refrain from "obstructing action taken by women in pursuit of their health goals." Additionally, "barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women..."³⁵⁵

Rights to liberty and security of person, privacy and information – The ICCPR, Article 9 protects the rights to liberty and security of person, privacy, and information. All of which are pertinent to the promotion of women's reproductive rights, including access to TOP.

The United Nations Human Rights Council classifies the denial of access of legal abortion services as torture, it has said that States domestically authorize

A/34/46; 1249 UNTS 13; 19 *ILM* 33 (1980). (Hereafter, referred to as the "CEDAW").

³⁵⁵ CEDAW Committee, General Recommendation 24, Women and Health (Article 12), U.N. Doc. No. A/54/38/Rev.1 (1999) para 14. (Hereafter, referred to as General Recommendation 24).

TOP must ensure that abortion services "are effectively available without adverse consequences to the woman or health professional."³⁵⁶

The United Nation's 1994 Cairo International Conference on Population and Development Programme of Action³⁵⁷ urges countries to strive toward global access to reproductive health services including sexual health and family planning, reduction of maternal mortality³⁵⁸ and the accommodation of mutable reproductive health needs.³⁵⁹ It states that, "reproductive health-care programs should be designed to serve the needs of women, including adolescents..."³⁶⁰

The World Health Organization states that MVA, D&C, and D&E are generally recommended for patient care; yet, hysterotomies and hysterectomies are contra-indicated due to the serious complications the procedures entail.^{361,362} D&X is not mentioned, nor is specifically contra-indicated.

D&X can be beneficial to women with rare medical conditions, including autoimmune diseases.³⁶³ Moreover, it could prevent significant health risks associated with TOP procedures requiring dismemberment, which could

³⁵⁶ United Nations Human Rights Council (UNHRC) *UNHRC Report of the Special Rapporteur on torture and other cruel, inhumane or degrading treatment or punishment* (1 February 2013) UN Doc A/HRC/22/53 page 23. (Hereafter, referred to as "UNHRC").

³⁵⁷ United Nations Population Fund *Programme of Action of the International Conference on Population Development 20th Anniversary Edition* (2014) available at http://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf.

³⁵⁸ *Ibid* 8, 47.

³⁵⁹ *Ibid* 61.

³⁶⁰ *Ibid* 62.

³⁶¹ World Health Organization *Clinical Practice Handbook for Safe Abortion* (2014) 22, 23 & 35. (Hereafter, referred to as "WHO 2014") available at http://apps.who.int/iris/bitstream/10665/97415/1/9789241548717_eng.pdf.

³⁶² World Health Organization, Department of Reproductive Health and Research *Safe Abortion: Technical and Policy Guidance for Healthy Systems* 2 ed (2012) 40 – 42. (Hereafter, referred to as "WHO 2012") available at http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf.

³⁶³ C Ruse 'Partial-birth Abortion on Trial' (2006) 31(2) *Human Life Review* 90.

adversely affect fertility.³⁶⁴ Additionally, women may personally prefer D&X because it does not involve dismemberment. Furthermore, it could be medically necessary when severe fetal malformations precipitate LTOP. For instance, in cases of hydrocephaly, cephalocentesis is necessary to reduce the diameter of the grossly enlarged fetal skull to prevent grievous harm to the patient.³⁶⁵

TOP is a personal and private matter exclusively affecting women. Not only should women be informed of salubrious TOP procedures, these procedures should be easily available and accessible. Therefore, proscription of D&X will abridge women's rights to privacy, choice, bodily integrity, information, and health care. Women requiring LTOP that suffer from blood diseases or autoimmune conditions may require D&X.³⁶⁶ If it is proscribed, women afflicted with these conditions will be unfairly discriminated against based on their health conditions and more importantly their lives could be jeopardized. What is more, this would be indicative of the States blatant disregard for women's health needs. Moreover, if the physician in good faith considers D&X medically necessary, lives could be needlessly endangered if it is proscribed. Consequently, infringing the rights to equality and non-discrimination, as well as life. Furthermore, physicians could be arbitrarily deprived of their rights to liberty for performing D&X in good faith if it is criminalized. Therefore, proscription constitutes a barrier to women's health and amounts to torture. Accordingly, PBA should be implemented and performed without legal consequence.

Evidently proscription of PBA has no standing in IHRL. Furthermore, the 1996 Constitution and CTOPA upholds and promotes the abovementioned rights. Consequently, it is highly improbable that South Africa will proscribe the implementation of PBA. Thus, IHRL appears to reinforce the implementation of

³⁶⁴ *Ibid.*

³⁶⁵ *National Abortion Federation, et al v. Ashcroft* 03 Civ. 8695 (RCC) Ruling and Opinion (hereafter, referred to as "NAF") at 59 available at http://prochoice.org/wp-content/uploads/naf_v_ashcroft_ruling_pdf.

³⁶⁶ Ruse (note 364 above) 90.

PBA, which could be a potentially life-saving procedure that allows women to exercise a number of human rights relevant to their reproductive and general health.

4.2. Foreign Law

Foreign law facilitates the examination of comparative abortion law, which will aid us in determining which countries have identified PBA as an issue and why. It assists us in establishing whether PBA is a pressing global issue demanding redress. The following countries, with the exception of United States of America, were selected on the basis of their shared legal and linguistic heritage as former British Commonwealth States.^{367, 368} Moreover, Commonwealth States possess shared constitutional principles; additionally, the Westminster model constitution influenced the constitutions of several former Commonwealth States, which enables courts to "share jurisprudence on constitutional matters".³⁶⁹ Although, The United States of America was not a Commonwealth State, its legal system originated from English common law, which formed the basis of federal and individual state law.³⁷⁰

4.2.1. United Kingdom

The Abortion Act 1967³⁷¹ regulates TOP laws in the United Kingdom.

According to the Abortion Act, TOP can only be performed "if two registered medical practitioners... in good faith" certify that:³⁷² (a) "the pregnancy has not exceeded its 24th week and that the continuance of the pregnancy" will pose a significant risk "of injury to the physical and mental health of the pregnant

³⁶⁷ Despite the fact that South African common law is highly influenced by Roman-Dutch law, English common law principles still hold influence in South African law and is still referred to when solving legal problems. See KK Mwenda *Comparing American and British Legal Education Systems: Lessons for Commonwealth African Law Schools* (2007) 3.

³⁶⁸ D Kleyn & F Viljoen *Beginner's Guide for Law Students* 4 ed (2010) 20.

³⁶⁹ J Hatchard *Directory of Commonwealth Law Schools 2003/2004* (2003) 51.

³⁷⁰ JM Scheb & JM Scheb II *Criminal Law* 6 ed (2012) 10.

³⁷¹ The Abortion Act 1967 c. 87 (Hereafter, referred to as the "Abortion Act").

³⁷² *Ibid* S 1.

women or any existing children...”;³⁷³ (b) abortion “is necessary to prevent grave, permanent injury to the mental or physical health of the pregnant woman”;³⁷⁴ (c) continued pregnancy will threaten the life of the woman;³⁷⁵ or (d) “there is a significant risk that if the child were born it would suffer from such physical or mental abnormalities, as to be seriously handicapped.”³⁷⁶

In an emergency context it is acceptable for one registered medical practitioner to perform TOP, provided he or she believes in good faith that it is obligatory to prevent death or irreparable harm to the mental or physical health of the patient.³⁷⁷

Further, TOP must be performed in a NHS hospital or any other authorized facility.³⁷⁸ NHS UK recommends D&E and IOL for LTOP³⁷⁹, D&X is not mentioned. The Abortion Act does not prescribe TOP procedures. Ergo, physicians must decide which TOP method is most appropriate for the patient. Therefore, the physician can perform D&X if he or she believes in good faith that it is safe and appropriate in the given circumstance.

The Abortion Act regulates abortion laws in England, Scotland and Wales. Hence, D&X is not legally proscribed in these countries and can be employed within the physician's discretion. Proscription of PBA will undermine the Abortion Act which endeavors to save the lives and promote the health of British women.

4.2.2. The Republic of Ireland & Northern Ireland

³⁷³ *Ibid* S 1(a).

³⁷⁴ *Ibid* S 1(b).

³⁷⁵ *Ibid* S 1(c).

³⁷⁶ *Ibid* S 1(d).

³⁷⁷ *Ibid* S 1(4).

³⁷⁸ *Ibid* S 1(3).

³⁷⁹ National Health Services (hereafter, referred to as “NHS”) Choices ‘How Is It Performed?’ available at www.nhs.uk/Conditions/Abortion/Pages/How-is-it-performed.aspx.

The Protection of Life during Pregnancy Act³⁸⁰ currently regulates abortion in Ireland.^{381,382}

PLDPA permits abortion on the following grounds: “Risk of loss of life from physical illness” – TOP is legally permitted^{383(a)} if two medical practitioners can “certify in good faith that:”³⁸⁴ (i) “there is a real and substantial risk of loss of the woman’s life from a physical illness and”³⁸⁵ (ii) TOP is the only way to avert the risk.³⁸⁶ One of the two medical practitioners must be an obstetrician.³⁸⁷

³⁸⁰ Protection of Life during Pregnancy Act Number 35 of 2013. (Hereafter, referred to as “PLDPA”).

³⁸¹ Previously the Offences against Person Act 1861 24 & 25 Vic 100, regulated Irish abortion laws. S 58 of the Act criminalized the intent to procure an abortion. S 59 prohibited any person from supplying instruments, substances or drugs used to procure any unlawful abortions. Subsequently, the Criminal Justice Act (Northern Ireland) 1945 c. 15 created the offence of child destruction. S 25(1) of the Act criminalized the abortion of a child capable of being born alive unless it is proven that termination is necessary to preserve the life of the mother. Thus, creating an exception to the S 58 offence. These stringent laws lead to a number of cases illustrating Ireland’s unwillingness to provide safe and legal access to abortion services even when necessary. See *Attorney General v X* [1992] ILRM 401; *Northern Health and Social Services Board v F and G* [1993] NI 268; and *Northern Health and Social Services Board v A & Ors* [1994] NIJB 1.

³⁸² Ireland enacted PLDPA as a result of the global criticism surrounding the case of Savita Halappanavar. In 2012, Halappanavar was denied an abortion despite the fact that continued pregnancy severely jeopardized her health. She died as a result. Her death prompted Ireland to draft the POLDPA Bill. See, A McAuley 'The Challenges to Realising the Right to Health in Ireland' in B Toebees ... et al (eds) *The Right to Health: A Multi-Country Study of Law, Policy and Practice* (2014); K Pollitt *Pro: Reclaiming Abortion Rights* (2014); K Holland *Savita: The Tragedy That Shook a Nation* (2013) and C Meehan *A Just Society for Ireland? 1964 - 1987* (2013). Two years prior The European Court of Human Rights ordered Ireland to develop a legislative framework that guarantees the right to abortion in the instance where life is in danger. See *A, B and C v Ireland* NO 25579/05 Eur. Ct. H.R. (2010).

³⁸³ PLDPA (note 380 above) S 7(1).

³⁸⁴ *Ibid* S 7(1)(a).

³⁸⁵ *Ibid* S 7(1)(a)(i).

³⁸⁶ *Ibid* S 7(1)(a)(ii).

³⁸⁷ *Ibid* S 7(2).

“Risk of loss of life from physical illness in emergency” – TOP shall be lawful where ³⁸⁸(a) “a medical practitioner... believes in good faith that there is an immediate risk of loss of the woman's life from physical illness” ³⁸⁹ (b) and TOP is immediately necessary to save her life.³⁹⁰

“Risk of loss of life from suicide”– TOP shall be lawful where³⁹¹ (a) “three medical practitioners... certified in good faith that”³⁹² (i) “there is a real and substantial risk of loss of the woman’s life by way of suicide and”³⁹³(ii) TOP is necessary to prevent the risk.³⁹⁴ One medical practitioner must be an obstetrician³⁹⁵ and two must be psychiatrists.³⁹⁶

Although, PLDPA is not as expansive as the Abortion Act, similarities can be drawn between the two. Much like the Abortion Act, it seems as if PLDPA places emphasis on the role of the physician. It is left to the physician to decide whether or not abortion is necessary in the given circumstances. Furthermore, the wording of PLDPA, principally the words "believes in good faith" indicates that the physicians does not necessarily have to prove the existence of the grounds listed in Sections 7, 8, and 9. All that is required is the reasonable opinion of the physician made in good faith that TOP is necessary.

