

## ARTICLES

# THE THERAPEUTIC EXCEPTION: ABORTION, STERILIZATION AND MEDICAL NECESSITY IN COSTA RICA

MARÍA CARRANZA

### Keywords

medical discretion,  
medical necessity,  
therapeutic abortion,  
therapeutic sterilization,  
contraceptive sterilization,  
Costa Rica

### ABSTRACT

Based on the case of Rosa, a nine-year-old girl who was denied a therapeutic abortion, this article analyzes the role played by the social in medical practice. For that purpose, it compares the different application of two similar pieces of legislation in Costa Rica, where both the practice of abortion and sterilization are restricted to the protection of health and life by the Penal Code. As a concept subject to interpretation, a broad conception of medical necessity could enable an ample use of the therapeutic exception and a liberal use of both surgeries. The practice of therapeutic sterilization has been generalized in Costa Rica and has become the legitimate way to distribute contraceptive sterilization. In contrast, therapeutic abortion is very rarely practiced. The analysis carried out proposes that it is the difference in social acceptance of abortion and sterilization that explains the different use that doctors, as gatekeepers of social morality, make of medical necessity.

In January 2003, a news article shocked Costa Rica. Rosa,<sup>1</sup> a nine-year-old Nicaraguan girl, was three months pregnant.<sup>2</sup> The child, the daughter of Nicaraguan peasants working in Costa Rica, was admitted to the hospital in Turrialba, a city 53 km from the capital (San José), where her pregnancy was classified as ‘very high risk’.<sup>3</sup>

There is a paucity of literature referring to the consequences of pregnancy during childhood, which

might be explained by the relative low frequency of cases. Nonetheless, it would be logical to assume that risks of adverse maternal outcomes, including death, which have been recognized to increase among girls under 16,<sup>4</sup> as well as the negative social and psychological consequences of early pregnancy, particularly when enforced, would only increase with pregnancy at age nine.

Nonetheless, and in spite of the fact that the Costa Rican Penal Code allows the practice of

<sup>1</sup> A pseudonym given to the girl by the press.

<sup>2</sup> R. Rodríguez. 2003. Alarma Embarazo de Niña: Menor de 9 Años con Tres Meses de Gestación. *La Nación* 31 January. Available at: [http://www.nacion.com/ln\\_ee/2003/enero/31/pais3.html](http://www.nacion.com/ln_ee/2003/enero/31/pais3.html) [Accessed 20Aug 2006].

<sup>3</sup> ‘Embarazo de altísimo riesgo’.

<sup>4</sup> A. Conde-Agudelo, J. Belizán & C. Lammers. Maternal-perinatal Morbidity and Mortality Associated with Adolescent Pregnancy in Latin America: Cross-sectional Study. *Am J Obstet Gynecol* 2005; 192: 342–349; A. Menacker et al. Births to 10–14 Year-Old Mothers, 1990–2002: Trends and Health Outcomes. *Natl Vital Stat Rep* 2004; 53: 1–19.

Address for correspondence: María Carranza, Instituto Costarricense de Investigación y Enseñanza en Nutrición y Salud (INCIENSA), Apdo-4-2250, Tres Ríos, Cartago, Costa Rica. [mcarranza@inciensa.sa.cr](mailto:mcarranza@inciensa.sa.cr)

abortion to avoid risk to the woman's health or life, attending physicians<sup>5</sup> at the two hospitals<sup>6</sup> where the girl was admitted for 22 days did not consider practicing a therapeutic abortion.<sup>7</sup> According to Dr Eliseo Vargas, head of the Costa Rican social security system (Caja Costarricense de Seguro Social) at that time, the possibility of a therapeutic abortion was not even discussed because 'there were no indications to do so'.<sup>8</sup> Even if the child's pregnancy was considered 'very high risk', 'at the time of her evaluation . . . there were no signals that her health or life could be affected, and the fetus was in very good condition.'<sup>9</sup>

With the help of the Nicaraguan Human Rights Ombudsman's Office,<sup>10</sup> Rosa was taken to Nicaragua where her parents requested the performance of a therapeutic abortion.<sup>11</sup> In accordance with the law, the Nicaraguan Ministry of Health set up a commission of three doctors to evaluate the case. After an uncompromised but, if judged in retrospect, 'enabling' verdict from the commission, according to which keeping the pregnancy or carrying out a therapeutic abortion would put the child at risk of 'severe harm or even death',<sup>12</sup> 16 weeks into her pregnancy Rosa underwent a clandestine abortion at a private clinic.

Rosa's case highlighted, both in Costa Rica and Nicaragua, the subject of therapeutic abortion. This

<sup>5</sup> Rosa was seen by physicians (pediatricians, perinatologists, obstetrician-gynecologists and psychiatrists), psychologists and social workers, some of them as members of the Committee of Abused Children working at each hospital in the social security system, and her case was discussed at an interdisciplinary level. See Asamblea Legislativa de la República de Costa Rica. Departamento de Comisiones. Comisión Especial de la Mujer, Acta de la Sesión Ordinaria N. 29, March 27th, 2003: 16. Testimony of Dr. Eliseo Vargas Garcia, President of Caja Costarricense de Seguro Social.

