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Conscience Protection on Abortion: No Threat to Life

Claim:

Abortion advocates have long claimed that federal laws protecting conscience rights on abortion endanger women's lives. When the Hyde/Weldon amendment was first enacted as part of the Labor/HHS appropriations bill in 2004, they said "the provision could allow hospitals to *turn away women* who need emergency abortions because they are hemorrhaging, experiencing heart failure, or suffering any one of a host of other grave complications of pregnancy. The measure could permit callous disregard for women's health despite federal and state laws that generally require hospitals to treat patients in medical emergencies."[1] In recent years, as Congress has considered bills to make the Hyde/Weldon amendment's protections more secure (e.g., H.R. 358 in the 112th Congress, H.R. 4828 in the 114th Congress), these critics renewed their claim that such legislation "would allow a hospital to *turn away a pregnant woman* experiencing a life-threatening complication without further regard for her health or well-being."[2]

Facts:

1. The problem with constantly repeating such a charge, *after* such an allegedly "dangerous" law has been in place for many years, is that one must explain why one's prediction never came true. The fact is, the Hyde/Weldon amendment and other federal laws have protected conscience rights on abortion in all circumstances for many years, with some laws in effect since 1973; the great majority of states have similar laws.[3] And no one has documented a case in which any of these laws led anyone to "turn away" a pregnant woman, or prevented a woman from obtaining emergency treatment needed to save her life.

2. Nothing in these laws authorizes anyone to "turn away a pregnant woman" needing treatment. Since 1986, federal law has *forbidden* emergency rooms to turn away patients in medical emergencies, and requires them to provide treatment to stabilize the medical condition of such patients -- including pregnant women. But this law, the Emergency Medical Treatment and Active Labor Act (EMTALA), does not require that *abortion* be the stabilizing treatment in any case. In fact, "emergency medical condition" is defined as a condition that may jeopardize "the health of the individual (or, with respect to a pregnant woman, the health of the woman **or her unborn child**)," and the goal of treatment is to prevent deterioration of the health of both mother and child. See 42 USC §1395dd (emphasis added).

3. As the Obama administration reaffirmed in 2011 when issuing a regulation on enforcement of the Hyde/Weldon amendment, there is no conflict between that amendment (or parallel provisions in the pending federal bills) and EMTALA. The two bodies of law operate "side by side." EMTALA requires care for the pregnant woman and her unborn child, without second-guessing health care providers' judgments as to what treatment is most appropriate; the conscience laws ensure that health care providers who care for pregnant woman and their

children will not be penalized or otherwise discriminated against by governmental bodies that insist the treatments they provide *must* be abortions.[4]

4. Catholic health facilities, in particular, are guided by an ethical code forbidding *all* direct abortions. Yet data show that they provide the finest and most effective medical care in the country.[5] No Catholic hospital has been found to violate EMTALA because of its policy on respect for all human life, born and unborn. Creating "exceptions" to such providers' civil rights would force Catholic facilities, physicians and nurses to leave medicine or violate their consciences. It could also pose serious problems for the vast majority of all hospitals which do not generally provide abortions. This would undermine women's access to life-affirming health care.

5. Genuine treatments are available for the conditions cited as reasons for "therapeutic" abortion.[6] A woman experiencing heart failure needs cardiac treatment, and an abortion may only exacerbate her condition. A woman hemorrhaging during pregnancy needs the hemorrhaging controlled. At times, if treatment for a pregnant woman's life-endangering condition may also risk harm to the child, many doctors recommend an abortion before they will provide treatment – not because the abortion is needed for the mother, but because otherwise the child may be born *alive* with some injury, and the doctor wants to avoid any chance of legal liability for "wrongful birth." A doctor risks no liability for recommending abortion, even if it has no chance of improving the mother's condition. This creates what an eminent maternal-fetal medicine expert calls "a tremendous imbalance" in pressures on physicians to recommend abortion over other treatments: Doctors incur no penalty for "wrongful abortion."[7] Congress should not increase such bias toward abortion by removing longstanding conscience protections from doctors who are able and willing to save both mother and child.

6. While pro-life health care providers have a long history of respecting and saving women's lives, abortion providers have a well-documented history of *taking* the lives of *hundreds* of women since *Roe v. Wade* was decided in 1973. Almost all these women were perfectly healthy until they died at abortion providers' hands; most probably assumed that because abortion is legal it is "safe."[8] Effective protection of women from the dangers of legal abortion has often been opposed by pro-abortion groups – the same groups that claim they want to protect women's lives by punishing physicians who do *not* provide abortions.[9]

Abortion advocates have long held that physicians who want to provide abortions – even the grotesque late-term procedure called partial-birth abortion, now banned by federal law and many state laws – must be allowed full discretion to choose such procedures, even without evidence that they are needed for women's health. Now they say that physicians who provide care for women and their unborn children without performing abortions must have their civil rights suppressed, even without evidence that such coercion would help women. Congress should not support this biased and selective agenda, which values "choice" only if it is a choice for abortion.

[1] American Civil Liberties Union, "Safeguard Women's Access to Critical Reproductive Health Care: Repeal the Women's Health Care Refusal Provision" (2005), www.aclu.org/safeguard-womens-access-critical-reproductive-health-care-repeal-womens-health-care-refusal-provisio (emphasis added).