The Irish Family Planning Association lists D&E and IOL as the two methods employed for LTOP.³⁹⁷ However, PLDPA does not specify which abortion

³⁸⁸ *Ibid* S 8(1).

³⁸⁹ *Ibid* S 8(1)(a).

³⁹⁰ *Ibid* S 8(1)(b).

³⁹¹ *Ibid* S 9(1).

³⁹² *Ibid* S 9(1)(a).

³⁹³ *Ibid* 9(1)(a)(i).

³⁹⁴ *Ibid* S 9(1)(a)(ii).

³⁹⁵ *Ibid* S 2(a).

³⁹⁶ *Ibid* S 2(b)-(c).

³⁹⁷ Irish Family Planning Association (hereafter, referred “IFPA”) *Medical & Surgical Abortion* available at <https://www.ifpa.ie/Pregnancy-Counselling/Your-Options/About-Abortion/Medical-Surgical-Abortion>.

procedures should be employed. Thus, the physician is at liberty to use whichever procedure is appropriate and suitable to the patient's unique situation. Therefore, it would not be unlawful for the physician to employ D&X, if according to his or her reasonable opinion it would be the most appropriate method in a given circumstance. Thus, the physician is not bound by the recommendations of the IFPA.

If Ireland were to proscribe D&X, which could be safer than D&E and even necessary in some instances, it could undermine the purpose of PLDPA by endangering lives and the health of Irish women.

4.2.3. United States of America

The term 'partial-birth abortion' originated in United States of America and is a colloquialism for D&X.³⁹⁸ According to the Centers for Disease Control and Prevention, 1.3 per cent of TOP are performed after 20 weeks of gestation.³⁹⁹ It is estimated that PBA represents less than 20 per cent of that statistic.⁴⁰⁰

The Partial-Birth Abortion Ban Act⁴⁰¹

The PBABA was enacted in 2003 and proscribed and criminalized PBA.⁴⁰² Those convicted under the PBABA have to either pay a fine, serve a two-year prison sentence, or both.⁴⁰³ However, the PBABA includes a health exception

³⁹⁸ Hull & Hoffer (note 4 above) 276.

³⁹⁹ SH Ainsworth & TE Hall *Abortion Politics in Congress: Strategic Incrementalism and Policy Change* (2011) 7.

⁴⁰⁰ *Ibid* 8.

⁴⁰¹ Partial-Birth Abortion Ban Act Pub.L. 108-105. (Hereafter, referred to as the "PBABA") available at <https://www.law.cornell.edu/uscode/text/18/1531>.

⁴⁰² *Ibid* S 1(A) states: "the term "partial-birth abortion" means an abortion in which the person performing the abortion — deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus..."

⁴⁰³ *Ibid* (a).

in life-threatening cases.⁴⁰⁴The constitutionality of PBABA was challenged in *Gonzales v Carhart* 550 U.S. 124 (2007). Before we analyze this ruling it is necessary to review three landmark cases that shaped the judgment delivered in the aforementioned case.

*Roe v Wade*⁴⁰⁵

The constitutionality of Texan statutory law criminalizing TOP was brought under scrutiny in *Roe*. Articles “1191-1194 and 1196 of Texas State Penal Code” prohibited individuals from procuring and attempting to procure abortion⁴⁰⁶ except in cases of necessity.⁴⁰⁷ Jane Roe was denied access to safe abortion services because her life was not endangered.⁴⁰⁸ Furthermore, she lacked the necessary funds to travel across state to legally and safely procure TOP.⁴⁰⁹ *Roe* then sought a declaratory judgment declaring Texan abortion laws prima facie unconstitutional, unconstitutionally ambiguous and infringed her constitutional right to privacy.⁴¹⁰

The Supreme Court found that State laws prohibiting abortion without considering the period of gestation violates the Due Process Clause of the Fourteenth Amendment safeguarding women's privacy rights, inclusive of TOP, against State action.⁴¹¹ Although, the State cannot override the right to privacy, it does have a genuine interest in preserving the health of both mother and child; the latter's interests advance during the progression of pregnancy.⁴¹²

In the first trimester, decisions regarding TOP are to be determined by the woman's physician, thereafter the State has the option of regulating abortion

⁴⁰⁴ *Ibid.*

⁴⁰⁵ *Roe v Wade* 410 U.S. 113 (1973). (Hereafter, referred to as “*Roe*”).

⁴⁰⁶ *Ibid* 118.

⁴⁰⁷ *Ibid* 119.

⁴⁰⁸ *Ibid* 120 – 121.

⁴⁰⁹ *Ibid.*

⁴¹⁰ *Ibid.*

⁴¹¹ *Ibid* 163 – 164.

⁴¹² *Ibid.*

procedures salubrious to women's health.⁴¹³ The Texan criminal abortion law was deemed unconstitutional.⁴¹⁴

*Planned Parenthood of South Pennsylvania v Casey*⁴¹⁵

This case concerned the following provisions of the Pennsylvania Abortion Control Act of 1982: S 3205,⁴¹⁶ S 3206,⁴¹⁷ S3209,⁴¹⁸ S 3203,⁴¹⁹ and S 3214.⁴²⁰

The petitioners sought an order declaring the provisions prima facie unconstitutional.⁴²¹

The Supreme Court upheld the following three aspects of Roe:

1. Women are legally entitled to TOP without undue State interference before fetal viability.⁴²²

⁴¹³ *Ibid.*

⁴¹⁴ *Ibid* 166.

⁴¹⁵ *Planned Parenthood of South Pennsylvania v Casey* 505 U.S. 833 (1992). (Hereafter, referred to as "Casey").

⁴¹⁶ *Ibid* 902. This section states that abortion cannot be performed without the voluntary and informed consent of the woman (save for emergencies). Further, at least 24 hours before the abortion is performed, the attending physician is required to inform the woman of the nature of the procedure or treatment along with the risks and alternatives of the procedure

⁴¹⁷ *Ibid* 904. This section states that unless there is an emergency situation, a minor or mentally incompetent woman is required in the case of a minor to provide the attending physician with the informed consent of at least one of her parents along with her own. In the case of the mentally incompetent woman, she must provide her own consent along with that of her guardian

⁴¹⁸ *Ibid* 908. This section requires that a married woman provide the attending physician with a signed statement that she notified her spouse of her intention to procure an abortion. Unless an exception applies under this section.

⁴¹⁹ *Ibid* 902.

⁴²⁰ *Ibid* 909-10. This section concerns the reporting requirements placed on facilities that provide abortions to women.

⁴²¹ *Ibid* 845.

⁴²² *Casey* (note 416 above) 846.

2. The State has the authority to restrict TOP post viability, provided an exception exists in the law permitting TOP in cases of necessity.⁴²³

3. The State holds a genuine interest in safeguarding the health of mother and child.⁴²⁴

Nevertheless, the court rejected the trimester framework developed in *Roe*. It stated that although women are entitled to TOP before fetal viability, there is no reason why the State cannot take steps to assist the woman in making informed reproductive decisions.⁴²⁵ The Supreme Court reasoned that the State does have the authority to enact rules and regulations aimed at encouraging women to acknowledge adoption as a viable option to TOP.⁴²⁶ Moreover, the State will assist her to a certain extent if she decide to keep the child.⁴²⁷

The Supreme Court concurred that the “trimester framework” undermined the State's fetal interest; the judges employed the undue burden standard to determine the constitutionality of the provisions.⁴²⁸ It was found that none of the provisions were unduly burdensome, save for S 3214.⁴²⁹

*Stenberg v Carhart*⁴³⁰

The State of Nebraska imposed an injunction on PBA, contravention of the ban would result in the revocation of the offender's national medical license.⁴³¹ Carhart contended that the law violated the Federal Constitution.⁴³²

⁴²³ *Ibid.*

⁴²⁴ *Ibid.*

⁴²⁵ *Ibid* 872.

⁴²⁶ *Ibid.*

⁴²⁷ *Ibid.*

⁴²⁸ *Ibid* 874.

⁴²⁹ *Ibid.*

⁴³⁰ *Stenberg v Carhart* 530 U.S 914 (2000). (Hereafter, referred to as “Stenberg”).

⁴³¹ *Ibid* 922.

⁴³² *Ibid* 922 – 923. The District Court deemed the statute to be unconstitutional and on appeal the Eighth Circuit affirmed.

The Court reasoned that as pregnancy progresses, D&E necessitates fetal dismemberment, which entails the removal of fetal parts via the cervix through to the birth canal but D&E is the safest LTOP procedure.⁴³³

D&X is an alternative to D&E employed after 16 weeks of gestation, and since D&X occasions the removal of the intact fetus, fewer instruments penetrate cervix, resulting in fewer complications.⁴³⁴ The District Court preferred D&X since it is more salubrious to women's health.⁴³⁵

The court found the ban to be unconstitutional for two reasons: it lacked a health exception and imposed an undue burden on women:

Health Exception – The court was of the view that the injunction did nothing to strengthen Nebraska's interest in fetal protection.⁴³⁶ There are several feticidal TOP methods available for use pre-viability and post-viability.⁴³⁷ Thus, irrespective of any State interest, a health exception is necessary.⁴³⁸

Further, the government's constitutional obligation to permit TOP where "necessary in appropriate medical judgment" indicates that the government must acknowledge differing medical opinions.⁴³⁹ If medical authorities assert that prohibition of a certain procedure could be life-threatening, a health exception is required.⁴⁴⁰

Undue Burden – The court found that the prohibition was inclusive of D&E as it specifically proscribes:

⁴³³ *Ibid* 924 – 926.

⁴³⁴ *Ibid* 927 – 929.

⁴³⁵ *Ibid*.

⁴³⁶ *Ibid* 930.

⁴³⁷ *Ibid*.

⁴³⁸ *Ibid* 931.

⁴³⁹ *Ibid* 937.

⁴⁴⁰ *Ibid* 938.

the delivery of a substantial portion of a living child for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child.⁴⁴¹

According to the Court, D&E requires the dismemberment of substantial parts of the living fetus through the vagina, subsequently resulting in “the delivery of substantial portion of the fetus.”⁴⁴² Consequently, the court found that the ban must be struck down for imposing an undue burden.⁴⁴³

*Gonzales v Carhart*⁴⁴⁴

The court held that the PBABA promotes the government's genuine and significant interest in safeguarding the life of the fetus.⁴⁴⁵ Further, the PBABA was not void for vagueness,⁴⁴⁶ nor did it excessively burden women.⁴⁴⁷

The court noted that according to Casey, the State does have a valid and considerable interest in protecting the life of the fetus.⁴⁴⁸ Yet, Casey prevents the State from proscribing abortion pre-viability, which restricts the State from furthering its interests.⁴⁴⁹ Pre-viability, the State cannot adopt regulations that will unduly burden TOP.⁴⁵⁰ Post-viability, the State can proscribe abortion provided there is a health exception.⁴⁵¹

⁴⁴¹ *Ibid* 938.

⁴⁴² *Ibid* 939.

⁴⁴³ *Ibid* 945-46.

⁴⁴⁴ *Gonzales v Carhart* 550 U.S. 124 (2007). (Hereafter, referred to as “Gonzales”).

⁴⁴⁵ *Ibid* 14 – 16.

⁴⁴⁶ *Ibid* 16 – 20.

⁴⁴⁷ *Ibid* 20 – 26.

⁴⁴⁸ *Ibid* 14.

⁴⁴⁹ *Ibid* 15.

⁴⁵⁰ *Ibid* 15 – 16.

⁴⁵¹ *Ibid*.

It was alleged that PBABA encompasses D&X and D&E, rendering it unconstitutionally vague.⁴⁵² It was argued that physicians may unintentionally perform what is described as PBA within the Act, resulting in what could be considered vaginal delivery; consequently subjecting themselves to superfluous penalties.⁴⁵³ The court found that PBABA lists several "scienter requirements" requiring knowledge and intent, the definition makes provision for certain "anatomical landmarks" regarding fetal delivery.⁴⁵⁴ Thus, if the fetus is not delivered vaginally, the physician will not be penalized.⁴⁵⁵ Therefore, the PBABA does not excessively burden women.⁴⁵⁶

Moreover, the court opined that PBABA expresses "respect for the dignity of human life"⁴⁵⁷ and maintains the morality of the medical profession.⁴⁵⁸ Pertaining to the health exception, the court noted that if PBABA omitted a health exception it would be unconstitutional.⁴⁵⁹

Since *Gonzales*, 32 States have proscribed PBA with health exceptions ranging from broad to narrow depending on the state.⁴⁶⁰

The United States of America is the only country in the world to identify an issue with D&X.