<sup>6</sup> After 19 days at the hospital in Turrialba City, Rosa was transferred for further examination to a multi-specialty hospital in the capital city, where she stayed three more days and was released.

<sup>7</sup> Asamblea Legislativa de la República de Costa Rica, *op. cit.* note 5.

<sup>8</sup> *Ibid.*: 15: My translation.

<sup>9</sup> *Ibid.*: 14: My translation.

<sup>10</sup> Procuraduría de Derechos Humanos de Nicaragua; See H.L. MacNaughton et al. Invoking Health and Human Rights to Ensure Access to Legal Abortion: The Case of a Nine-Year-Old Girl from Nicaragua. *Health Hum Rights* 2006; 9: 63–86.

<sup>11</sup> There is no evidence that Rosa's parents requested a therapeutic abortion in Costa Rica. According to MacNaughton et al., *ibid.*, the possibility of a therapeutic abortion was not discussed by Costa Rican doctors with Rosa's parents.

<sup>12</sup> MacNaughton et al., *ibid.*: 85–86, endnote 90. My translation.

came at a moment when Latin America, one of the regions of the world with the most restrictive legislation on abortion, was witnessing the implementation of further restrictions. In 1997, El Salvador modified its Penal Code and eliminated all exceptions to the abortion prohibition.<sup>13</sup> In October 2006, three years after Rosa received her abortion, the Nicaraguan Congress approved a modification to the Penal Code which punished therapeutic abortion.<sup>14</sup>

The fact that the attending medical doctors in Costa Rica did not consider carrying out a therapeutic abortion, even given the extreme circumstances of Rosa's case, can be considered a paradigmatic example of the degree of medical discretion that exists in the application of the legislation on abortion. Based on Rosa's case, this article analyzes the influence of the social in medical practice. For that purpose, it compares the different application in Costa Rica of two similar regulations. Both the practice of abortion and sterilization are restricted by the Penal Code to the protection of health and life. As a concept subject to interpretation, the use of a broad conception of health could enable a liberal use of both surgeries. The practice of therapeutic sterilization has been generalized in Costa Rica, but that has not been the case with abortion. Therapeutic abortion is very rarely practiced, as Rosa's case clearly exemplifies. This analysis proposes that it is the difference in social acceptance of the two procedures that explains the different use that doctors, as gatekeepers of social morality, make of the potential loophole offered by both pieces of legislation.

## RESORT TO THE THERAPEUTIC: ABORTION AND STERILIZATION

The stipulations of the Penal Codes can be considered moral ones if we understand by this that they represent a society's decision to punish practices

<sup>13</sup> A. Rahman, L. Katzive & S. Henshaw. A Global Review of Laws on Induced Abortion, 1985–1997. *Int Fam Plan Perspect* 1998; 24: 56–64.

<sup>14</sup> Sala de Redacción. 2006. Congreso Aprueba Penalización de Aborto Terapéutico en Nicaragua. *La Nación* 26 October. Available at: [http://www.nacion.com/ln\\_ee/2006/octubre/26/ultima-sr874450.html](http://www.nacion.com/ln_ee/2006/octubre/26/ultima-sr874450.html) [Accessed 15 Dec 2006].

that it considers to be negative.<sup>15</sup> In this sense, the punishment of abortion and sterilization by the Costa Rican Penal Code, and the codes of most Latin American countries, represents a moral decision. In this consideration, the Catholic Church has played, and continues to play, a decisive role.<sup>16</sup> In the Church's view, the central role accorded to reproduction in the family and the sanctity of human life is threatened by both abortion and sterilization. Costa Rica is, according to the Constitution, a confessional state, and the influence of the Catholic Church is felt at legislative, political and moral levels.

In spite of the condemnation of abortion and sterilization, many societies have established exceptional circumstances under which these surgeries can be legitimately practiced. Medical necessity is one of those,<sup>17</sup> and in many countries, abortion and sterilization are not punishable if carried out to protect a woman's health or life.<sup>18</sup>

This exception is based on nonspecific juridical concepts. To apply the medical necessity exception, it is necessary to establish which situations represent a risk to the woman's health or life, as well as the magnitude of that risk. It is also necessary to establish *what* health, and even which life, is being protected. Doctors, as owners of the expert criteria in matters of health, have been designated by society, with a fair amount of their own participation,<sup>19</sup> as those in charge of administering the exceptional use of abortion and sterilization. They are the ones in charge of determining the medical necessity of the

surgery – ultimately, what sterility is worth causing and which fetal life should not be spared – becoming, in the process, the ultimate guardians of social morality.

But medical necessity is an object of interpretation. There are a wide range of meanings that can be given to 'health', from the more restricted, which only takes into account physiology, to the broadest, which considers mental and social wellbeing as well.<sup>20</sup> The use of a broad conception of life and health (broad constructionism according to Luker<sup>21</sup>) will permit an ample use of the exception. To the contrary, the use of a limited definition of these concepts (strict constructionism, according to the same author) will limit its application.

