1989

Reproductive Health; Series I; File 129

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#129 Reproductive Health

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MAR 31 1989

TO: **ANA Board of Directors**

Executive Directors
Presidents
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FROM: Lucille A. Joel, Ed.D., R.N., F.A.A.N.
President

DATE: March 28, 1989

RE: ANA Activities Related to Reproductive Health

Like many of you, ANA is increasingly receiving inquiries regarding the Association's official position on abortion. In recent weeks, several ANA organizational units have been discussing the multiple issues surrounding rights of individuals related to reproductive health. This spring the Supreme Court of the United States will hear the abortion rights case of Webster v. Reproductive Health Services (see enclosed briefing paper). Because of this, there is a possibility that the Roe v. Wade decision (the 1973 landmark decision that extended constitutional protection to a woman's right to have an abortion) may be modified or overturned.

The ANA Board of Directors has held five conference calls to address actions appropriate for the Association to take on this matter. These calls were held on March 10th, 18th, 20th, 25th, and 27th. The Board of Directors determined that ANA should develop a position on reproductive health that purposefully remained silent on the issue of abortion, pro or con, but that focused on abortion as a symptom of social failure and on the broader social issues being debated under the rubric of abortion, i.e., the individuals right to access to care, to privacy, to a confidential relationship with their provider of health services, and the providers own ethical obligations in that relationship. The Board also decided that ANA should prepare an amicus brief to the Supreme Court of the United States encompassing the position statement.

Members of the Constituent Forum Executive Committee and the Board of Directors have contacted all SNA's to share the intent of the Association related to the position statement and amicus brief on reproductive health. SNA's favorably supported ANA's advocacy role in addressing individual and nurses rights.

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Enclosed for your information and use are the following:

1) Briefing Paper on The Supreme Court of the United States and the Right to Privacy Related to Reproductive Choice

2) Background on ANA Policy Related to Access to Care, Information and Privacy

3) ANA's Statement on Reproductive Health (note this statement can be used until the statement on formal letterhead arrives in the communications packet).

The amicus brief will be filed on Thursday, March 30th. A communications packet will be sent on March 31st under a special mailing to all SNA's. The communications packet will include 1) a communications plan outlining how ANA plans to manage public relations efforts around the issue, 2) ANA's amicus brief, 3) a press release from ANA to public media and nursing and health care press, 4) a Question and Answer briefing paper on ANA's stance on reproductive rights, 5) guides for SNA's to use in responding to calls 6) ANA Statement on Reproductive Health and 7) any other relevant materials related to communications. You should receive this on Monday April 3, the day that we intend to launch our public relations efforts. If you have any helpful suggestions or questions related to this issue and communications please call Cynthia Cizmek or Cathy Koeppen in the Kansas City office. Additional information will be sent to you following the April Board of Directors meeting regarding the appointment of an ANA task force to address underlying health and social welfare problems that have contributed to the abortion-related concerns confronting society today.

The Board hopes that this background information will provide SNA's with some anticipatory guidance in responding to potential inquiries. If you have any questions please contact Karen O'Connor, M.A., R.N., Director of the Division on Practice and Economics.

LAJ:SSM:dp:038

Enclosures

cc: ANA Cabinet and Council Chairpersons
House of Delegates Standing Committees

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AMERICAN NURSES' ASSOCIATION

Briefing Paper

The Supreme Court of the United States
and the Right to Privacy Related to Reproductive Choice

INTRODUCTION

It is recognized that 1989 will be a year filled with much discussion, debate, and possible changes in American's right to privacy related to reproductive choice. In the case of Webster v. Reproductive Health Services, (851 F.2d 1071, 8th Cir., 1988), the Supreme Court of the United States may re-examine its 1973 Roe V. Wade decision and reconsider whether and to what extent privacy related to reproductive choice remains a constitutional right. If the Court redefines the perimiters of reproduction privacy, the decision will have broad ramifications for reproductive health care in general and may foreshadow the Supreme Court's views on other constitutional issues.