4.2.4. Australia

⁴⁵² *Ibid* 16.

⁴⁵³ *Ibid* 24.

⁴⁵⁴ *Ibid* 17 – 18.

⁴⁵⁵ *Ibid*.

⁴⁵⁶ *Ibid* 26.

⁴⁵⁷ *Ibid* 27.

⁴⁵⁸ *Ibid* 28.

⁴⁵⁹ *Ibid* 31.

⁴⁶⁰ Guttmacher (note 20 above).

Australian abortion laws differ by state. The state of Victoria has some of the most liberal abortion laws.⁴⁶¹ Victoria's Abortion Law Reform Act⁴⁶² permits abortion on demand up to 24 weeks, provided a registered medical practitioner performs it.⁴⁶³ TOP is also available to females of any age.⁴⁶⁴ TOP can only be performed if, at least two physicians reasonably believe that TOP "is appropriate in all circumstances".⁴⁶⁵

VALRA does not regulate TOP procedures, this decision lies with the physician. Accordingly, if the physician reasonably believes that D&X is appropriate and necessary, it may be employed. Still, VALRA remains controversial and several attempts have been made to amend it, particularly the request to proscribe PBA.⁴⁶⁶ Thus, confirming its use in Australia.

4.2.5. Canada

There is no federal law in Canada regulating abortion.⁴⁶⁷ Abortion is funded under the Canadian Health Act, R.S.C 1985, c. C-6, as a medically necessary health service.⁴⁶⁸ There is no restriction on TOP regarding gestational ages, thus indicating that abortion is permissible at any gestational age. The Abortion

⁴⁶¹ H Douglas and K Kerr 'Abortion law reform and the context of decision-making' (2015) 25(1) *Griffith Law Review* 130.

⁴⁶² Victoria's Abortion Law Reform Act No. 58 of 2008. (Hereafter, referred to as "VALRA").

⁴⁶³ *Ibid* S 4.

⁴⁶⁴ *Ibid* S 3.

⁴⁶⁵ *Ibid* S 5 (1)a – b.

⁴⁶⁶ O Milman 'Geoff Shaw Proposes Radical Changes To Victoria's Abortion Laws' *The Guardian* 8 May 2014 available at www.theguardian.com/world/2014/may/08/geoff-shaw-proposes-radical-changes-victoria-abortion-laws.

⁴⁶⁷ See *R v Morgentaler* [1988] 1 S. C. R. 30. This groundbreaking case determined Canada's contemporary abortion laws. In this case the Supreme Court held that the Criminal Code of Canada's S 251.4, which denied TOP unless performed at, accredited hospitals with the required certification of approval from the Therapeutic Abortion Committee, as unconstitutional. It infringed women's right to security of person under section 7 of the Canadian Charter of Rights and Freedoms.

⁴⁶⁸ C Sethna & M Doule 'Journey of Choice? Abortion, Travel, Women's Autonomy' in SJ Murray & D Holmes (eds) *Critical Interventions in the Ethics of Healthcare: Challenging the Principle of Autonomy in Bioethics* (2009) 163, 165.

in Canada website lists PBA as a procedure employed in the country⁴⁶⁹ although it is unknown how frequently the procedure is used.⁴⁷⁰

4.3. Conclusion

Proscription and criminalization of PBA is untenable from an IHRL perspective. It abridges several human rights protected by various international treaties ratified by South Africa; particularly the rights to life, health, equality, liberty and security of person, privacy and information.

Proscription and criminalization of PBA may be detrimental to the health and well-being of patients, and could potentially be life-threatening in certain circumstances. It may also result in the imprisonment of physicians who perform it in good faith.^{471,472,473} Accordingly, it is highly unlikely that South Africa will proscribe PBA since the 1996 Constitution and CTOPA protects and promotes the aforementioned rights. Thus, IHRL appears to reinforce the implementation of PBA, which is a potentially life-saving procedure that permits women to exercise a number of human rights relevant to their reproductive and general health.

A review of foreign law reveals that PBA is not a pressing issue. Abortion legislation in the UK, Ireland, Australia and Canada do not regulate TOP procedures. They merely recommend certain methods or identified for use, including D&X.^{474,475,476,477} Still, the choice of abortion procedure remains within

⁴⁶⁹ Abortion in Canada *Methods: Methods of abortion* available at <http://abortionincanada.ca/methods/>. (Accessed January 2015).

⁴⁷⁰ RI Martin *The Most Dangerous Branch: How The Supreme Court Of Canada Has Undermined Our Law And Our Democracy* (2005) 104-105.

⁴⁷¹ Ruse (note 364 above) 90.

⁴⁷² NAF (note 366 above) 59.

⁴⁷³ UNHRC (note 357 above) 23.

⁴⁷⁴ NHS (note 380 above).

⁴⁷⁵ IFPA (note 398 above).

⁴⁷⁶ Milman (note 467 above).

⁴⁷⁷ Martin (note 471 above) 104 – 105.

the discretion of the physician. Therefore, if the physician believes in good faith that D&X is appropriate and necessary for the patient, it is permissible. It seems that these countries have not proscribed D&X as it will undermine the object their respective legislations, which is to protect the lives and health of women requiring TOP.

United States of America is the only country to proscribe and criminalize D&X, except in life-threatening cases. It is submitted that South Africa should not be influenced by the United States of America in this respect.

CHAPTER FIVE

5. NORMATIVE ARGUMENTS AGAINST PARTIAL-BIRTH ABORTION

This chapter will examine the ethical and legal arguments underpinning proscription of PBA. It will determine whether the assertions outline are persuasive enough to justify proscription of PBA in South Africa.

5.1. Fetal Pain

The discourse surrounding the existence of fetal pain has been contentious among medical experts. Human beings are capable of expressing pain through various reactions, the most basic is the reflex motor reaction⁴⁷⁸ followed by the stress response.⁴⁷⁹ The most complex reaction is "perception of pain" and the accompanying emotional reactions.⁴⁸⁰

Extensive medical evidence confirms that the necessary structures to experience fetal pain develops as early as seven weeks⁴⁸¹ and the fetus is capable of feeling pain throughout its body by 20 weeks.⁴⁸² It responds to touch by week eight⁴⁸³ and by week 14 it has a full repertoire of bodily movements that can be evoked spontaneously or by its' environment.⁴⁸⁴ At week 20 it is capable of responding to stimuli in a way that is indicative of pain, for example it will wince if met with painful stimuli.⁴⁸⁵ The application of painful stimuli

⁴⁷⁸ Where one will quickly remove the stimulated body part away from the painful stimulus.

⁴⁷⁹ An unconscious reaction resulting in the secretion of cortisol and β -endorphin concentrations.

⁴⁸⁰ C Greco & S Khojasteh 'Pediatric, infant and fetal pain' in AD Kaye & RV Shah (eds) *Case Studies in Pain Management* (2015) 379, 379.

⁴⁸¹ SWG Derbyshire 'Can fetuses feel pain?' (2006) 332(7546) *British Medical J* 909.

⁴⁸² M Van de Velde & F De Buck 'Fetal and Maternal Analgesics/Anesthesia for Fetal Procedures' (2012) 31(4) *Fetal Diagnosis and Therapy* 206.

⁴⁸³ R Gupta, M Kilby & G Cooper 'Fetal surgery and anaesthetic implications'. (2008) 8(2) *Continuing Education in Anaesthesia and Critical Care & Pain* 74.

⁴⁸⁴ C Bocchi ...et al 'Ultrasound and Fetal Stress: Study of the Fetal Blink-Startle Reflex Evoked by Acoustic Stimuli' in G Buonocore & CV Bellieni (eds) *Neonatal Pain: Suffering, Pain and Risk of brain damage in the Fetus and Newborn* (2008) 31, 31.

⁴⁸⁵ DJ Mellor ... et al 'The importance of 'awareness' for understanding fetal pain.' (2005) 49(3) *Braresearch Reviews* 457.

triggers a fetal stress response between 18 – 20 weeks.⁴⁸⁶ Consequently, this stress response may lead to long or short-term neurodevelopmental deficiencies.⁴⁸⁷ Ergo, anesthesia and analgesics are administered during fetal surgery to prevent this complication.⁴⁸⁸ Still, the fetus would purportedly require between five and 50 times the dosage administered to an adult for the anesthesia to be effective.⁴⁸⁹

Sonograms taken during TOP illustrate fetal distress.⁴⁹⁰ Although, the fetus lacks a fully developed cortex, it can experience pain; children without cerebral cortexes resulting from congenital deformities, can experience pain.⁴⁹¹ Neurotransmitters mediating pain are present in the second trimester but the neurotransmitters diminishing pain only appear in the third; consequently, fetuses aged between 20 – 30 weeks are particularly vulnerable to pain.⁴⁹²

Since PBA coincides with this period, it is presumed that the fetus will experience excruciating pain throughout the procedure. PBA is not supported by deontology because it necessitates the intentional killing of the fetus. Killing is against the dictates of morality and is morally reprehensible. Additionally, the

⁴⁸⁶ LB Myers ... et al 'Fetal endoscopic surgery: indications and anaesthetic management.' (2004) 18(2) *Best Practice & Research Clinical Anaesthesiology* 242.

⁴⁸⁷ MA Rosen 'Anesthesia for Fetal Surgery and Other Intrauterine Procedures' in DH Chestnut ... et al (eds) *Chestnut's Obstetric Anesthesia: Principles and Practice* 4 ed (2009) 123, 131-132.

⁴⁸⁸ SJ Lee ... et al 'A Systematic Multidisciplinary Review of the Evidence.' (2005) 294(8) *J of the American Medical Association* 951.

⁴⁸⁹ The reason why such a high dosage is required is because the placental membrane separates the blood circulation of the fetus and mother. When anesthesia is administered intravenously to the mother, the anesthetic would have to penetrate the placental membrane and be of a significant concentrate to have any effect on the fetus. See *National Abortion Federation, et al v. Ashcroft* Transcripts Tr. New York: Day 11, page 54: 14-23 (Anand) & page 60: 13-17 (Anand) available at www.priestsforlife.org/pba/nyhighlights.pdf.

⁴⁹⁰ R Joseph *Human Rights and the Unborn Child* (2009) 92.

⁴⁹¹ M Beshkar 'The Presence of Consciousness in the Absence of the Cerebral Cortex.' (2008) 62(7) *Synapse* 554.

⁴⁹² Joseph (note 491 above) 93.

physician acts maleficently by inflicting wanton harm, which could supposedly be prevented if an alternative procedure is employed that does not occur within 20 – 30 weeks of gestation or adoption.

5.2. Informed Consent

It seems as if proscription infringes women's right to make autonomous reproductive health decisions. However, the *National Abortion Federation, et al v Ashcroft*⁴⁹³ demonstrated how physicians may willfully repudiate patient-autonomy when employing PBA. The case illustrated how patients were denied vital information necessary for informed consent. Patients were not informed of the procedure in a comprehensible manner, instead physicians employed hyper-technical medical terms that were unintelligible to patients.⁴⁹⁴ Some chose to evade questions on fetal pain, others deliberately withheld information about fetal pain and some falsely reassured patients that anesthesia ensures painless demise.⁴⁹⁵

In South Africa, the NHA obligates physicians to solicit informed consent prior to any medical examination, treatment or surgery.⁴⁹⁶ Physicians must inform patients of all medical or surgical procedures available to them⁴⁹⁷ and the accompanying risks, benefits, costs, and consequences of each option.⁴⁹⁸ Patients must also be informed of their right to refusal and the accompanying risks, implications and obligations.⁴⁹⁹ The physician is required to inform the patient in a comprehensible manner, appropriate to their literary level.⁵⁰⁰ Patients must understand and appreciate the information before voluntarily

⁴⁹³ *National Abortion Federation, et al v Ashcroft* 03 Civ. 8695 (RCC).

⁴⁹⁴ *National Abortion Federation, et al v Ashcroft* 03 Civ. 8695 (RCC) *Transcripts* at Tr. New York: Day 3 515: 24-516: 1 (Johnson); Tr. New York: Day 5, page 21 (Westhoff); Tr. New York: Day 9, page 69 (Chasen). (Hereafter, referred to as “NAF Transcripts”).