But not everything ends with the definition of health. Predictive capabilities of medical science are poor, and it is impossible for medical doctors to quantify, with any degree of precision, the magnitude of the risk that a pregnancy represents to a given patient. At the same time, even if it is true that we live in a risk society,<sup>22</sup> and that risks to health appear to multiply around us, those risks can increasingly be subject to intervention. Medical technology has experienced an astonishing development during the last 60 years<sup>23</sup> and, as a consequence, indisputable medical indications for sterilization and abortion have progressively diminished and almost disappeared.<sup>24</sup> Each case becomes

<sup>15</sup> R. Cook, B. Dickens & L. Bliss. International Developments in Abortion Law from 1988 to 1998. *Am J Public Health* 1999; 89: 579–586; M. Htun 2003. *Sex and the State: Abortion, Divorce, and the Family under Latin American Dictatorships and Democracies*. New York, NY: Cambridge University Press.

<sup>16</sup> R. Cook & B. Dickens. Human Rights Dynamics of Abortion Law Reform. *Hum Rights Q* 2003; 25: 1–59.

<sup>17</sup> Other exceptions are in case of rape (Brazil) or when there are strong probabilities that the fetus will be seriously impaired.

<sup>18</sup> Rahman et al., *op. cit.* note 13.

<sup>19</sup> The medical profession has played a prominent role both in criminalizing abortion and establishing the therapeutic exception. For England, see J. Keown. 1988. *Abortion, Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803 to 1982*. Cambridge: Cambridge University Press. For the United States, see K. Luker. 1984. *Abortion & the Politics of Motherhood*. Berkeley, CA: University of California Press; L. Reagan. 1997. *When Abortion Was a Crime. Women, Medicine, and Law in the United States, 1867–1973*. Berkeley, CA: University of California Press.

<sup>20</sup> World Health Organization (WHO). 1948. *Constitution of the World Health Organization*. Geneva: WHO: See Preamble. Also see S.J. Macintyre. The Medical Profession and the 1967 Abortion Act in Britain. *Soc Sci & Med* 1973; 7: 121–134.

<sup>21</sup> Luker, *op. cit.* note 19. The author applies the term to the definition of life in abortion. I consider that it also applies to the definition of health and sterilization.

<sup>22</sup> U. Beck. 1992. *Risk Society: Towards a New Modernity*. London: Sage.

<sup>23</sup> E. Pellegrino. 1979. The Sociocultural Impact of Twentieth-Century Therapeutics. In *The Therapeutic Revolution. Essays in the Social History of American Medicine*. M. Vitek & C. Rosenberg, eds. Philadelphia, PA: University of Pennsylvania Press: 245–266.

<sup>24</sup> Both surgeries had similar recommendations. They were practiced, many times together, in cases of deformities of the pelvis, chronic diseases of the kidney and heart, tuberculosis, diabetes, toxemia, and mental disturbances, among others. On abortion, see H. Packer & R. Gampell. Therapeutic Abortion: A Problem in Law and Medicine. *Stan L Rev* 1959; 11: 417–455; Luker, *op. cit.* note 19; K. Niswander. Medical Abortion Practices in the United States. *W Res L Rev* 1965–1966; 17: 403–423. On sterilization, see W. Williams. Indications for Therapeutic Sterilization in Obstetrics. When is Advice Concerning the Prevention of Conception Justifiable? *JAMA* 1928; 91: 1237–1242; B.P. Watson.

‘a case’, and medical indications for these surgeries are a matter of opinion, even for doctors.<sup>25</sup> As categorical indications for sterilization and abortion diminish, things that are, in theory, foreign to medical science tend to appear and gain relevance. The value accorded to fetal life,<sup>26</sup> the woman’s age, the number of her children, her interest in the surgery, and even the empathy that her case generates,<sup>27</sup> have proven, in different contexts, to be decisive in cataloging women as deserving or not of abortion or sterilization.<sup>28</sup>

Given the contested character of abortion and sterilization both in legal and social terms, the use that doctors make of medical discretion in the recommendation of these surgeries – the extent to which they decide to (re)interpret the exception – will be influenced by their personal acceptance of abortion and sterilization, as well as that of their colleagues, and broader society.<sup>29</sup> As gatekeepers with discretion, doctors have the capacity to be generous in their definition of health and estimation of risk, and thus to facilitate access to abortion and sterilization or, to the contrary, be restrictive in their interpretations and conservative in the distribution of these surgeries.