Nurses, individually and in groups, have been following the discussions and the possibility that the Supreme Court will revisit the Roe V. Wade issues. On January 9, 1989, the Supreme Court of the United States agreed to hear arguments in the Missouri case of Webster v. Reproductive Health Services (851 F.2d 1071, 8th Cir., 1988). Webster is an appeal by the Missouri attorney general of a decision by the U.S. Court of Appeals for the Eighth Circuit that invalidated several provision of a Missouri law regulating abortion. These provisions include defining human life as beginning at conception; requiring expensive, risky, and usually medically unnecessary tests before determining fetal viability prior to an abortion; banning the use of public funds for counseling or encouraging a woman to have an abortion; and banning access to public facilities and employees for abortions. A date for argument before the Supreme Court will be scheduled after both sides have filed briefs, possibly as early as spring, 1989. On November 10, 1988, the Reagan administration filed an amicus brief urging the Court to use Webster as an opportunity to reconsider Roe v. Wade, the 1973 ruling that established women's constituional right to abortion.

State nurses' associations, student nurses, and other nursing, health care and trade organizations are inquiring regarding ANA's position. The general consensus is that it is timely for ANA to consider a position on reproductive choice issues. The following points can be considered today, which were noted and relevant in 1968 when the ANA Division on Maternal and Child Health Nursing presented the "Statement to Study State Abortion Legislation":

- ANA, as the professional organization for nurses, has the responsibility to speak up on social health issues, and take a "position."
- ANA does not expect that a "stand" taken by the organization will coincide with every nurse's point of view.
- Nurses need to be aware of social issues that have bearing on health, and ANA has the responsibility to keep them informed.

BACKGROUND INFORMATION

In 1973, the Supreme Court of the United States affirmed what several states had already established: that the decision to have an abortion during the first trimester (12 weeks) of pregnancy should be left entirely to the woman and her physician. During the second trimester, the Court said states could regulate the abortion procedure, but for only one purpose - to protect the woman's health. Subsequent to viability of the fetus, the state may regulate abortion further or proscribe it; except when necessary to preserve the woman's life or health (Roe v. Wade, 410 U.S. 113, 1973).

Since 1973, the Supreme Court has ruled on several abortion cases (see attachment 1), each time maintaining the right of individuals to make their own personal decisions. The Court has also ruled that neither the federal nor state government may be required to fund abortions not otherwise provided by statute. But the Court has consistently struck down efforts to end or complicate access to abortion by regulations such as mandatory waiting periods or exposing all patients to anti-abortion materials (Voters for Choice, "Winning with Choice: A Guide to Message and Strategy, 1988" p.12).

Experience since 1973 demonstrates that when abortion is available to women, they use it during the first several weeks when abortion is safest (S.K. Henshaw, "Characteristics of U.S. Women Having Abortions, 1982-1983." Family Planning Perspectives 19:1, 1987, p.6). Since Roe v. Wade, deaths related to abortion have dropped by 90 percent ("Celebrating Roe v. Wade: Dramatic Improvements in American Health." Published by National Abortion Federation, January 1989, p.1).

Although death rates attributable to childbirth have also declined in recent years (by 53%), deaths attributable to abortion have declined much more sharply. The greater decline is a direct result of the abortion procedure having been legalized (C. Tietze and S.K. Henshaw, "Induced Abortion: A World Review," The Alan Guttmacher Institute, 1986, pp.109-110). Today women rarely die from legal abortions and they experience complications in less than one half of one percent of abortions. (Ibid and National Abortion Federation Fact Sheet: "Safety of Abortion." revised 1988). Statistically, abortion has become one of the safest surgical procedures available (NAF, 1989, p.3).

The total number of legal abortions reported to the Centers for Disease Control (CDC) from the 50 states and the District of Columbia was 1,333,521 in 1984 and 1,328,570 in 1985 (MMWR, vol. 37/No.46, November 25, 1988, p.713). The number of abortions reported for 1984 was approximately 5% higher than the number reported for 1983, where as virtually no change occurred in the number reported between 1984 and 1985 (Ibid). As in previous years, women obtaining abortions in 1984 and 1985 tended to be young, white and unmarried and to have had no live births. CDC initiated national abortion surveillance in 1969. Between 1969 and 1982, the reported number of women obtaining abortions increased yearly. However, the annual percentage increase in numbers of abortions declined continuously between 1976 and 1982, from 9.2% for 1976-1977 to 0.2% for 1981-1982. Since 1980, the abortion numbers, ratios, and rates appear to be relatively stable, with minor year-to-year fluctuations.