⁴⁹⁵ *Ibid.*

⁴⁹⁶ Singh (note 171 above) 117.

⁴⁹⁷ NHA (note 124 above) S 6(1)(b).

⁴⁹⁸ *Ibid* S 6(1)(c).

⁴⁹⁹ *Ibid* S 6(1)(d).

⁵⁰⁰ *Ibid* S 6(2).

consenting to or refusing treatment; failure to solicit informed consent diminishes patient-autonomy.⁵⁰¹ Therapeutic privilege is the only exception to informed consent.⁵⁰² Physicians are permitted to withhold vital information until after the administration of health services, unless disclosure is contrary to the patient's best interest.⁵⁰³

In NAF, patients did not properly consent to PBA because the physicians deliberately failed to properly solicit informed consent. Further, physicians abused therapeutic privilege since disclosure did not pose a significant risk to patient health.

5.3. Wanton Abuse

The following evidence illustrates physicians' wanton abuse of D&X. The discussion offered concerns three physicians.

Martin Haskell – Haskell was the first physician to provide an in-depth description of D&X.⁵⁰⁴ He described D&X as a quick outpatient procedure performed between 20 – 24 weeks of gestation, under local anesthetic.⁵⁰⁵ Haskell preferred D&X given the complexity and lengthy duration of D&E.⁵⁰⁶ 80 per cent LTOPs he performed were purely elective, the remaining 20% were for genetic disorders.^{507,508}

⁵⁰¹ See Chapter 2.

⁵⁰² Singh (note 171 above) 120.

⁵⁰³ NHA (note 124 above) S 8(3).

⁵⁰⁴ Haskell, M. *Dilation and Extraction for Late Trimester Abortion*. Presented at the National Abortion Federation Risk Management Seminar, September 13, 1992 available at <http://www.sharonvilleclinic.com/uploads/6/2/0/0/6200039/idx.pdf>

⁵⁰⁵ FB Gerard *Abortion — Murder or Mercy? Analysis and Bibliography* (2001) 45.

⁵⁰⁶ Congressional Record—Extension of Remarks. A Closer Look at Partial-Birth Abortions. Hon. Robert K Dornan of California in the House of Representatives. September 1997. E1745-6. (Hereafter referred to as "Congressional Record".)

⁵⁰⁷ DJ Garrow *Liberty and Sexuality: The Right to Privacy and the making of Roe v Wade* (1998) 719.

⁵⁰⁸ J Leo *Incorrect Thoughts: Notes on Our Wayward Culture* (2001) 118.

James McMahon – McMahon pioneered D&X⁵⁰⁹, reportedly performing over one thousand procedures.⁵¹⁰ In 1995 he submitted a comprehensive account of the number of PBA procedures he had performed, which exceeded two thousand cases; McMahon stated that only 175 cases of those cases were performed on maternal indications.⁵¹¹

It was revealed that 22 per cent of the 175 cases were performed because of depression; 16 per cent “for conditions consistent with the birth of a normal child”; and in one third of the cases continued pregnancy posed a significant risk to the mother.⁵¹² In 56 per cent of the cases the reason cited was “fetal flaws” including cleft palates, cystic hydroma, cystic fibrosis, and duodenal atresia.⁵¹³ All of which were mental or neurological impairments and superficial deformities that could be surgically corrected or managed; other ‘maternal indications’ included chicken pox, diabetes and nausea.⁵¹⁴ McMahon openly stated that he performed elective PBA.⁵¹⁵

David Grundmann – Grundmann was the medical director of Planned Parenthood Australia, he preferred D&X because it is a quick outpatient procedure performed under local anesthesia without additional analgesics, and prevents live birth.⁵¹⁶ According to Grundmann Australian hospitals provide LTOP in life-threatening circumstances, severe cases of fetal malformation and threats to the woman’s physical and mental health.⁵¹⁷ Moreover, his clinic performed PBA in the following additional instances:

1. Minor or doubtful fetal abnormalities

⁵⁰⁹ Garrow (note 508 above) 719.

⁵¹⁰ Gerard (note 506 above) 45.

⁵¹¹ Congressional Record (note 507 above) E1743.

⁵¹² *Ibid.*

⁵¹³ *Ibid.*

⁵¹⁴ *Ibid.*

⁵¹⁵ Gerard (note 506 above) 46.

⁵¹⁶ Congressional Record (note 507 above) E1743.

⁵¹⁷ *Ibid.*

2. Extreme maternal immaturity i.e. girls in the 11 to 14 age group
3. Women that do not know they are pregnant
4. Intellectually impaired women who are unaware of basic biology
5. Major life crisis or major change in socio-economic circumstances.⁵¹⁸

Evidently, abuse of PBA has been committed by physicians as a result of its convenience and efficiency. Unfortunately, it is apparent that PBA can be used to needlessly abort healthy fetuses for trivial reasons.

Applied to virtue ethics, the physicians have openly expressed that D&X is efficient and expedient but their reasons for performing D&X on healthy fetuses were fabricated. Evidently their motives for employing D&X was convenience. Hence, the gratuitous use of PBA cannot be justified by this theory. Further, the principles of non-maleficence and beneficence are violated because the physicians unnecessarily and unjustifiably employed D&X to abort healthy fetuses and fetuses with superficial fetal abnormalities that could be easily corrected or defects that could be managed.

5.4. PBA, Infanticide & Neonaticide

According to the National Abortion Federation, D&X can be performed via breech presentation or cephalic presentation; in the latter instance, physicians can use instruments to crush the fetal skull externally.⁵¹⁹ Allegedly, D&X is performed without fetal anesthesia.⁵²⁰ Thus, subjecting the fetus to intolerable pain. This correlates with Brenda Pratt Shafer's testimony, she was a registered nurse who witnessed Martin Haskell perform PBA. She said:

The baby's little fingers were clasping and unclasping, and his little feet were kicking then the doctor stuck the scissors in the back of his head, and the baby's arms jerked out, like a startled reaction, like a flinch, like a baby does when he thinks he is going to fall... The doctor opened up the scissors, stuck a high-

⁵¹⁸ *Ibid.*

⁵¹⁹ M Paul ... et al *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care* (2009) 173.

⁵²⁰ Schwarz & Latimer (note 324 above) 63.

powered suction tube into the opening, and sucked the baby's brains out. Now the baby went completely limp.⁵²¹

It is not difficult to make a correlation between PBA and infanticide. The fetus is killed during live birth presumably to prevent physicians from being prosecuted for neonaticide.⁵²² Essentially, PBA deprives the fetus of life on the brink of personhood.

The AMA affirmed that PBA substantially differs from other abortion procedures ethically, as the viable fetus is partially delivered before it is killed; thus attaining an individual right to autonomy and constitutes neonaticide⁵²³

Kreeft says there is no significant moral difference between infanticide and PBA just like “there is no difference between killing a child” a just before or just after birth.⁵²⁴ Considering the arguments justifying abortion, there is a possibility that similar arguments could justify infanticide⁵²⁵ or “after-birth abortion”.⁵²⁶

5.5. Conscientious Objection

⁵²¹ I Shapiro *Abortion: The Supreme Court Decisions 1965-2007* 3 ed (2007) 263.

⁵²² R Parsley *Silent No More: Bringing moral clarity to America...while freedom still rings* (2006) 144.

⁵²³ AMA Board of Trustees Factsheet on H.R. 1122 (June 1997), in App. To Brief to Association of American Physicians and Surgeons et al. as Amici Curiae 1. (Hereafter, referred to as “AMA”).

⁵²⁴ P Kreeft *Three Approaches To Abortion: A Thoughtful and Compassionate Guide Today's Most Controversial Issue* (2002) 63.

⁵²⁵ ME Guy *Bloodshed before Abortion: America's Choice* (2011) 214.

⁵²⁶ See A Giubilini & F Minerva 'After-birth abortion: why should the baby live?' (2013) 39(5) *J Medical Ethics* 261-263.

All of the religions surveyed condemn TOP, except in life-threatening circumstances.^{527,528,529,530,531,532,533} Accordingly, if PBA is performed in outside of an emergency context, PBA is completely outlawed from a religious context. Religious views and beliefs are constitutionally protected⁵³⁴, both patient and physician hold the right to conscientious objection. Thus, implementation of PBA can abridge the rights of both parties if the patient's life is not in jeopardy and the physician is required to perform PBA.

5.6. PBA is Unsuitable in Medical Emergencies, Unsafe & Unnecessary

Some writers claim that D&X is ineffective in medical emergencies.⁵³⁵ The term 'emergency' is defined as "a dramatic, sudden situation or event, which is of a passing nature in terms of time" and precludes chronic illnesses⁵³⁶. Emergencies rise suddenly, requiring immediate medical attention. D&X is performed over two to three days owing to gradual cervical dilation, which ostensibly renders it futile in an emergency context.^{537,538}

Furthermore, some experts claim that D&X entails additional medical complications compared to D&E, specifically: ruptured uterus, abruption, amniotic fluid embolus, and uterine trauma from breech conversion.^{539,540} The

⁵²⁷ Schiff (note 191 above) 87.

⁵²⁸ Kelly (note 205 above) 108 – 109.

⁵²⁹ Pauls (note 207 above) 434.

⁵³⁰ Shanawani (note 220 above) 222.

⁵³¹ Alamri (note 221 above) 40.

⁵³² Bailey (note 232 above) 33.

⁵³³ Rakhudu (note 249 above) 56, 58 – 59.

⁵³⁴ 1996 Constitution (note 26 above) S 15(1).

⁵³⁵ CC Kuhne *Building Your Best Argument* (2010) 240.

⁵³⁶ *Soobramoney v Minister of Health (Kwazulu-Natal)* 1998 (1) SA 765 (CC) Para 38.

⁵³⁷ Schwarz & Latimer (note 324 above) 64.

⁵³⁸ Kuhne (note 536 above) 240.

⁵³⁹ EA Cawthon *Medicine On Trial: A Handbook with Cases, Laws, and Documents* (2004)

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⁵⁴⁰ Stenberg (note 431 above) 928.

sharp instruments used to pierce the fetal skull during cephalocentesis could result in iatrogenic laceration, secondary hemorrhage and infection.⁵⁴¹

Moreover, the American College of Obstetrics and Gynecology clarified that D&X is not the only LTOP procedure available.⁵⁴² Some physicians are of the opinion that proscriptio is necessary because "it is needlessly risky, inhumane and ethically unacceptable. This procedure is closer to infanticide than it to abortion".⁵⁴³ We are aware that suitable alternatives to D&X exist.⁵⁴⁴ Therefore, there are allegedly no compelling reasons justifying its use.

5.7. Conclusion

This chapter reviewed the assertions underpinning the proscriptio of PBA. Medical evidence substantiates the existence of fetal pain. Medical experts confirmed that between 20 – 30 weeks of gestation fetuses can experience a heightened sense of pain, but cannot mitigate pain until the third trimester.⁵⁴⁵ D&X coincides with this period, therefore it subjects the fetus to excruciating pain. Fetal anesthesia is ineffective unless vertiginous dosages detrimental to the patient's health is regularly administered to the fetus.⁵⁴⁶ Allegedly, PBA necessitates wanton infliction of harm, which violently killing the fetus. Therefore, it infringes the principles of beneficence and non-maleficence, and is rejected by deontology.

Further, PBA could breach informed consent and patient-autonomy. NAF showcased how physicians can deliberately withhold vital information from patients regarding PBA. Subsequently, denying them the opportunity to make informed and autonomous health decisions. When questioned about fetal pain, physicians evaded the question, responded in an incomprehensible manner, or

⁵⁴¹ *Ibid.*

⁵⁴² Stenberg (note 431 above) 966.

⁵⁴³ Schwarz & Latimer (note 324 above) 64.

⁵⁴⁴ See Chapter 3.

⁵⁴⁵ Joseph (note 491 above) 92.

⁵⁴⁶ NAF Transcripts (note 495 above) page 60: 13 – 17.

reassured patients that the anesthesia will prevent fetal pain.⁵⁴⁷ South African law requires physicians to obtain informed consent prior to any medical examination, surgery or treatment.⁵⁴⁸ Physicians are legally and ethically obligated to inform patients of the risks, benefits and consequences accompanying treatment options and refusal of treatment.⁵⁴⁹ Furthermore, patients must understand the information before making a voluntary decision.⁵⁵⁰

Moreover, evidence validates that some physicians deliberately abused PBA for their own convenience. These physicians have performed elective PBA on healthy women carrying healthy fetuses.⁵⁵¹ Where fetal abnormality was cited as a reason to perform PBA, the fetuses suffered from minor disabilities that could be surgically corrected or managed.⁵⁵² The physicians frequently fabricated their reasons for performing PBA. Their motives for doing so were clearly unethical.