History shows that, in fact, there has been a social use of medical necessity in the provision of abortion and sterilization. In the specific case of abortion, several countries, among them Costa Rica, have

made a limited use of the therapeutic exception.<sup>30</sup> In Costa Rica, as Rosa’s case clearly demonstrates, the definition of health used, as well as the estimation of the risk that the pregnancy presupposes, tends to be very conservative. But history also shows that, in restrictive contexts, a broad construction of medical necessity has enabled doctors to include nonmedical reasons, such as eugenics and population control,<sup>31</sup> in these surgeries’ indications. The therapeutic exception has also represented a loophole that, conditional with the approval of the physician, has granted women some reproductive autonomy; no less important, it has allowed them access to safe abortion.<sup>32</sup>

Previous to the liberalization of abortion in Canada, the USA and England, among others, a broad interpretation of health and life permitted a ‘liberal’ use of this surgery.<sup>33</sup> In these countries, a progressive diminution of strict medical indications for abortion was accompanied by an increasing rise in psychiatric indications.<sup>34</sup> During the 1950s and 1960s, American physicians interested in helping their patients get an abortion increasingly declared them as mentally unstable.<sup>35</sup> Data from a group of hospitals in Ann Arbor, Michigan showed that in 1968 psychiatric causes represented 69.6% of the indications for therapeutic abortion.<sup>36</sup>

Sterilization from the Point of View of the Obstetrician and Gynecologist. *Am J Obstet Gynecol* 1937; 34: 512–515.

<sup>25</sup> For the United States during the 1950s, see R. Solinger. ‘A Complete Disaster’: Abortion and the Politics of Hospital Abortion Committees, 1950–1970. *Fem Stud* 1993; 19: 240–261.

<sup>26</sup> Luker, *op. cit.* note 19.

<sup>27</sup> The circumstances of the pregnancy (rape), the responsibility in the use of contraceptives, the history of previous abortions, among others, have an influence in the empathy that each case will generate. For an example in Nicaragua, see H.L. MacNaughton, E. Mitchell & M. Blandón. Should Doctors Be the Judges? Ambiguous Policies on Legal Abortion in Nicaragua. *Reprod Health Matter* 2004; 12: 18–26.

<sup>28</sup> G. Davis & R. Davidson. ‘Big White Chief’, ‘Pontius Pilate’, and the ‘Plumber’: The Impact of the 1967 Abortion Act on the Scottish Medical Community, c. 1967–1980. *Soc Hist Med* 2005; 18: 283–306. The authors refer to deserving and undeserving abortions. I prefer to modify the term to refer to deserving women, and apply it to sterilization as well.

<sup>29</sup> C. Nathanson & M. Becker. Professional Norms, Personal Attitudes, and Medical Practice: The Case of Abortion. *J Health Soc Behav* 1981; 11: 181–211.

<sup>30</sup> For an example in Pakistan, see Rahman et al., *op. cit.* note 13; In the former GDR, see D. Harsch. Society, the State, and Abortion in East Germany, 1950–1972. *Am Hist Rev* 1997; 102: 53–84.

<sup>31</sup> B. Lerner. Constructing Medical Indications: The Sterilization of Women with Heart Disease or Tuberculosis, 1905–1935. *J Hist Med Allied Sci* 1994; 49: 362–379.

<sup>32</sup> The number of unsafe abortions in Central America was estimated at 700 000 around the year 2000 and the number of maternal deaths due to unsafe abortion estimated at 400. World Health Organization (WHO). 2000. *Unsafe Abortion: Global and Regional Estimates of Incidence of Unsafe Abortion and Associated Mortality in 2000*. Geneva: WHO. Available at: [http://www.who.int/reproductive-health/publications/unsafe\\_abortion\\_estimates\\_04/estimates.pdf](http://www.who.int/reproductive-health/publications/unsafe_abortion_estimates_04/estimates.pdf) [Accessed 21 Apr 2007].

<sup>33</sup> For the United States, see Luker, *op. cit.* note 19; J. Schoen. 2005. *Choice & Coercion: Birth Control, Sterilization, and Abortion in Public Health and Welfare*. Chapel Hill, NC & London: University of North Carolina Press. For England, see Keown, *op. cit.* note 19.

<sup>34</sup> For British Columbia, Canada, see W.J. Harris & L.S. Tupper. A Study of Therapeutic Abortion Committees in British Columbia. *U Brit Colum L Rev* 1977; 11: 81–118. For the United States, see Schoen, *op. cit.* note 33; Luker *op. cit.* note 19; Packer & Gampell, *op. cit.* note 24.

<sup>35</sup> Schoen, *op. cit.* note 33.

<sup>36</sup> C. Tietze. United States: Therapeutic Abortions, 1965 to 1968. *Stud Fam Plann* 1970; 1: 5–7.

The same happened with the provision of sterilization in contexts in which, if not necessarily prohibited by law, the legal use was ambiguous. In Puerto Rico,<sup>37</sup> the US,<sup>38</sup> Brazil<sup>39</sup> and Costa Rica,<sup>40</sup> among others, medical necessity allowed doctors to legitimately offer sterilization to those whom they considered deserving.

## THERAPEUTIC STERILIZATION IN COSTA RICA

The prevailing Costa Rican Penal Code declares any injury causing sterility a crime,<sup>41</sup> with the exception of those performed with the consent of the person and with the aim of benefiting health.<sup>42</sup> In spite of the fact that it does not explicitly mention sterilization, the prevailing interpretation of the Penal Code signals that only therapeutic sterilization is permitted. In accordance with this interpretation, in 1976 the College of Doctors and Surgeons issued the Regulation of Female and Male Sterilizations,<sup>43</sup> which made official the list of medical conditions that justified the surgery. In addition, as had occurred in the USA, Canada and England, the Regulation established the creation, in all public and private hospitals, of a Committee on Sterilization, in charge of evaluating and deciding on

requests for the surgery.<sup>44</sup> The Regulation of Sterilizations, which in 1988 acquired the status of Executive Decree, ruled on the practice of sterilization until 1999, when this surgery was finally liberalized.