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ANA ACTIVITIES RELATED TO REPRODUCTIVE CHOICE

Although ANA does not have an official position on abortion at this time, the association has addressed the issue for over 20 years. The 1968 ANA House of Delegates adopted the "Statement to Study State Legislation on Abortion" (see attachment 2). The recommendations and rationale in this statement are relevant to the abortion related issues being revisited by the Supreme Court today. "Because nurses have a real and enduring interest in the well-being of people, the ANA endorses efforts to promote discussion and understanding of the moral, ethical and professional issues involved in making changes in the existing abortion laws." (ANA HOD, May 1968). In 1978, the previously existing ANA Division on Maternal and Child Health Nursing Practice adopted a "Statement on Abortion." This statement described the rights and responsibilities of both clients/patients and of nurses and considered related philosophical and ethical issues. In 1984, the newly formed Council on Maternal-Child Nursing evaluated and revised the 1978 "Statement on Abortion." The council executive committee's rationale at that time for establishing a position was their support for the right of the woman to maintain control over her body; respect for the woman's life, and the dignity and right of humankind, unrestricted by gender. The executive committee believed in a position that would support respect for individual beliefs, and values, while seeking to promote the individual's health through reasonable responses to requests for services. The council executive committee recognized that it is within the domain of professional nursing to act as a client and nurse advocate.

In 1985, the Council on Maternal-Child Nursing was apprised that former position statements adopted by the Division on Maternal-Child Nursing Practice that were not sent to the ANA Board of Directors or House of Delegates for adoption would <u>not</u> be considered policy of the association. Therefore, the association did not have established policy or a position on abortion. As a result, the council was asked to consider the pros and cons of developing ANA policy regarding abortion. At that same time, the association recognized that the 1980's appeared to bring an increased focus on issues surrounding reproductive choice, especially abortion. The council agreed to request that the Committee on Ethics review and provide comments on the council's 1984 revised "Statement on Abortion" and their rationale. The council executive committee acknowledged at that time the statement contained material which could be deemed offensive to health professionals, consumers and/or political groups. The Committee on Ethics observed that the statement focused on patients rights to informed choice and the nurse's right to practice, rather than, as titled, "A Statement on Abortion." Accordingly, the Committee on Ethics believed the <u>Code for Nurses</u> and the interpretive statements provided adequate guidance on the issue of abortion, and thus the council executive committee did not recommend the development of a statement for consideration by the House of Delegates.

The Committee on Ethics specifically asked the council to consider the first plank of the <u>Code for Nurses</u> and one of its interpretive statements which state:

> "1. The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social and economic status, personal attributes, or the nature of the health problem."
>
> "1.3 The nurse's concern for human dignity and for the provision of high-quality nursing care is not limited by personal attitudes or beliefs. If opposed ethically to interventions in a particular case because of the procedures to be used, the nurse is justified in refusing to participate. Such refusal should be made known in advance and in time for other appropriate arrangements to be made for the client's nursing care. If the nurse becomes involved in such a case and the client's life is in jeopardy, the obligation is to provide for the client's safety, to avoid abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the client."

The council executive committee agreed that the <u>Code for Nurses with Interpretive Statements</u> outlined appropriate nursing actions in caring for a client receiving an abortion. Therefore, in 1988, the Council on Maternal Child Nursing reaffirmed that it was not necessary for the association to have a formal position statement on abortion and that the <u>Standards of Maternal and Child Health Nursing Practice</u> and <u>Standards of Practice for the Perinatal Nurse Specialists</u> will also help guide nurses and the profession in addressing issues related to reproductive choice.

Page 5 of the <u>Standards of Maternal and Child Health Nursing Practice</u> states that "clients' rights include the right to be autonomous, the right to make an informed decision, and the right to one's domain, including one's body, one's life, one's property, and one's privacy. After a clear explanation, due considerations, and an opportunity to question, a competent client has the right to make decisions about care, without coercion. Competent clients have the right not to seek or to use health care recommendations." "In the care of the unborn, the infant, or the very young child, the parent should make informed decisions about care, provided the child's rights are not violated." Additional ethical responsibilities in MCH nursing practice addressed in this document notes that "Nurses have the right to decide, without coercion, not to participate in activities which they deem immoral" (p.5-6).