PBA has been likened to infanticide and neonaticide. Essentially, the fetus is killed whilst being delivered alive, supposedly to prevent physicians from being prosecuted for neonaticide.⁵⁵³ The AMA argues that the partial-birth aspect of PBA affords the fetus the right to autonomy separate of the woman; therefore, constituting neonaticide.⁵⁵⁴ Further, it has been argued that eventually infanticide may be justified for the same reasons as abortion.⁵⁵⁵

⁵⁴⁷ NAF Transcripts (note 495 above) pages 21, 69.

⁵⁴⁸ Singh (note 171 above) 117.

⁵⁴⁹ NHA (note 124 above) S 6(1)(b)-(d).

⁵⁵⁰ *Ibid* S 6(2).

⁵⁵¹ Leo (note 509 above) 118.

⁵⁵² Congressional Record (note 507 above) at E1743.

⁵⁵³ Parsley (note 523 above) 144.

⁵⁵⁴ AMA (note 524 above).

⁵⁵⁵ Guy (note 525 above) 214.

South Africa's prevailing religions usually do not support the use of TOP, unless it is necessary in an emergency context.^{556,557,558,559,560,561,562} Accordingly, if PBA is performed in none-life-threatening circumstances, it is religiously condemned. Religious beliefs are constitutionally protected in SA, therefore physicians and patients are entitled to conscientiously object to the use of PBA, particularly if it infringes their religious beliefs.⁵⁶³

Lastly, D&X is allegedly unsuitable in an emergency context. This claim is predicated on the fact that D&X can last more than two days; since emergencies are sudden events requiring immediate attention, D&X is futile.^{564,565,566,567} Some medical experts claim that D&X involves added risks compared to D&E, including ruptured uterus, abruption, amniotic fluid embolus, and uterine trauma.⁵⁶⁸ Others propound that D&X is unnecessary, insalubrious and odious.⁵⁶⁹ Therefore, since less harmful alternatives to D&X exist, those procedures should be employed instead.

In conclusion, there remains uncertainty as to whether any of the aforementioned arguments are compelling enough to justify the proscription of PBA. In fact, all of the arguments can be applied to any surgical TOP method. This matter will be addressed in the subsequent chapter.

⁵⁵⁶ Schiff (note 191 above) 87.

⁵⁵⁷ Kelly (note 205 above) 108 – 109.

⁵⁵⁸ Pauls (note 207 above) 434.

⁵⁵⁹ Shanawani (note 220 above) 222.

⁵⁶⁰ Alamri (note 221 above) 40.

⁵⁶¹ Bailey (note 232 above) 33.

⁵⁶² Rakhudu (note 249 above) 56, 58 – 59.

⁵⁶³ 1996 Constitution (note 26 above) S 15(1).

⁵⁶⁴ Kuhne (note 536 above) 240.

⁵⁶⁵ Schwarz & Latimer (note 324 above) 64.

⁵⁶⁶ Mayled & Ahluwalia (note 225 above) 128.

⁵⁶⁷ Rakhudu (note 249 above) 56, 58 – 59.

⁵⁶⁸ Cawthon (note 539 above) 266.

⁵⁶⁹ Schwarz & Latimer (note 324 above) 64.

CHAPTER 6

6. NORMATIVE ARGUMENTS SUPPORTING PBA

The objective of this chapter is to catechize the cogency of and respond to the postulations raised in the previous chapter. It will provide an explanation as to why the aforementioned allegations cannot apply to PBA exclusively without impacting all fetocidal surgical abortion procedures. In doing so it will determine whether proscription of PBA would undermine the ethical and constitutional rights of South African women.

6.1. Fetal Pain

Medical evidence suggests that the fetus lacks the necessary physiological and neuroanatomical structures to perceive pain since a thalamocortical connection is necessary to fully experience pain.⁵⁷⁰ Evidence of the presence of the thalamocortical connection in the fetus is weak.⁵⁷¹ In order to perceive pain, conscious awareness of noxious stimuli is required; although a stress response is triggered in the fetus, it is not indicative of fetal pain since both stress and motor reflex responses are triggered by enjoyable stimuli.⁵⁷² Functional thalamocortical connections are necessary for awareness of noxious stimuli and thalamocortical fibres only present in the final trimester; therefore, it is unlikely for fetuses to fully experience pain before 29 – 30 weeks.⁵⁷³

Mounting evidence indicates that fetuses live in a state of sedation whilst in utero.^{574, 575} This seems to correlate with journalist Margaret Woodbury's witness account of the LTOP of fetuses aged 19 – 23 weeks. She found that

⁵⁷⁰ Derbyshire (note 482 above) 910.

⁵⁷¹ CL Lowery ... et al 'Neurodevelopmental Changes of Fetal Pain' (2007) 31(5) *Seminars in Perinatology* 276.

⁵⁷² Lee (note 489 above) 954.

⁵⁷³ *Ibid.*

⁵⁷⁴ Royal College of Obstetricians and Gynecologists (hereafter, referred to as "RCOG") Fetal Awareness: Review of Research and Recommendations for Practice: Report of a Working Party March 2010 (2010).

⁵⁷⁵ M Fitzgerald 'The Development of Nociceptive Circuits.' (2005) 6 *Nature Reviews: Neuroscience* 513.

throughout D&X and D&E the fetuses were completely flaccid, however, she was unsure whether this resulted from fetal anesthetic or lack of pain perception.⁵⁷⁶

The existence of fetal pain remains uncertain. Nevertheless, even if the existence of fetal pain was inexorable, D&X cannot be solely excluded on this ground. If fetal pain begins to manifest at seven weeks⁵⁷⁷ and if definitive by 20 weeks⁵⁷⁸, all surgical TOP procedures spanning the first and early second trimester should be proscribed as a result of fetal pain. If fetal pain is ineluctable by week 20, and the fetus is extremely vulnerable between weeks 20 – 30,⁵⁷⁹ all LTOP procedures should be proscribed since all are fetocidal and may transpire within this period.

Therefore, the argument that PBA should be prohibited based on the existence of fetal pain is indefensible. This argument cannot be viewed dogmatically. Proscription of PBA does not negate the feticide of surgical TOP.

The argument that D&X is unethical on the grounds of fetal pain is untenable. All surgical TOP procedures are fetocidal. Accordingly, all procedures could be unethical according to beneficence, maleficence and deontology. Especially, since adoption and neonatal palliative care would completely eradicate fetal harm and pain.

6.2. Informed Consent & Wanton Abuse

Presuming that physicians intentionally fail to solicit informed consent for D&X because it is abhorrent, is erroneous. Physicians could withhold information relating to any TOP procedure as it is a sensitive subject. It is difficult to inform the patient of what feticide entails. Thus, the physician's reticence in discussing

⁵⁷⁶ MA Woodbury "A doctor's right to choose" Salon.com (2002) available at http://archive.salon.com/mwt/feature/2002/07/24/late_term/index.html.

⁵⁷⁷ Derbyshire (note 482 above) 909.

⁵⁷⁸ Van de Velde & De Buck (note 483 above) 206.

⁵⁷⁹ Joseph (note 491 above) 93.

the procedure is understandable. However, if the patient wishes to be informed, the physicians should oblige provided it is not against the patient's best interests. Still, the NHA does not obligate physicians to comprehensively detail what each procedure entails. The NHA requires the disclosure of the risks, benefits and consequences accompanying treatment options and refusal of treatment options.⁵⁸⁰ Time restraints in the public health sector could affect the informed consent process, particularly in an emergency context. This argument is not restricted to D&X.

Evidence purportedly verifying the wanton abuse of D&X does not negate the abuse of alternative LTOP procedures. For instance, the physician may choose to perform D&E even though IOL is the most suitable procedure since D&E is less complex and involves less complications.⁵⁸¹ Conversely, the physician may choose to perform IOL instead of D&E because it is a longer and a more complex procedure, which is probably costlier.⁵⁸² Therefore, this argument cannot be applied exclusively to D&X. What is more, the evidence is rather paltry. Only three doctors have been identified for their alleged abuse of PBA. Surely, one cannot repudiate the procedure based on three allegations of supposed abuse.

6.3. PBA Constitutes Feticide

The claim that PBA constitutes infanticide or neonaticide and is inhumane, is unfounded. Neonaticide and infanticide refer to the killing of a newborn child within the first six days of its life and the first year of its life, respectively.⁵⁸³ In order to satisfy these elements PBA must entail the killing of a legal person, which the fetus is not.⁵⁸⁴ Feticide transpires within the womb; therefore, PBA

⁵⁸⁰ NHA (note 124 above) S 6(1)(b)-(c)

⁵⁸¹ KA Shaw & K Lerma 'Update on second-trimester surgical abortion' (2016) 28 *Current Opinion in Obstetrics and Gynecology* 511 – 512.

⁵⁸² Callahan (note 280 above) 341.

⁵⁸³ S Mathews ... et al 'Child deaths in South Africa: Lessons from the child death review pilot' (2016) 106(9) *SAMJ* 851.

⁵⁸⁴ Boezaart (note 43 above) 11.

constitutes feticide. Moreover, killing of the live fetus is not a requisite of D&X⁵⁸⁵ since D&X does not preclude miscarriages.

Furthermore, nearly all surgical TOP procedures require fetal dismemberment namely: MVA,⁵⁸⁶ S&C,⁵⁸⁷ D&C⁵⁸⁸ and D&E⁵⁸⁹. IOL and modern hysterotomies and hysterectomies employ fetocidal solutions, which usually induces feticide via asphyxiation and incineration.^{590,591} Previously, if the fetus survived a hysterotomy it was smothered to death with its own placenta or drowned in a bucket of water⁵⁹², which undoubtedly constitutes neonaticide. The fact that majority of TOP procedures occur within the womb does not repudiate their brutality. It seems as if there is an issue with D&X because the fetus is partially delivered. Consequently, enabling us to see it, which makes us realize that it was living entity. Regardless, in actuality D&X is significantly less destructive than its alternatives.

6.4. Necessity, Added Risks & Medical Emergencies

The assertion that PBA is unnecessary and involves added risks, is fallacious. ACOG confirmed that D&X could be the best option for certain patients.⁵⁹³ In fact D&X offers a number of unique safety benefits. It poses fewer risks of “uterine perforation”, “cervical laceration” and less penetration of the uterus is required, which prevents harm to those with compromised immune systems, including patients with chorioamnionitis who are prone to uterine perforation.⁵⁹⁴

⁵⁸⁵ James (note 334 above) 1161.

⁵⁸⁶ Hamoda (note 282 above) 186.

⁵⁸⁷ Gupta (note 287 above) 365.

⁵⁸⁸ Beckmann (note 293 above) 298.

⁵⁸⁹ Chou (note 301 above) 139.

⁵⁹⁰ Alcorn (note 313 above) 185.

⁵⁹¹ Sharma (note 325 above) 341.

⁵⁹² Schwarz & Latimer (note 324 above) 62.

⁵⁹³ Stenberg (note 431 above) 996.

⁵⁹⁴ NAF (note 366 above) 53.

Further, D&X decreases the risk of “sharp bone fragments” injuries to the uterus and cervix, and drastically decreases the risk of retention of fetal tissue, which is life-threatening.⁵⁹⁵ Additionally, D&X makes it relatively easy for physician to remove the fetal head from the vagina compared to D&E; the latter requires fetal dismemberment, which exacerbates cervical injury.⁵⁹⁶ Additionally, D&X is a relatively quick procedure; this in itself is salutary.⁵⁹⁷ Consequently, the patient will be exposed to less trauma, “blood loss and anesthesia”, which prevents serious harm to patients suffering from blood disorders.⁵⁹⁸

Furthermore, D&X may be required when severe fetal malformation is detected late into pregnancy. For example, hydrocephaly can only be detected towards the end of the second trimester; it occurs when the fetal skull becomes so enlarged that it doubles in size, resulting in severe brain damage.⁵⁹⁹ Thus, natural delivery will substantially compromise the woman's health, whereas D&X prevents significant cervical injury to the woman by reducing the diameter of the skull.⁶⁰⁰ Evidently, D&X is an advantageous procedure capable of preventing grievous harm and death.