Surprisingly, given its supposed illegality, sterilization as a method of family planning was very common. In 1999, 21% of women (married or cohabiting) between 15 and 44 years old were sterilized,<sup>45</sup> and 95% of those surgeries had been conducted at the social security hospitals.<sup>46</sup> The history of the provision of sterilization shows that, from the time this surgery was introduced in Costa Rica in the 1940s, until it was liberalized in 1999, 'medical necessity' played a fundamental role in its distribution.<sup>47</sup>

A doctor interested in helping his patient become sterilized had to reconfigure her interest in sterilization into one of the pathologies capable of justifying the surgery. Varicose veins, obstetric risk, multiparity, repeated cesarean sections and uterine dystopia, among others, were the main reasons for the surgery.<sup>48</sup> For example, between 1969 and 1971, 'vascular causes' (varicose veins) constituted 47% of the medical causes of the sterilizations performed in one of the two hospitals in the social security system.<sup>49</sup> In another hospital, 80.7% of the 420 sterilizations performed from January 1973 to May 1974 were motivated by multiparity.<sup>50</sup>

Diverse factors converged to turn the therapeutic route into the natural way to access sterilization: a strong medical tradition, in Costa Rica and beyond,

<sup>37</sup> H.B. Presser. 1974. *La Esterilización y el Descenso de la Fecundidad en Puerto Rico*. Bogotá & New York, NY: Asociación Colombiana para el Estudio de la Población, & The Population Council.

<sup>38</sup> Schoen, *op. cit.* note 33; Lerner, *op. cit.* note 31.

<sup>39</sup> A. Caetano & J. Potter. Politics and Female Sterilization in North-east Brazil. *Popul Dev Rev* 2004; 30: 79–108; K. Johnson, B. Janowitz & C. Bessa. Sterilization Approval and Follow-Through in Brazil. *Stud Fam Plann* 1986; 17: 188–198.

<sup>40</sup> M. Carranza. Sobre una Relación 'Prolífica'. El Papel de 'la Salud' en la Propagación de la Esterilización Contraceptiva en Costa Rica. *Dynamis* 2004; 24: 187–212.

<sup>41</sup> Article 123 reads, 'Se impondrá prisión de tres a diez años, si la lesión causare . . . la incapacidad de engendrar o concebir.' Article 123 belongs to the 1970 Penal Code. Lesions causing sterility were also included as criminal acts in previous Penal Codes (1941 and 1918), albeit in different articles (202 & 258, respectively). See F. Castillo 1984. *La Esterilización Voluntaria en el Derecho Penal Costarricense*. San José: PASDIANA: 7, footnote 15.

<sup>42</sup> Article 129 reads, ' . . . no son punibles las lesiones que se produzcan al lesionado con su consentimiento, cuando la acción tenga por fin beneficiar la salud de otro.'

<sup>43</sup> Reglamento de Esterilizaciones Femeninas y Masculinas. Colegio de Médicos y Cirujanos, August 1976.

<sup>44</sup> For Canada, see Harris & Tupper, *op. cit.* note 34. For the United States, see Schoen, *op. cit.* note 33; Luker, *op. cit.* note 19; and Packer & Gampell, *op. cit.* note 24.

<sup>45</sup> M. Chen Mok et al. 2001. *Salud Reproductiva y Migración Nicaragüense en Costa Rica 1999–2000: Resultados de una Encuesta Nacional de Salud Reproductiva*. San José: Copieco. According to EngenderHealth, Costa Rica ranks number 19 among the 20 countries in the world with the highest prevalence of female sterilization. EngenderHealth. 2002. *Contraceptive Sterilization: Global Issues and Trends*. New York, NY: EngenderHealth.

<sup>46</sup> Chen Mok, *ibid.*

<sup>47</sup> M. Carranza. Una Política Subrepticia: La Provisión de la Esterilización Contraceptiva en Costa Rica. *Diálogos Revista Electrónica de Historia* 2006; 7: 208–241.

<sup>48</sup> *Ibid.*

<sup>49</sup> O. Solís & V. Solís. 1971. *Análisis de Ochocientas Veintidós Salpingectomías Realizadas en el Hospital Dr. Calderón Guardia*. San José: Asociación Demográfica Costarricense.