In 1987, President Reagan directed the U.S. Surgeon General to prepare a comprehensive report on the health effects of abortion on women. ANA was one of 27 organizations that met with Surgeon General Koop to discuss the mental and physical health effects of abortion on women. ANA focused comments to the Surgeon General toward needs in the areas of access to care, primarily prenatal care and child care. The Surgeon General learned from this project that, even among groups committed to confirming a woman's right to legal abortion, there was a consensus that any abortion represented a failure in some part of society's support system - individual, family, church, public health, economic, or social. However, regarding possible mental health effects of abortion, he stated "... I have concluded in my review of this issue that, at this time, the available scientific evidence about the psychological sequelae of abortion simply cannot support either the preconceived beliefs of those pro-life or of those pro-choice. For example, there are almost 250 studies reported in the scientific literature which deal

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with the psychological aspects of abortion. All of these studies were reviewed and the more significant studies were evaluated by staff in several of the Agencies of the Public Health Service against appropriate criteria and were found to be flawed methodologically. In their view and mine, the data do not support the premise that abortion does or does not cause or contribute to psychological problems. Anecdotal reports abound on both sides. However, individual cases cannot be used to reach scientifically sound conclusions. It is to be noted that when pregnancy, whether wanted or unwanted, comes to full term and delivery, there is a well documented, low incidence of adverse mental health effects."

PUBLIC VIEWS ON ABORTION

There is a wide divergence of thinking among the general public on several aspects of the very complex and sensitive issue of reproductive choice. Surgeon General C. Everett Koop, in a letter to President Ronald Reagan on January 9, 1989, stated "It is difficult to label the opposing groups in the abortion controversy. Those against abortion call themselves pro-life. On the other hand, those who are not pro-life say they are not pro-abortion; rather they refer to themselves as pro-choice and supporters of a woman's right to choose abortion. It is also true that some who are pro-choice are personally opposed to abortion. It is not clear to them where the lines should be drawn between the right of the fetus and the right of the mother. So the pro-choice forces are not monolithic. Nor are the pro-life forces monolithic. Many ardent pro-life individuals who are dedicated to preserving the life of the fetus do not consider contraception to be ethically, morally, or religiously wrong. But others in the pro-life camp do; indeed, some equate contraception with abortion."

The most recent national survey of public attitudes about abortion was conducted in December, 1987 and January, 1988 by Democratic pollster Harrison Hickman of Hickman-Maslin and Republican pollster Linda Divall of American viewpoints. The results were clear and consistent with other reputable public opinion data on this issue:

- The vast majority of Americans (88%) say abortion should be legal (54% said "always"; 34% said sometimes).

- 87% of the public believes that if abortions were made illegal, women would be physically harmed in abortions performed by unqualified people.

- Privacy is an important issue. Most Americans reject the idea that government should interfere in private, personal decisions. The many years of activism, rhetoric and tactics by "anti-choice" groups seemingly has not moved public opinion on the abortion issue, and most people (82%) say their opinions are firm and will not change because they understand that the prohibition of abortion will have damaging effects. The belief is that the right to privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy. The

detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.

Despite the fact that the country has not been "moving to the right" on this issue, the continuing perception of anti-abortion strength at the polls leads many in Congress to attempt to appease "right to life activists" by tolerating their assaults on an increasingly wide range of issues related to abortion. However, if one traces the evolution of abortion as a political issue, particularly since the Supreme Court decided Roe v. Wade in 1973, and analyzes the role that abortion has, or more often has not, played in federal level elections since that time, the results dispel the common political wisdom that being pro-choice is inherently dangerous politically. The anti-abortion activists have not been able to deliver on their threats to retaliate at the polls against members of Congress who do not support their agenda.

Among nurses, neither the pro-choice or right to life issue is neatly marked in black or white, but in shades of gray. It is clear that nurses within ANA hold a variety of opinions about the highly sensitive and debatable issue of abortion (e.g. some nurses have requested ANA to work towards delegalizing abortion in the U.S. and other nurses have encouraged the association to work for the continued provision of legal, safe and accessible family planning and abortion services). Nonetheless, as the largest group of health care professionals in the country, and in as much as the nursing profession accepts the obligation of providing competent nursing care as its major responsibility, nurses have a responsibility to give the patient objective information and to provide access to resources in accordance with the patient's emotional, psychological and physical needs.

In a recent edition of the Oregon Nurse (official publication of the Oregon Nurses' Association), Elayne Puzan, R.N., wrote "The right to life which underpins our Constitution has been distorted for political purposes. The impassioned debate about abortion is a case in point. The polarization engendered by this important women's health issue has destroyed the middle ground of reconciliation. What remains are rigid labels hurled across tightly drawn lines. The very effort to protect the unborn has degenerated into a violation of the rights of others. If "right to life" is anything more than an emotional, inflammatory slogan, surely its purpose cannot be achieved by blocking clinic doorways and denying women access to the health care they seek. As nurses, we seldom express our views publicly on controversial issues... our collective silence is unfortunate. Nurses have the opportunity

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to watch life more closely than most... mindful of our professional responsibility, we (must) advocate for our patients... Especially in matters related to health care, our opinions merit serious consideration and need to be heard."