The argument that PBA is not a viable option in an emergency context is specious. D&E is a two-day procedure.⁶⁰¹ Hence, D&E would be unsuitable in an emergency setting. Further, IOL requires in-patient admission and could become a "multiday process."⁶⁰² Accordingly, both alternatives would be unsuitable in an emergency context. The alternative is a hysterotomy or hysterectomy, which carry greater risks of maternal mortality than childbirth and

⁵⁹⁵ Stenberg (note 431 above) 936.

⁵⁹⁶ NAF (note 366 above) 50 – 51.

⁵⁹⁷ *Ibid.*

⁵⁹⁸ *Ibid.*

⁵⁹⁹ Stenberg (note 431 above) 929.

⁶⁰⁰ *Ibid.*

⁶⁰¹ J Brien & I. Fairbairn *Pregnancy & Abortion Counselling* (1996) 50. See JM Pollock *Criminal Law* 10 ed (2013) 691.

⁶⁰² Callahan (note 280 above) 341.

is contra-indicated.⁶⁰³ Just because a procedure cannot be performed immediately, does not disqualify its efficacy in an emergency context.

6.5. Conscientious Objection

In emergencies, physicians are ethically obligated to provide medical assistance⁶⁰⁴, irrespective of whether the person is a patient of the physician.⁶⁰⁵ Further, if the legal convictions of society deem a physician's failure to act as unlawful, liability will arise.⁶⁰⁶ The legal convictions of society will be appalled if physicians conscientiously object to providing medical assistance in an emergency context.⁶⁰⁷ Therefore, should pregnancy precipitate a medical emergency, physicians are obligated to perform TOP.⁶⁰⁸ The duty to assist in medical emergencies is reiterated in S 27(3) of 1996 the Constitution.⁶⁰⁹ Likewise, CTOPA authorizes LTOP when continued pregnancy is life-threatening.⁶¹⁰

Subsequently, physicians can conscientiously object to performing TOP provided another physician is available and prepared to do so, otherwise the physician is obligated to perform TOP despite his or her beliefs.⁶¹¹ If not, the physician will face legal consequences since conscientious objection cannot be justified in an emergency context.⁶¹²

⁶⁰³ WHO 2012 (note 363 above) 40 – 42.

⁶⁰⁴ 1996 Constitution (note 26 above) S 27(3).

⁶⁰⁵ D McQuoid-Mason 'State doctors, freedom of conscience and termination of pregnancy revisited' (2010) 3(2) *SAJBL* 75.

⁶⁰⁶ *Ibid.*

⁶⁰⁷ *Ibid.*

⁶⁰⁸ *Ibid.*

⁶⁰⁹ 1996 Constitution (note 26 above) S 27 (3) reads "no one may be refused emergency medical treatment."

⁶¹⁰ CTOPA (note 69 above) S 2(1)(c).

⁶¹¹ McQuoid-Mason (note 606 above) 76.

⁶¹² *Ibid.*

PBA is a LTOP procedure. Physicians are only required to perform D&X in an emergency context, provided no other physician is available.⁶¹³ Thus, the physician's rights will be limited in rare circumstances. If the physician fails to perform D&X and the patient suffers grievous harm or dies, the physician will be held criminally liable for failure to perform TOP.⁶¹⁴

6.6. Proscribing PBA is Unconstitutional & Unethical

As previously established, proscribing and criminalizing PBA will deny women information about and access to a reproductive health procedure that may be salubrious to their health. Further, it will prevent women from autonomously choosing a reproductive health procedure that may serve their personal and medical needs. Accordingly, the rights to health care, access to information, and bodily integrity will be infringed. PBA prevents significant health risks to women suffering from blood disorders and autoimmune conditions.⁶¹⁵ Proscription will unfairly discriminate against these patients on account of their health conditions; subsequently, endangering their health and lives. Furthermore, if continued pregnancy precipitates a medical emergency requiring D&X, the right to emergency medical treatment will be abridged.⁶¹⁶ For instance, should hydrocephaly necessitate LTOP and D&X is the safest TOP method,⁶¹⁷ legal proscription may lead to death if there is no health exception accompanying it. Therefore, proscription will deny women access to emergency medical treatment, compromising their health and lives.

Proscription will force physicians to employ alternative LTOP procedures, while D&X may be the safest and most appropriate in certain circumstances. Thereby, substantially increasing the risk of failed TOP. If TOP fails, the physician is left with two options: hysterotomy or hysterectomy. Subsequently, subjecting women to additional procedures, which will infringe the right to

⁶¹³ *Ibid.*

⁶¹⁴ *Ibid.*

⁶¹⁵ Ruse (note 364 above) 90.

⁶¹⁶ 1996 Constitution (note 26 above) S 27(3).

⁶¹⁷ NAF (note 366 above) 59.

dignity. Moreover, hysterotomies and hysterectomies carry a higher risk of maternal mortality than childbirth;⁶¹⁸ subsequently endangering the lives of women. If the physician performs D&X, he or she may be penalized and possibly imprisoned if PBA is criminalized. Hence, the right to security of person will be arbitrarily abridged.

Ethically, patients will be denied access to vital information that will enable them to make autonomous reproductive health care choices, advantageous to their health. Consequently, repudiating patient-autonomy. In cases where D&X is the most appropriate procedure but cannot be employed due to proscription (i.e. cases of hydrocephaly) and TOP fails, women would have to endure undue burdens in the form of additional TOP procedures. Consequently, this could jeopardize their health and their lives. Accordingly, proscription qualifies as an arbitrarily restrictive policy exacerbating maternal morbidity and mortality rates in South Africa. Thus, proscription undermines feminist ethics and the principle of justice. Furthermore, beneficence and non-maleficence would obligate the physician to perform D&X to prevent avoidable death or harm to the patient in cases of severe malformation requiring D&X. In this instance, proscription will infringe both principles.

Proscription will be of no medical benefit to abortion opponents. However, it could have grave consequences for patients who may require it. The reality is that proscription may eventuate death, thereby rendering the ban ethically and constitutionally unjustifiable. It will not prevent TOP as there will always be equal opportunities to commit feticide via the use of surgical TOP. Implementing D&X will produce beneficial consequences and the least amount of harm to the greatest number of people. Therefore, it is supported by consequentialism and utilitarianism.

If a patient suffers a miscarriage and the stillborn has a gestational age of 26 weeks, the death of the child must be registered.⁶¹⁹ A burial order will also be

⁶¹⁸ WHO (note 363 above) 40 – 42.

⁶¹⁹ BADRA (note 127 above) S 1.

granted for the child and the parents of the child are entitled to a religious burial ceremony if they wish to do so.⁶²⁰ The aforementioned religions discussed in Chapter 2 require specific burial practices. All monotheistic religions compel believers to cleanse and cover the body of the deceased in a precise manner before burial.^{621, 622, 623} Hinduism calls for water or grave burials for small children.^{624, 625} Some denominations of ATR require the deceased to be wrapped prior to burial.⁶²⁶ Since D&X delivers the body intact as opposed to D&E, it is most suitable for burials. IOL, hysterectomies and hysterotomies could be used, however, the fetocidal agents used can result in a visibly destroyed fetus,^{627, 628} which will be more traumatic for the patient and family members of the deceased. Therefore, implementation of D&X is capable of complying with religious bioethics and the right to religious freedom.

It is crucial that women's rights be promoted and protected, especially given South Africa's oppressive history. Prior to CTOPA, ASA fueled the oppression of women for decades by claiming that women could acquire safe and legal abortion; instead women were repressed and degraded all in the attempt to be considered for TOP.⁶²⁹

CTOPA identified the oppressive nature of ASA, repudiated it and defended women's sexual and reproductive rights. CTOPA promoted and preserved a number of constitutional rights, as well as acknowledged the sensitivity and

⁶²⁰ *Ibid* S 18.

⁶²¹ Z Jerrett 'Sub-Saharan Africa: West Africa' in S Joseph & A Nagmabadi (eds) *Encyclopedia of Women & Islamic Cultures: Family, Body, Sexuality and Health, Volume 3* (2003) 125, 125.

⁶²² M Keene *This is Judaism* (1996) 68.

⁶²³ DJ Sheard *Daily life in Arthurian Britain* (2013) 142.

⁶²⁴ A Michaels *Hinduism: Past and Present* (2004) 147.

⁶²⁵ C Hindmarch *On the death of a child* 3 ed (2009) 117.

⁶²⁶ EK Agorsah & GT Childs *Africa and the African Diaspora: Cultural Adaptation and Resistance* (2006) 70.

⁶²⁷ Cox & Demmit (note 316 above) 250.

⁶²⁸ Martinelli-Fernandez (note 317 above) 38 – 39.

⁶²⁹ Rebouche (note 68 above) 300.

private nature of women's reproductive rights. Thus, upholding feminist ethics. Furthermore, the South African courts have consistently upheld women's reproductive rights and rightfully respected women as autonomous agents, as evidenced in CLA 1998 and CLA 2005. CTOPA is a triumph for women and the feminist movement the world over. It is the epitome of what women's rights concerning sexuality and reproduction should be.

It is submitted that proscribing and criminalizing PBA is otiose. It will not circumscribe abortion. It has been established that the arguments underpinning proscription, equally apply to all surgical abortion methods. Subsequently, providing valid grounds for the proscription of all surgical abortion procedures. Consequently, resulting in the excessive limitation of women's constitutional rights, which is untenable. Proscribing PBA or any other abortion procedure that is potentially life-saving, is unconstitutional and unethical.

If anything is wrong with PBA, it essentially revolves around feticide. If that is the main purpose of proscribing the procedure, what exactly is the purpose of permitting abortion altogether? Abortion procedures provide abortionists with a number of techniques to induce feticide prior to abortion. Therefore, if there is nothing wrong with abortion as a whole, there should be no issues with PBA as there is no moral distinction between aborting the fetus in the first trimester or last trimester. The objective is fundamentally the same, to expel the contents of the uterus.

Perhaps, if the procedure was referred to medically as D&X, there would be no public upheaval. Especially, since the term "partial-birth abortion" is not recognized as a medical procedure. Consider D&E, which has yet to acquire a demonized colloquialism; D&E entails fetal mutilation and dismemberment, which is far more destructive than D&X. However, it does not incite public scorn as much as D&X does. The term PBA appears to have been conjured up by pro-life advocates to elicit an emphatic public response, which swayed the support of proscription in USA.

It is submitted that the implementation of PBA, which has proven to be a medically necessary, advantageous and life-saving LTOP procedure that facilitates the exercise of women's constitutional and ethical rights, should not be proscribed. More importantly, the implementation of D&X could mitigate maternal mortality and morbidity in South Africa. It is further submitted that the implementation of PBA is legally and ethically justifiable in South Africa. Accordingly, PBA should be effected without legal consequence.

6.7. Conclusion

This chapter examined and provided a response to the concerns raised in the previous chapter.

Medical evidence disputes the existence of fetal pain before the final trimester.^{630,631,632,633} However, even if the existence of fetal pain is certain, this assertion cannot apply exclusively to PBA. Some experts are of the opinion that fetal pain begins to manifest as early as seven weeks⁶³⁴ and is definitive by 20 weeks.⁶³⁵ Since all surgical TOP procedures are fetocidal, and transpire within the aforementioned period, all surgical TOP procedures should be prohibited on the grounds of fetal pain. This is untenable and would undeniably unduly burden women.

Equating PBA to infanticide and neonaticide is spurious. Infanticide and neonaticide necessitate the killing of a legal person which the fetus is not; therefore, PBA constitutes fetocide.^{636,637} Moreover, the killing of a living fetus is not a requirement of D&X.⁶³⁸ Thus, D&X may be employed in cases of

⁶³⁰ Lee (note 489 above) 954.

⁶³¹ *Ibid.*

⁶³² Fitzgerald (note 576 above) 513.

⁶³³ Woodbury (note 577 above).

⁶³⁴ Derbyshire (note 482 above) 909.

⁶³⁵ Van de Velde & De Buck (note 483 above) 206.

⁶³⁶ Mathews (note 584 above) 851.

⁶³⁷ Boezaart (note 43 above) 11.