<sup>50</sup> J. Blanch, Z. Pastor & C. Prada. 1975. *Estudio de Mujeres Esterilizadas*. San José: Asociación Demográfica Costarricense.

of therapeutic use of this surgery, in which, even if surreptitiously, contraception played a central role;<sup>51</sup> the prevalent interpretation of the Penal Code which indicated that only therapeutic sterilization was permitted; and the possibility that this route offered to avoid confrontations with the Catholic Church (at a political level but also at the individual level in the case of the doctor and his patient).<sup>52</sup> The Catholic Church has been tolerant with the de facto provision of sterilization, but it has opposed its regulation, even for therapeutic purposes. Costa Rican political elites have been careful in the extreme not to disturb the Catholic Church, and what might now be considered reproductive milestones (i.e. incorporation of family planning services among those offered by the State in 1968 and the regulation of contraceptive sterilization in 1999) have always implied negotiation and even bargaining with the head of the Church.<sup>53</sup>

## THERAPEUTIC ABORTION IN COSTA RICA

The Costa Rican Penal Code punishes the practice of abortion<sup>54</sup> with the exception of that practiced 'with the woman's consent . . . if it has been done with the aim of avoiding a risk to the life or health of the mother that could not be avoided by other means.'<sup>55</sup> According to the Caja Costarricense de Seguro Social (CCSS), the institution in charge of providing all public health services in the country, and where 91.5% of deliveries take place,<sup>56</sup> the highest number of therapeutic abortions practiced

in any given year between 1984 and 2003 amounts to seven. The median and the mean are two.<sup>57</sup>

There are no studies that analyze the provision of therapeutic abortion in Costa Rica, but my experience as a medical doctor indicates that the interruption of the pregnancy is considered only in the presence of very serious physical conditions (i.e. cancer), and only when the possibility of letting the pregnancy evolve to obtain a viable fetus has been ruled out. At the same time, the indication for the procedure arises always from the doctor, the wishes of the woman being relegated to merely consenting to (or not) the prescribed abortion.

However, the low number of therapeutic abortions does not indicate that women do not make use of this surgery, or that doctors do not practice it. The annual number of induced abortions in Costa Rica from 1988 to 1991 was calculated at between 6500 and 8500, a ratio of approximately one induced abortion for every 10 births, and a rate of one induced abortion for every 100 women 15–49 years of age.<sup>58</sup> These numbers are one third of those calculated for Chile and approximately half of those estimated for Brazil, Colombia and the Dominican Republic.<sup>59</sup> At the same time, the impression appears to be that physicians are frequently, and perhaps increasingly, the ones in charge of practicing abortions.<sup>60</sup> Doctors who decide to honor a woman's request and practice an abortion can do so in a clandestine way in their private offices, or surreptitiously at the social security hospitals, where the surgery is falsely registered as medical attention

<sup>51</sup> Lerner, *op cit.* note 31.

<sup>52</sup> M. Carranza. 2003. *Making Sense of Common Sense: Female Sterilization in Costa Rica*. University of Cambridge (unpublished PhD thesis).

<sup>53</sup> No study has analyzed the attitude of the Costa Rican Catholic Church regarding sterilization. The information I have collected indicates that at local churches priests tend to be tolerant of sterilization. *Ibid.*

<sup>54</sup> Costa Rican Penal Code. Section II, Articles 118, 119, 120 & 122.

<sup>55</sup> Costa Rican Penal Code. Section II, Article 121. 'No es punible el aborto practicado con consentimiento de la mujer por un médico o por una obstétrica autorizada . . . si se ha hecho con el fin de evitar un peligro para la vida o la salud de la madre y éste no ha podido ser evitado por otros medios'. It does not specify that the health to be protected should be physical and could be interpreted to cover mental health. See Rahman et al., *op. cit.* note 13.

<sup>56</sup> Chen Mok et al., *op. cit.* note 45.

<sup>57</sup> Caja Costarricense de Seguro Social, Sección Información Biomédica. In M.I. Brenes Varela. 1994. *Actitudes y Práctica del Aborto Inducido en Costa Rica*. Universidad de Costa Rica (unpublished MSc thesis); Base de Egresos Hospitalarios, Caja Costarricense de Seguro Social (CCSS). Data Base Centro Centroamericano de Población. Available at: <http://ccp.ucr.ac.cr/> [Accessed 20 Apr 2007]. Legally induced abortion (ICD-9), Medical abortion (ICD-10).

<sup>58</sup> Brenes Varela, *ibid.* This is the most recent estimate.

<sup>59</sup> *Ibid.*

<sup>60</sup> This impression seems to take hold in the low absolute number of maternal deaths due to abortion. Besides indicating a high level of access to health institutions for the treatment of complications, this could point towards the practice of abortion under safe conditions. M. Carranza & A. Gei. 2002. *Sólo Dios Sabe por qué Hace las Cosas: Mortalidad Materna en Costa Rica*. San José: EUNED; A. Ansorena. 1993. *¿Qué Hago? ¿Qué Hice? El Mundo Invisible de las Mujeres que Abortan. Estudio Antropológico sobre la Desaprobación Social del Aborto en Costa Rica*. Universidad de Costa Rica (unpublished undergraduate thesis).

to an abortion in progress.<sup>61</sup> In these cases, the difference with the practice of sterilization, prior to its liberalization, is not located in the doctor's participation or in the surreptitious character of the surgery. The difference is located in the doctor's declared agency in the surgical practice. In contrast to what happened with the provision of (contraceptive) sterilization, in which the physician played a prominent public role in justifying its medical necessity, in the case of abortion, medical agency is hidden. Resort to the therapeutic, which would allow a legitimate provocation of abortion, is practically nonexistent. What explains this difference?