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In Brief: Major U.S. Supreme Court Decisions Regarding Abortion, 1973-1988

Roe v. Wade, 410 U.S. 113 (1973) held unconstitutional Texas' statute prohibiting abortions except to save the life of the mother. The decision held that during the first trimester of pregnancy, the abortion decision and the abortion itself must be left to the woman and her attending physician. In the second trimester, the state may regulate the abortion procedure in ways reasonably related to the woman's health. Subsequent to viability,[31] the state may regulate abortion further or proscribe it, except when necessary to preserve the woman's life or health.

Doe v. Bolton, 410 U.S. 179 (1973) held unconstitutional Georgia's statute requiring that abortions be (1) conducted in accredited hospitals, (2) approved by a hospital abortion committee, (3) confirmed by other physicians, and (4) restricted to state residents. The decision upheld the requirement that physicians base abortion decisions on their best clinical judgment.

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) upheld (1) the statutory definition of viability, (2) provisions requiring a woman's consent for abortion, and (3) requirements for abortion reporting and recordkeeping with reasonable confidentiality requirements. The court held unconstitutional (1) a spousal consent provision, (2) a blanket parental consent requirement for unmarried minors, (3) a prohibition of amniocentesis after the first trimester, and (4) a requirement that physicians exercise professional care to preserve the fetus' life and health on pain of criminal and civil liability.

Bellotti v. Baird, 428 U.S. 132 (1976) held that the lower court should have asked the Massachusetts Supreme Judicial Court to interpret the meaning of Massachusetts' parental consent law and the procedures imposed by that law—and that the necessity for federal constitutional adjudication might be avoided if the statute were interpreted to permit an alternative to parental consent.

Beal v. Doe, 432 U.S. 438 (1977) held that the Social Security Act does not require states to fund non-therapeutic abortions[32] as a condition of participating in the Medicaid program.

Maher v. Roe, 432 U.S. 464 (1977) held that the Equal Protection Clause does not require a state to provide Medicaid funds for non-therapeutic abortions even though the state provides funds for childbirth expenses.

Colautti v. Franklin, 439 U.S. 379 (1979) held that the section of a Pennsylvania statute that imposed a standard of care by abortion providers when the fetus is or may be "viable" was "impermissibly vague."

Bellotti v. Baird, 443 U.S. 622 (1979) found unconstitutional, because it burdens the minor's right to seek an abortion, a Massachusetts statute that required a pregnant minor seeking an abortion to obtain her parents' consent, or to obtain judicial approval following notification of her parents.

Harris v. McRae, 448 U.S. 297 (1980) held that (1) Title XIX of the Social Security Act did not require participating states to fund medically-necessary abortions for which federal funds were made unavailable by the Hyde Amendment;[33] (2) the Hyde Amendment's restrictions on federal funding did not impinge on a woman's freedom to decide whether to terminate her pregnancy, and (3) the Hyde Amendment did not violate the Establishment Clause of the First Amendment.

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Williams v. Zbaraz, 448 U.S. 358 (1980) held that Illinois was not obligated under Title XIX to pay for abortions for which federal funds were unavailable under the Hyde Amendment and that funding restrictions in the Illinois statute did not violate the Equal Protection Clause.

H.L. v. Matheson, 450 U.S. 398 (1981) upheld a Utah statute requiring a physician to notify, if possible, parents of a minor seeking an abortion (as applied to an unemancipated minor girl living with and dependent upon her parents, and making no claim or showing as to her maturity or as to her relations with her parents).

Planned Parenthood of Kansas City, Missouri v. Ashcroft, 462 U.S. 476 (1983) held unconstitutional Missouri's requirement that abortions after twelve weeks of pregnancy must be performed in a hospital. The decision upheld provisions requiring (1) pathology reports for each abortion performed, (2) the presence of a second physician during abortions performed after viability, and (3) the consent of a parent or juvenile court for minors' abortions.