⁶³⁸ James (note 334 above) 1161.

miscarriages. Furthermore, the majority of surgical abortion procedures employ fetal dismemberment^{639,640,641,642} or incorporate feticidal solutions that usually asphyxiate and incinerate the fetus.^{643, 644} Ergo, D&X is one of the least destructive LTOP procedures.

It is understandably difficult to inform patients of what LTOP entails. However, if the patient wishes to be informed of the details of a particular procedure, the physician should oblige, provided it is not against the patient's best interests. Nevertheless, the NHA does not obligate physicians to expound the details of a procedure.⁶⁴⁵ Furthermore, time restraints in the public health sector may make it difficult to properly solicit informed consent for any TOP procedure, especially in emergency contexts requiring LTOP.

Regarding wanton abuse of PBA, the argument is not restricted to PBA since physicians are capable of abusing any LTOP. For instance, the physician may employ D&E since it is simpler and safer than IOL.⁶⁴⁶ Conversely, the physician could employ IOL as it is longer and costlier than D&E.⁶⁴⁷

The claims that D&X is unnecessary and riskier than other LTOP procedures, is spurious. D&X has proven to be advantageous and a potentially life-saving procedure.^{648, 649, 650, 651, 652} The allegation that D&X is unsuitable in an

⁶³⁹ Hamoda (note 282 above) 186.

⁶⁴⁰ Beckmann (note 293 above) 298.

⁶⁴¹ Gupta (note 287 above) 365.

⁶⁴² Chou (note 301 above) 139.

⁶⁴³ Alcorn (note 313 above) 185.

⁶⁴⁴ Sharma (note 325 above) 341.

⁶⁴⁵ NHA (note 124 above) S 6(1)(b)-(c)

⁶⁴⁶ Shaw & Lerma (note 582 above) 511 – 512.

⁶⁴⁸ NAF (note 366 above) 53.

⁶⁴⁹ *Ibid.*

⁶⁵⁰ Stenberg (note 431 above) 936.

⁶⁵¹ NAF (note 366 above) 50 – 51.

⁶⁵² Stenberg (note 431 above) 929.

emergency because of its duration, is imprecise. Both D&E and IOL can exceed than two days.⁶⁵³ Therefore, according to that logic neither procedure would be suitable in an emergency. This is untenable.

D&X will not unduly burden physicians' rights to conscientious objection. D&X is a LTOP procedure, which is reserved for certain circumstances.⁶⁵⁴ Conscientiously objectors to D&X are only required to perform D&X in medical emergencies if another physician is unable to do so.⁶⁵⁵ If the physician fails to perform D&X, and the patient suffers serious harm or dies, the physician will be held criminally liable.⁶⁵⁶

Lastly, proscription will infringe several constitutional rights. Specifically the rights to access to information⁶⁵⁷, bodily integrity⁶⁵⁸, equality and non-discrimination,⁶⁵⁹ freedom of religion⁶⁶⁰, health, life⁶⁶¹, dignity⁶⁶², security of person.⁶⁶³ Subsequently proscription will repudiates autonomy decisions and may require women to LTOP procedures that carry greater risks of maternal mortality than childbirth if TOP fails.⁶⁶⁴ Consequently, proscription will exacerbate maternal morbidity and mortality in South Africa. Thus, undermining the principles of beneficence, non-maleficence, justice and feminist ethics.

Proscription will undermine the 1996 Constitution, the legislature and judiciary, which have consistently protected and promoted women's reproductive rights.

⁶⁵³ Callahan (note 280 above) 341.

⁶⁵⁴ COTPA (note 69 above) S 2(1)(c).

⁶⁵⁵ McQuoid-Mason (note 606 above) 76.

⁶⁵⁶ *Ibid.*

⁶⁵⁷ 1996 Constitution (note 26 above) S 32.

⁶⁵⁸ *Ibid* S 12(2).

⁶⁵⁹ 1996 Constitution (note 26 above) S 9(3).

⁶⁶⁰ *Ibid* S 15.

⁶⁶¹ *Ibid* S 27 & 11.

⁶⁶² 1996 Constitution (note 26 above) S 10

⁶⁶³ *Ibid* S 12(1)(a).

⁶⁶⁴ WHO 2012 (note 363 above) 40 – 42.

Proscription is otiose. It will not circumscribe TOP, nor will it medically benefit anyone. It is unconstitutional and unethical.

This chapter has illustrated how the proscription of PBA is legally and ethically unjustifiable. It is submitted that proscription predicated on the grounds listed in Chapter 5 would buttress proscription of all surgical TOP procedure, which is unconstitutional, unethical and untenable. It is further submitted that the implementation of PBA, which has proven to be a medically necessary, advantageous and life-saving LTOP procedure that facilitates the exercise of women's constitutional and ethical rights, should not be proscribed. Moreover, the implementation of D&X could mitigate maternal mortality and morbidity in South Africa. Furthermore, it is submitted that the implementation of PBA is legally and ethically justifiable in South Africa. Accordingly, PBA should be effected without legal consequence.

CHAPTER SEVEN

7. RECOMMENDATIONS

The principal argument advanced by opponents of D&X is that it odiously and needlessly destroys fetuses.^{665,666} However, this paper clearly illustrates that the implementation of D&X is legally and ethically justifiable since it promotes the facilitates the exercise of several constitutional and ethical rights. More importantly, the implementation of D&X could mitigate maternal mortality and morbidity in South Africa. Yet, D&X opponents are under the impression that a ban will prevent the violent destruction of fetuses and somehow regulate abortion. In actuality, all surgical abortion techniques incorporate feticide.^{667,668,669,670,671,672,673} Prohibiting D&X will not circumscribe feticide or abortion.

Still, humane methods to induce fetal demise exist. Thus, it is submitted that physicians faced with LTOP should employ the following method:

7.1. Induced Fetal Demise

If continued pregnancy necessitates LTOP of a living fetus, it is submitted that feticidal agents should be employed to induce fetal cardiac asystole. RCOG recommends the use of intracardiac potassium chloride, which is to be injected into the left ventricle of the fetal heart with the aid of ultrasound control under sterile conditions.⁶⁷⁴ The physician must administer the agent until the

⁶⁶⁵ Saletan (note 6 above) 233.

⁶⁶⁶ White (note 7 above) 133.

⁶⁶⁷ Hamoda (note 282 above) 186.

⁶⁶⁸ Beckmann (note 293 above) 298.

⁶⁶⁹ Gupta (note 287 above) 365.

⁶⁷⁰ Chou (note 301 above) 139.

⁶⁷¹ Alcorn (note 313 above) 185.

⁶⁷² Sharma (note 325 above) 341.

⁶⁷³ James (note 334 above) 1161.

⁶⁷⁴ S Kumar *Handbook of Fetal Medicine* (2010) 24.

permanent asystole is achieved, which will culminate in painless demise.^{675,676} Thereafter, LTOP will commence. It is submitted that the patient, assisted by the physician during the informed consent process, should determine the LTOP procedure. Intracardiac potassium chloride ensures fetal demise, thus there will be no legal, ethical or medical consequences that may arise if the child happened to survive the procedure.

However, it is submitted that D&X should take precedence over D&E procedures considering that there are fewer complications involved, provided D&E is not necessary. Further, D&X should also take precedence over IOL since D&X is performed on an outpatient basis and the patient would not have to endure a painful and protracted labour process before delivering the fetus, provided IOL is not necessary.

Nevertheless, the decision is ultimately left with the patient after the physician has provided her with all of the necessary information that she is legally and ethically entitled to.

7.2. Neonatal Palliative Care

As previously mentioned, neonatal palliative care refers to holistic and extensive care aimed at preventing and alleviating neonatal pain and suffering.⁶⁷⁷ It is submitted that neonatal palliative care should be considered in the following categories:^{678,679,680}

⁶⁷⁵ L Govender & J Moodley 'Late termination of pregnancy by intracardiac potassium chloride injection: 5 years' experience at a tertiary referral centre (2013) 103(1) *SAMJ* 48.

⁶⁷⁶ JC Callahan 'Ensuring a Stillborn: The Ethics of Lethal Injection in Late Abortion' in JC Callahan (ed) *Reproduction, Ethics and the Law: Feminist Perspective* (1995) 267, 267.

⁶⁷⁷ A Catlin & B Carter 'Creation of a Neonatal End-of-Life Palliative Care Protocol' (2002) 22 *Journal of Perinatology* 184-185.

⁶⁷⁸ K Sibson, F Craig & A Goldman 'Palliative Care for Children' in C Faull, YH Carter & L Daniels *Handbook of Palliative Care* 2 ed (2005) 295, 296.

⁶⁷⁹ J Bhatia 'Palliative Care in the fetus and newborn' (2006) 26 *Journal of Perinatology* S24.

⁶⁸⁰ EAPC Taskforce for Palliative Care in *Children Palliative Care For Infants, Children and Young People* (2009) 19.

Extremely premature neonate.⁶⁸¹ When delivery becomes necessary and results in the birth of an extremely premature neonate, accurate medical information is vital as it will assist the physician and parents of child in deciding whether to administer intensive care or neonatal palliative care.⁶⁸²

Careful attention must be paid to obstetric history, particularly ultrasound dating scans as this will establish an accurate gestational age.⁶⁸³ Once the accurate gestational age has been estimated by the physician and agreed upon by the parents, a decision can be made regarding the administration of intensive care or neonatal palliative care.⁶⁸⁴

If the gestational age is below 23 weeks, the neonate will not be resuscitated since it is against the child's best interests.⁶⁸⁵ If the gestational age is at least 23 weeks and the fetal heartbeat is present during labour, the child will be resuscitated; however, if the parents decide not to revive the child it will be in its best interests not to do so.⁶⁸⁶

If the gestational age is at least 24 weeks, the child will be resuscitated unless the parents and physicians agree that it is contrary to its best interests.⁶⁸⁷ If the

⁶⁸¹ British Association of Perinatal Medicine 'Palliative Care (Supportive and End of Life Care) A Framework for Clinical Practice in Perinatal Medicine' (2010) 2.

⁶⁸² British Association of Perinatal Medicine 'Management of Babies Born Extremely Preterm at less than 26 weeks of gestation – A framework for Clinical Practice at the time of Birth' (2008) 1 – 2. (Hereafter, referred to as "BAPM".)

⁶⁸³ *Ibid.*

⁶⁸⁴ *Ibid* 2.

⁶⁸⁵ *Ibid.* If the parents request to speak to another senior pediatrician or neonatologist about the prospects of survival of the child, their wishes must be respected.

⁶⁸⁶ *Ibid* 2-3.

⁶⁸⁷ *Ibid* 3. Whether or not the child will progress to intensive care will depend on its hearts' response to the lung inflation. Further if upon examination, the child is proven to be more immature than expected. Withholding resuscitation might be in its best interests.

gestational age exceeds 25 weeks, the child will be resuscitated and sent to intensive care.⁶⁸⁸

If the gestational age is uncertain but is estimated to be 23 weeks, a senior sonographer should conduct the ultrasound; if the fetal heartbeat is heard during labour, resuscitation should commence.⁶⁸⁹ The decision to resuscitate "must be in the best interest of the child."⁶⁹⁰

Ultimately "the mortality rates increase proportionally with decreasing gestational age" of premature neonates.^{691, 692}

Neonates suffering from lethal congenital abnormalities including trisomy 13, 15 and 18, anencephaly⁶⁹³, complex congenital heart disease and renal agenesis⁶⁹⁴ or renal tubular dysgenesis^{695,696,697}

Neonatal palliative care should only be considered once the diagnosis of the lethal fetal abnormality is established, which will be achieved by antenatal

⁶⁸⁸ *Ibid.*

⁶⁸⁹ *Ibid.*

⁶⁹⁰ *Ibid.* Continuation or withdrawal of resuscitation depends on the heart response to the lung inflation. The child's admission to intensive care is dependent on its response to mask ventilation. If its heart rate improves it will be given ventilatory support and then transferred to the neonatal unit for further examination.

⁶⁹¹ RE Behrman & AS Butler (eds) *Preterm Birth: Causes, Consequences and Prevention* (2007) 314.

⁶⁹² T Marchant ... et al 'Neonatal Mortality Risk Associated with Preterm Birth in East Africa, Adjusted by Weight for Gestational Age: Individual Participant Level Meta-Analysis' (2012) 9(8) *Public Library of Science Medicine* 2.

⁶⁹³ Child is born without parts of its brain or skull.

⁶⁹⁴ Failure of the child to develop kidneys.

⁶⁹⁵ Severe underdevelopment of kidneys.