## SOCIAL ACCEPTANCE

The use of therapeutic exception requires that the doctor attributes to himself/herself the responsibility for recommending the surgery. The agency that the doctor attributes to himself/herself in the provision of abortion and sterilization and, as a consequence, the use that he/she makes of the therapeutic loophole, will be influenced by the degree of social approval of the surgeries. In Costa Rica, social approval of abortion and sterilization differ substantially.

In the case of sterilization, social opinion and conduct coincide and both contradict the legal and religious mandate.<sup>62</sup> The growing percentage of sterilized women (6.1% in 1964,<sup>63</sup> 14.7% in 1976,<sup>64</sup> 19.7% in 1993<sup>65</sup> and 21% in 1999<sup>66</sup>), goes hand in hand with a favorable perception of the surgery. Sterilization is easily discussed, and the decision to undergo the procedure does not generate major moral conflicts,

even for active practicing Catholics.<sup>67</sup> Women from diverse socio-demographic sectors, their mothers, husbands, friends and doctors appear to consider that sterilization, after a couple of children, is the best option for contraception.<sup>68</sup> As early as 1986, the National Survey on Fecundity and Health showed that 88% of the women interviewed were in favor of sterilization when a pregnancy could be dangerous to the woman's health, and 66% when the reason for sterilization was the lack of economic means to raise children.<sup>69</sup> In such a context, the will of the woman was not problematic: patients felt free to request sterilization and doctors felt at ease in honoring women's requests.

Diverse factors have come together to produce this perception of sterilization, including a growing social approval of family planning; particular notions of family, gender and reproduction in which sterilization fits quite easily;<sup>70</sup> an increasing familiarity of the population with medical institutions and interventions in the body;<sup>71</sup> and also, and among others, the increasing provision of the surgery by health professionals. Medical doctors have felt free to offer sterilization and have been motivated to do so.<sup>72</sup> In this way, they have contributed to its acceptance and expansion.

The picture is different in the case of abortion. Abortion has to do with fetal life. The Costa Rican Civil Code protects the person from 300 days before birth<sup>73</sup> and almost everybody appears to agree that life should be preserved from the moment of conception. Even if the perception of abortion has become

<sup>61</sup> Eight thousand, five hundred and sixty-three abortions were attended at the CCSS institutions in 2003. Of these, 5661 were registered as non-specified, 2661 as incomplete and 76 as spontaneous. See Base de Egresos Hospitalarios, Caja Costarricense de Seguro Social (CCSS), *op. cit.* note 57.

<sup>62</sup> Contraceptive sterilization was permitted via Executive Decree. Many medical doctors are of the opinion that it is still prohibited. See Carranza, *op. cit.* note 40.

<sup>63</sup> Of the Central Valley, married or united between 20 and 50 years. M. Gómez. 1968. *Informe de la Encuesta de Fecundidad en el Área Metropolitana*. San José: Universidad de Costa Rica. Instituto Centroamericano de Estadística.

<sup>64</sup> At national level. Caja Costarricense de Seguro Social (CCSS). 1994. *Encuesta Nacional de Salud Reproductiva de 1993*. San José: CCSS.

<sup>65</sup> In the country, married or united, between 15 and 49 years. *Ibid.*

<sup>66</sup> Chen Mok et al., *op. cit.* note 45.

<sup>67</sup> Carranza, *op. cit.* note 52.

<sup>68</sup> *Ibid.*

<sup>69</sup> Asociación Demográfica Costarricense (ADC). 1987. *Encuesta Nacional de Fecundidad y Salud, Costa Rica 1986*. San José: ADC.

<sup>70</sup> Carranza, *op. cit.* note 52.

<sup>71</sup> This familiarity goes back to at least 1917 with the programs of the Rockefeller Foundation and was propelled by the social security system. See S. Palmer. 2003. *From Popular Medicine to Medical Populism: Doctors, Healers, and Public Power in Costa Rica, 1800–1940*. Durham, NC: Duke University Press; and G. Miranda. 1994. [1988]. *La Seguridad Social y el Desarrollo en Costa Rica*. San José: EDNASS/CCSS.

<sup>72</sup> During the 1970s, agencies interested in population control promoted, by means of doctors and the laparoscope, sterilization in Latin America, Costa Rica included. See Carranza, *op. cit.* note 40.