City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983) held unconstitutional, as not reasonably related to protecting women's health, an ordinance that mandated (1) performing in a hospital all abortions after the first trimester of pregnancy, (2) parental consent or a judicial order for all unmarried minors under the age of 15 seeking abortion, (3) specific information under "informed consent," (4) a 24-hour waiting period, and (5) specific requirements for disposal of fetal tissue.

Simopoulos v. Virginia, 462 U.S. 506 (1983) upheld, as legitimate to protect women's health, Virginia's requirement that second-trimester abortions be performed in a licensed "hospital," which was defined to include outpatient clinics.

Diamond v. Charles, 106 S.Ct. 1697 (1986) held that without an appeal by the state, a physician's status as a pediatrician, parent, or "protector of the unborn" did not accord him standing to challenge an Illinois abortion law.

Thornburgh v. American College of Obstetricians & Gynecologists, 106 S.Ct. 2169 (1986) held unconstitutional, as not reasonably related to protecting women's health, portions of a Pennsylvania statute that required (1) detailed information to be given under "informed consent," (2) public reports and disclosure of detailed information about abortions performed, and (3) a stated degree of care for postviability abortions that included the presence of a second physician but did not include exceptions for medical emergencies to protect the woman's health.

The Supreme Court has repeatedly struck down state laws that interfere with the abortion decision.

Attachment 2

AMERICAN NURSES' ASSOCIATION

Statement to Study State Legislation on Abortion

During the past biennium, there has been marked activity by individuals and lay and professional groups to change the existing abortion laws in the states.

The changes recommended have followed the general provisions of the 1959 Model Penal Code of the American Law Institute, which provides for legal termination of pregnancy to preserve the life and health of the mother when either would be seriously jeopardized by continuance of pregnancy; when there is substantial risk of fetal anomalies; and when pregnancy results from rape or incest. The Penal Code also specifies that therapeutic abortions for the above reasons should be performed only by licensed physicians in accredited hospitals, after consultation with medical colleagues.

The concern of the American Nurses' Association about this social health issue stems from the belief that the health and welfare of women and their families are seriously imperiled by the loose application of the present abortion laws and/or the disregard of them. It does not imply that nurses should make the decisions or perform abortions.

The American Nurses' Association, the professional organization of registered nurses, concerned with the health and welfare of individuals and families, supports the movement to examine and modify existing abortion laws where they have proven to be inadequate to meet the needs of society in reducing the number of illegal abortions.

Because nurses have a real and enduring interest in the well-being of people, the ANA endorses efforts to promote discussion and understanding of the moral, ethical and professional issues involved in making changes in the existing abortion laws.

Adopted by ANA House of Delegates, May 1968.

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American Nurses' Association

Background on ANA Policy Related to
Access to Care, Information and Privacy

The American Nurses' Association (ANA) believes that an individual has the right to privacy and free speech, to a confidential relationship with their health care provider(s), and to equal access to care, including the right to choose their health care provider(s). Because nurses have a real and enduring interest in the well-being of people, ANA supports efforts to promote discussion and understanding of the moral, ethical, and professional issues involved in legislation and regulation pertaining to significant public and social health issues. The Code for Nurses mandates that nurses collaborate with members of the health profession and other citizens in promoting community and national efforts to meet the health needs of the public.

The rights and responsibilities of both clients and nurses are philosophical and ethical issues. In addressing the health of the public, ANA gives due consideration to both the needs and rights of clients/consumers and those of nurses.

One of the roles of ANA as the national professional association of nurses is to influence and monitor the development and progress of legislative and regulatory initiatives that affect access to health care as well as individual human rights. ANA supports the availability of quality health care, the confidentiality of that care, and respect for the individual. Nurses cannot support initiatives that ignore individual human rights, decrease access to available health care resources, and increase the potential for adverse health conditions.

Nursing ethics is concerned about the just allocation of resources in society, equitable access to health and nursing care, and the protection of the health and welfare of the socially vulnerable, disvalued, or disadvantaged. These are human rights concerns, grounded in nursing's social ethics. ANA has adopted and continues to prioritize the goal to maintain and strengthen nursing's role in client advocacy. ANA supports nursing's right and obligation to assist the client to determine and control the use of health resources. Health care should be a basic human right, and it is the right of the consumer to have equal access to health care services based on need. ANA opposes discrimination against health care consumers based on financial resources or the lack thereof.