⁶⁹⁶ MB Hellsten & J Kane 'Symptom Management in Pediatric Palliative Care' in B R Ferrel & N Coyle (eds) *Textbook of Palliative Nursing* 2 ed (2006) 895, 896.

⁶⁹⁷ ACG Breeze ... et al 'Palliative care for prenatally diagnosed lethal fetal abnormality' (2007) 92(1) *Archive of Disease in Children: Fetal and Neonatal Edition* F56.

ultrasound screening, amniocentesis and cordocentesis.⁶⁹⁸ Use of MRI or 3D and 4D ultrasound scanning is encouraged to provide more information about the diagnosis.⁶⁹⁹ Fetal echocardiography should be conducted and examined by the perinatal cardiologist if cardiac anomalies are present and the diagnosis must be confirmed by a fetal medicine consult.⁷⁰⁰

Thereafter, a multidisciplinary team will discuss whether there is consensus on diagnosis and prognosis of the fetal abnormality.⁷⁰¹ The team will consider whether the diagnosis carries any maternal health implications; where definitive diagnostic tests can be conducted and the lethal condition confirmed, this step is not necessary.⁷⁰²

The patient can either accept or reject TOP, concerning the latter, neonatal palliative care will be administered to the child.⁷⁰³ If the abnormality is not fatal and the fetus' prospect of survival is positive, neonatal palliative care is precluded.⁷⁰⁴

Neonates suffering from serious medical or surgical conditions where maximal treatment is futile. Relevant conditions include severe hypoxic ischemic encephalopathy or severe necrotizing enterocolitis.⁷⁰⁵

Accurate diagnosis and prognosis is crucial. Advanced prenatal diagnostic testing will provide an accurate diagnosis and genetic testing should be

⁶⁹⁸ British Association of Perinatal Medicine (hereafter, referred to as "BAPM") 'Palliative Care (Supportive and End of Life Care) A Framework for Clinical Practice in Perinatal Medicine' (2010) 2.

⁶⁹⁹ *Ibid.*

⁷⁰⁰ *Ibid.*

⁷⁰¹ *Ibid* 3.

⁷⁰² *Ibid.* Should any uncertainty regarding the diagnosis or prognosis remain, a second opinion should be sought. Either the relevant department will arrange for this or it can be done by another tertiary center if the parents so wish.

⁷⁰³ *Ibid.*

⁷⁰⁴ *Ibid.*

⁷⁰⁵ *Ibid* 2.

utilized.⁷⁰⁶ At least two pediatricians or neonatologists must confirm the prognosis of the fetus, which must be confirmed by a multidisciplinary team.⁷⁰⁷ If the neonate is in unbearable pain two senior pediatricians or neonatologists must examine the child and confirm the diagnosis in order for neonatal palliative care to be administered in the child's best interest.⁷⁰⁸

Therefore, it is submitted that neonatal palliative care is a suitable alternative to LTOP in cases when the latter is not required.

7.3. Conclusion

Although the implementation of D&X is legally and ethically justifiable, painless methods of inducing fetal demise, exist. It is submitted that physicians should employ either fetocidal agents in conjunction with LTOP or neonatal palliative care as an alternative to LTOP in cases where it is not required.

Regarding the use of fetocidal agents, it is recommended that intracardiac potassium chloride be used to induce fetal cardiac asystole; the physician will administer the agent into the left ventricle of the fetal heart until asystole is achieved.^{709,710,711} Thus, inducing fetal demise humanely and painlessly prior to LTOP. Further, there will be no legal, ethical or medical consequences that may arise if the child happened to survive the procedure since intracardiac potassium chloride ensures fetal demise. It is submitted that the choice of LTOP procedure should be within the discretion of the patient with the assistance of the physician during the informed consent process.

Neonatal palliative care refers to the provision of holistic and extensive care to prevent and alleviate neonatal pain and suffering; neonatal palliative care aims

⁷⁰⁶ *Ibid* 3.

⁷⁰⁷ *Ibid* 3.

⁷⁰⁸ *Ibid* 4.

⁷⁰⁹ Kumar (note 676 above) 24.

⁷¹⁰ Govender & Moodley (note 677 above) 48.

⁷¹¹ Callahan (note 678 above) 276.

to improve the neonatal quality of living and dying.^{712,713} neonatal palliative care is usually performed in the following instances:

1. Extremely premature neonates – In this category the gestational age and health of the child is used to determine whether intensive care or neonatal palliative care will be administered to the child; if the neonate is below 23 weeks neonatal palliative care will be administered.⁷¹⁴ If it is aged between 23 – 24 weeks and over 25 weeks it will be resuscitated and given intensive care.⁷¹⁵

2. Lethal fetal congenital abnormalities – neonatal palliative care is only administered if the diagnosis is firmly established, in such cases the patient usually has a choice of TOP or neonatal palliative care.⁷¹⁶ If the abnormality is not fatal and the prospects of survival are strong, neonatal palliative care is precluded.⁷¹⁷

3. Maximal medical or surgical treatment is futile and only prolongs neonatal pain and suffering – In this category, neonatal palliative care would be in the child's best interests. The accuracy of the child's diagnosis is fundamental in this situation.⁷¹⁸ At least two pediatricians or neonatologist would have to examine the child and confirm that the child is experiencing unbearable pain, thereafter neonatal palliative care will be administered.⁷¹⁹

⁷¹² Sibson (note 681 above) 296.

⁷¹³ Bhatia (note 682 above) S24.

⁷¹⁴ BAMP (note 685 above) 1 – 3.

⁷¹⁵ *Ibid* 2 – 3.

⁷¹⁶ *Ibid*.

⁷¹⁷ *Ibid* 3.

⁷¹⁸ *Ibid*.

⁷¹⁹ *Ibid*.

CHAPTER EIGHT

8. CONCLUSION

The objective of this dissertation was to dissect the ethical and legal implications of implementing PBA in South Africa. Consequently, this paper had to determine whether the use of PBA is constitutionally and ethically permissible.

Accordingly, it was necessary to first review the history of South African abortion laws and discuss TOP in the context of ethics. These discussions were necessary in order to gauge the legal and ethical implications of PBA. Furthermore, it laid the foundation for the arguments raised in favor and against the implementation of PBA in South Africa. Moreover, these discussions influenced the recommendations outlining the use of feticidal agents to induce painless and humane fetal demise prior to LTOP and the use of neonatal palliative care as an alternative to LTOP.

Thereafter, the nature and methodology of surgical abortion procedures was reviewed. Subsequently, a comprehensive account of the arguments advanced by opponents and exponents of PBA were analyzed in order to provide an objective view of the ethics and constitutionality of PBA. Once concluding that the implementation of PBA is constitutionally and ethically justifiable, the aforesaid recommendations were outlined.

Chapter I reviewed the history of South African abortion laws, which revealed that women were deprived of safe and legal abortion services⁷²⁰, and stripped of their basic human rights enshrined in the 1996 Constitution.⁷²¹

The 1996 Constitution and CTOPA rectified the injustices of ASA by upholding several constitutional rights, as well as providing safe and legal TOP services. Additionally, CTOPA acknowledged and endorsed fetal interests as evidenced

⁷²⁰ Rebouche (note 68 above) 300.

⁷²¹ *Ibid.*

by its gestational framework.⁷²² While common and statutory law acknowledges fetal interests,^{723,724,725} South African courts clarified that maternal interests take precedent since fetal personhood is not legally recognized.^{726,727} However, physicians conscientiously objecting to TOP are not obligated to perform TOP, except in medical emergencies.⁷²⁸ Still, CTOPA does not regulate feticide. Consequently, all abortion procedures are permissible until legally proscribed.

Chapter II provided a discussion on abortion and ethics, which was necessary to gauge the ethical implications of implementing PBA. The discussion featured TOP in the context of secular bioethics, religious bioethics, secular morality, and the boni mores. The Chapter on ethics underpinned the arguments posited in support of and against the implementation of PBA addressed in Chapters V and VI as well as the recommendations postulated in Chapter VII regarding the use of fetocidal agents and neonatal palliative care.

Chapter III delivered an overview of surgical TOP procedures, which revealed that all are fetocidal and some are more destructive than others. However the purpose of the procedures are the same, and that is to expel the fetus. Induced fetal demise and neonatal palliative care was introduced in this chapter. The former could be used as an aid to all TOP procedure and it will ensure humane fetal demise, thus preventing any legal, ethical and medical consequences that could arise from the child surviving the procedure. The latter, could be a viable alternative to LTOP where patients prefer to this procedure to LTOP and patients are healthy enough to bear the child.

As per S 39 of the 1996 Constitution, Chapter IV provided a survey on international human rights law and foreign law, which revealed that IHRL

⁷²² COTPA (note 69 above) S 2(1).

⁷²³ Boezaart (note 43 above) 13.

⁷²⁴ BADRA (note 127 above) Sections 1 and 18.

⁷²⁵ NHA (note 124 above) Sections 1 and 57.

⁷²⁶ CLA 1998 (note 111 above) 1123B/C.

⁷²⁷ CLA 2005 (note 102 above) 528H/I – J.

⁷²⁸ 1996 Constitution (note 26 above) S 27(3).

reinforces the implementation of PBA. Proscription infringes several fundamental human rights, specifically the rights to: life, freedom of choice, health and health care, privacy, equality and non-discrimination, security of person, and access to information. Foreign law indicates that there is no issue with the implementation of PBA. The only country in the world to identify an issue with and proscribe PBA is the United States of America.

Chapter V examined the assertions underpinning the proscription of PBA.

PBA opponents argue that the existence of fetal pain⁷²⁹; isolated instances of alleged intentional repudiation of patient-autonomy and wanton abuse perpetrated by physicians performing PBA^{730,731,732}; PBA's supposed likeliness to infanticide and neonaticide^{733, 734} and its infringement of the right to conscientious objection when performed in non-emergency contexts⁷³⁵; coupled with its alleged futility in emergency contexts and additional complication, justifies its proscription.^{736, 737, 738} The verity of the aforementioned arguments is precarious since they can be applied to any surgical TOP method, which would provide grounds for the proscription of all surgical abortion methods. This is untenable.

Chapter VI questioned the veracity of, and responded to, the arguments advanced in Chapter V.

⁷²⁹ Joseph (note 491 above) 93.

⁷³⁰ NAF Transcripts (note 495 above).

⁷³¹ Congressional Record (note 507 above) E1745-6.

⁷³² Leo (note 509 above) 118.

⁷³³ Parsley (note 523 above) 144.

⁷³⁴ AMA (note 524 above).

⁷³⁵ 1996 Constitution (note 26 above) S 15(1).

⁷³⁶ Kuhne (note 536 above) 240.

⁷³⁷ Schwarz & Latimer (note 324 above) 64.

⁷³⁸ Stenberg (note 431 above) 966.

The ethical postulations buttressing proscription outlined in Chapter V, are flawed. Each argument can be applied to any fetocidal abortion procedure. Therefore, proscription of every fetocidal TOP procedure would be justifiable. Proscription of D&X does not circumscribe abortion services. Yet, it undoubtedly contravenes women's constitutional rights. In fact, proscription of D&X could endanger the lives of women. Thus, it has been submitted that the implementation of PBA, which has proven to be a medically necessary and life-saving LTOP procedure that facilitates the exercise of women's constitutional and ethical rights, should not be proscribed. Moreover, the implementation of D&X could mitigate maternal mortality and morbidity in South Africa. It is further submitted that the implementation of PBA is legally and ethically justifiable in South Africa.

Chapter VII acknowledged that although the implementation of D&X is constitutionally and ethically justifiable, fetal pain can be averted. Accordingly, it is submitted that intracardiac potassium chloride be used to induce fetal cardiac asystole in conjunction with LTOP when the procedure is required. As it ensures fetal demise in a humane and painless way.

Neonatal palliative care could be an alternative to LTOP when the procedure is not required. Neonatal palliative care refers to the provision of holistic and extensive care to prevent and alleviate neonatal pain and suffering; neonatal palliative care aims to improve the neonatal quality of living and dying.^{739,740} Neonatal palliative care is usually performed on extremely premature neonates, neonates with lethal fetal congenital abnormalities, and when maximal medical or surgical treatment is futile and only prolongs neonatal pain and suffering.

⁷³⁹ Catlin (note 680 above) 184 – 185.

⁷⁴⁰ Bhatia (note 682 above) S24.

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