[2] American Civil Liberties Union, "House Holds Hearing on Dangerous Abortion Legislation" (Feb. 9, 2011), at www.aclu.org/reproductive-freedom/house-holds-hearing-dangerous-abortion-legislation (emphasis added).

[3] For federal laws see USCCB Secretariat of Pro-Life Activities, "Current Federal Laws Protecting Conscience Rights" (February 2016), at http://www.usccb.org/issues-and-action/religious-liberty/conscience-protection/upload/Federal-Conscience-Laws.pdf.

[4] On the relationship between conscience laws like Hyde/Weldon and other federal laws like EMTALA, the Administration said: "The conscience laws and the other federal statues have operated side by side often for many decades. As repeals by implication are disfavored and laws are meant to be read in harmony, the Department fully intends to continue to *enforce all the laws it has been charged with administering*…. [E]ntities must continue to comply with their… EMTALA… obligations, *as well as* the *federal health care provider conscience protection statutes*." Department of Health and Human Services, "Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws," 76 *Fed. Reg.* 9968-77 (Feb. 23, 2011), at 9973, 9974 (emphasis added).

[5] In 2010 a study of 255 health systems found: "Catholic and other church-owned systems are significantly more likely to provide higher quality performance and efficiency to the communities served than investor-owned systems. Catholic health systems are also significantly more likely to provide higher quality performance to the communities served than secular not-for-profit health systems." David Foster, Ph.D., M.P.H., *Research Brief: Differences in Health System Quality Performance by Ownership* (Thomson Reuters, August 9, 2010), at http://www.nonprofithealthcare.org/uploads/Study_Finds_Quality_in_Nonprofit_Health_Systems_Better-with_Church-Owned_the_Best.pdf. A similar study in 2013 also found that "not-for-profit church-owned hospitals have had the greatest success in achieving balanced excellence (highest overall score on the balanced scorecard) in serving their communities…. [T]he church-owned hospitals are still leading other ownership groups in delivering high value to their communities with reliable high quality and efficiency and high patient perception of care at a reasonable cost." David Foster, Ph.D., M.P.H., Louise Zrull, and Jean Chenoweth, *Research Brief: Hospital Performance Differences by Ownership* (Truven Health Analytics, June 2013), at http://100tophospitals.com/portals/2/assets/HOSP_12678_0513_100TopHopPerfOwnershipPaper_RB_WEB.pdf.

[6] When Congress debated a conscience rights bill in 2011, letters were read into the record from four experts with many decades' experience in high-risk obstetrics and emergency medicine, affirming that there is no need for an exception in conscience laws on abortion in order to serve women's life and health. *Cong. Record*, October 13, 2011, pages H6877-8. Even a physician who performed abortions for decades writes: "The idea of abortion to save the mother's life is something that people cling to because it sounds noble and pure -- but medically speaking, it probably doesn't exist." Don Sloan, M.D. and Paula Hartz, *Choice: A Doctor's Experience with the Abortion Dilemma* (New York: International Publishers, 2nd ed, 2002), p. 46. Over half a century ago, when medical science was less developed, Planned Parenthood's own medical director said that "medically speaking, that is, from the point of view of diseases of the various systems, cardiac, genitourinary, and so on, it is hardly ever necessary today to consider the life of a mother as threatened by a pregnancy." Mary S. Calderone, M.D., "Illegal Abortion as a Public Health Problem," *American Journal of Public Health* (July 1960), pp. 948-954 at 948-9.

[7] "No matter what the personal convictions of the mother, she must receive her care in a system in which every possible problem of maternal or fetal well-being is a test of whether the pregnancy will be allowed to continue. And in that balance, the developing human has little or no value. There is no counterweight to 'wrongful birth.' There is no 'wrongful abortion'." Thomas Murphy Goodwin, M.D., "Medicalizing Abortion Decisions," *First Things*, March 1996, pp. 33-36 at 35-6; http://www.firstthings.com/article/1996/03/003-medicalizing-abortion-decisions.

[8]See Centers for Disease Control and Prevention, *Abortion Surveillance – United States, 2012* (Nov. 27, 2015), p. 40, Table 23, documenting 492 women's deaths from abortion (at least 424 from legal abortion) from 1973 when abortion was legalized through 2011 (with the "case-fatality rate" *higher* in 2008-2011 than during the previous 15 years); available at http://www.cdc.gov/mmwr/pdf/ss/ss6410.pdf. . Such figures may be a significant understatement. See David Reardon, Ph.D., "The Cover-Up: Why U.S. Abortion Mortality Statistics Are Meaningless" (2000), at http://afterabortion.org/2000/the-cover-up-why-u-s-abortion-mortality-statistics-are-meaningless/.

[9] See: Melinda Henneberger, "Kermit Gosnell's Pro-Choice Enablers (Is This What an Industry That Self-Regulates Looks Like?)," *Politics Daily*, January 23, 2011; William Saletan, "The Back Alley: How the Politics of Abortion Protects Bad Clinics," *Slate*, February 16-25, 2011 (Seven-part series), at www.slate.com/articles/news_and_politics/the_back_alley.html.