Clients' rights include the right to be autonomous, the right to make an informed decision, and the right to one's domain, including one's body, one's life, one's property, and one's privacy. After a clear explanation, due consideration, and an opportunity to question, a competent client has the right to make decisions about care, without coercion. Clients have the right not to seek or to use the recommendations of health care providers. Equal access to health care services includes the right of consumers to choose health care services and the provider of those services. Clients have the right to competent, supportive care, both physical and psychological. They also have the right to freedom from the imposition of others' beliefs. Clients have the right to receive their health care in an environment that provides privacy and competent nursing care. Clients have the right to a confidential relationship with their chosen health care provider, and this should be respected.

The nurse has the right to share all relevant health care information with the client in order for the client to be an informed consumer of health care services. Nurses have the responsibility to provide clients with objective information and provide access to resources related to their individual health care needs. Nurses have a right to their own moral, ethical, and religious beliefs. Nurses have a responsibility to give good care without imposing their own personal beliefs on any client. If opposed ethically to interventions in a particular case because of the procedures to be used, the nurse is justified in refusing to participate. Such refusal should be made known in advance and in time for other appropriate arrangements to be made for the client's nursing care. If the nurse becomes involved in such a case and the client's life is in jeopardy, the nurse is obliged to provide for the client's safety, to avoid abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the client. The nurse has a right and responsibility to seek employment in areas where the nurse will not be assigned the care of clients whose health care needs may conflict with the nurse's ethical and philosophical beliefs. Nurses have a right to an educational preparation that will enable them to meet the emotional, physical, and psychological needs of the variety of clients to whom they may provide care.

In order to meet the multiple health and welfare issues related to reproductive rights challenging our society today, ANA believes that society as a whole needs to strengthen its support systems -- individual, family, church, public health, economic, and social. The health care community needs to be more aggressive in developing additional and effective reproductive planning strategies that meet society's diverse cultural, economic, and social/generational needs. Equal access to health care services by all members of society must increase. In addition, society must provide those resources to support the needs of children and families in order to promote the public and social health of our nation's citizens for the betterment of society as a whole.

SSM:ds
3/28/89

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3/28/89

#129 Reproductive Health

AMERICAN NURSE'S ASSOCIATION

Statement on Reproductive Health

As health care providers, nurses have a long and proud history of support for a fair and equitable health care delivery system in which all Americans have access to basic health services, including services related to reproductive health. The foundation of such a system rests on the broader social rights of privacy, free speech, freedom of choice, confidentiality between client and provider, and equity of access to essential services.

The American Nurses' Association (ANA) believes that abortion is largely a symptom of social failure. The controversy over abortion is just one of many stages on which the critical social issues of access to care, freedom of choice, and the right to privacy are being played out.

The American Nurses' Association cannot support initiatives that ignore individual human rights, decrease access to care, or increase the potential for adversity in the human condition. Should the Supreme Court of the United States rule to reverse the 1973 Roe v. Wade decision, a serious situation of unequal access could be created. States would predictably choose to take differing positions on the legality and financing of abortion. Therefore, many women would inevitably rely on illegal procedures performed in clandestine systems, resulting in a return to high mortality and morbidity.

ANA believes that the health care client has the right to privacy and the right to make decisions about personal health care based on full information and without coercion. It is the obligation of the health care provider to share with the client all relevant information about health choices that are legal and to support that client regardless of the decision the client makes. Abortion is a reproductive alternative that is legal and that the health care provider can objectively discuss when counseling clients. If the state limits the provision of such information to the client, an unethical and clinically inappropriate restraint will be imposed on the provider and the provider-client relationship will be jeopardized.

Just as the client has rights, the nurse also has rights, including the right to refuse to participate in a particular case on ethical grounds. However, if the nurse becomes involved in such a case and the client's life is in jeopardy, the nurse is obliged to provide for the client's safety, to avoid abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the client.

The fact that thousands of American women are seeking abortion is a symptom, not the disease. The treatment lies in addressing the problems underlying a deteriorating social fabric. Health care providers have the right and responsibility to seek viable solutions to problems that signal social failure, such as ineffective family planning, deficient prenatal care, drug and alcohol abuse, domestic violence, unsuccessful parenting, sexually transmitted disease, and inadequate child care.

As one of the major national health care provider organizations, the American Nurses' Association believes it has a responsibility to continue its advocacy for a healthier nation. To this end, ANA has established a task force to address health and social problems and policies that have contributed to the abortion-related concerns confronting society today. Policy recommendations from this task force will provide future direction for ANA programs in the legislative and regulatory arenas as well as those programs that address nursing practice.

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3/27/89