<sup>73</sup> Costa Rican Civil Code. Book I, Chapter I, Article 31. Available at: [http://www.costaricalaw.com/LEGALNET/civil\\_law/\\_civil\\_law.php](http://www.costaricalaw.com/LEGALNET/civil_law/_civil_law.php) [Accessed 21 Apr 2007].

more liberal during the last years,<sup>74</sup> it is still condemned by most of the population. The opinion of the majority of women regarding this surgery is even more conservative than the law: in 1999, 55.1% of women aged 15–49 living in Costa Rica were completely against abortion, and only 37.7% accepted it in the case of risk to the health or life of the mother or in case of incest.<sup>75</sup> In turn, the sense that I have acquired from Costa Rican women through the many years that I have lived and carried out research among them corroborates these women's answers. Abortion is not favorably perceived by Costa Rican women. A woman can even call herself a feminist in Costa Rica and be against abortion.<sup>76</sup>

In contrast to what occurred with sterilization prior to 1999, when all the social sectors, with the exception of the head of the Catholic Church and some of its most renowned followers, seemed to agree that it was necessary to broaden access to this surgery, the liberalization of abortion does not appear to be a subject of discussion, even for women's organizations. The case of the member of the Legislative Assembly, Nuri Vargas, who, in 1991, tried unsuccessfully, and with devastating costs for her public life and political career, to modify the Penal Code and decriminalize abortion in case of rape,<sup>77</sup> is a reminder of the danger of dealing with the subject. It could also be proposed that the low absolute number of deaths linked to illegal abortion, if compared with other Latin American countries, has kept the problem from being framed as one of public health.<sup>78</sup>

## SHOULD DOCTORS BE THE JUDGES?<sup>79</sup>

By means of an analysis of the different use of the therapeutic exception in abortion and sterilization in Costa Rica, this article has shown the power that medical discretion has in the distribution of these

<sup>74</sup> Brenes Varela, *op. cit.* note 57.

<sup>75</sup> Chen Mok et al., *op. cit.* note 45.

<sup>76</sup> Carranza, *op. cit.* note 52.

<sup>77</sup> The modification can be considered conservative. It permitted abortion only during the first eight weeks of pregnancy and required that the rape charge be brought before the criminal courts. See Ansorena, *op. cit.* note 60.

<sup>78</sup> Carranza & Gei, *op. cit.* note 60.

<sup>79</sup> The title of MacNaughton et al., *op. cit.* note 27.

surgeries, and also the powerful influence that social morality has in the (declared) exercise of medical practice. Prior to the liberalization of sterilization, doctors, as part of a society that viewed this surgery favorably, felt relatively free to offer sterilization and attend patients' requests for the surgery. The illegality of this surgery was perceived as something outmoded and in need of change, for limiting family size by means of sterilization, in spite of Catholicism, has become almost a tenet of the Costa Rican family.

The case of abortion is different. The (declared) social consensus dictates that life should be preserved from conception, even in the face of a threat to the mother's health. In this case, doctors behave as the rest of the society does: they publicly condemn abortion and privately practice it. Doctors, who have contributed to familiarizing the population with sterilization and even served as vehicles for its legitimate provision, prefer to hide their faces in the case of abortion. Women's requests for abortion are only served clandestinely.

Hence, the refusal of medical doctors to consider a therapeutic abortion in Rosa's case must be understood as a moral decision. Whether the pregnancy put Rosa's health or life at risk and to what extent were questions that probably could have been debated indefinitely. However, what was a certainty to all was the social repercussions of deciding in favor of an abortion. Predictably, the balance tipped because of the weight of factors that had little or nothing to do with scientific evidence (though we might note that this does not exist in a pure state). The fact that Rosa was treated at a public institution and subject to the attention of the media was, without doubt, a determinant in the evaluation of her case. A decision in favor of abortion would have required physicians to appear more liberal than the average member of Costa Rican society, a decision which would have asked them to risk much and obtain little in return.

The answer as to why Nicaraguan doctors were more 'permissive' in their judgment of the need for abortion, and that three of them even risked being prosecuted to carry out an abortion on Rosa,<sup>80</sup>

<sup>80</sup> E. Romero. 2003. Acusación Ronda a los Abortistas. *La Prensa* 22 February. Available at: <http://laprensa.com.ni/archivo/2003/febrero/22/nacionales> [Accessed 28 Mar 2007].

requires research of its own. One can speculate that in a country where most of the population does not have access to medical services, doctors are more sensitized to the devastating effects of unsafe abortion. At the same time, Nicaraguan civil society, including women's organizations, is much stronger than its Costa Rican counterpart. Initial timid requests for therapeutic abortion in Costa Rica, which gained momentum and turned into an uproar in Nicaragua, probably made the commission of doctors who evaluated Rosa's case feel that they could not simply serve the interests of the Catholic Church. At the same time, that same uproar probably offered the three doctors who decided to carry out the abortion on Rosa a much-needed source of social support.

That the therapeutic exception to abortion is vague is true, and that 'a vague law can expose women and girls who seek abortion to ideologically-driven information and clinical care'<sup>81</sup> is true as well. At the same time, the regulation of sterilization in Costa Rica has shown that even a clear and specific regulation can be interpreted. In my assessment, the locus of the problem does not necessarily reside in the ambiguity of the legislation but in allowing doctors (and the therapeutic exception) to decide matters that they should not. Rosa's pregnancy was much more than a medical problem, and the decision whether or not to carry out an abortion much more than a question of (her) health.

<sup>81</sup> MacNaughton et al., *op. cit.* note 27, p. 20.

In a conservative context, the therapeutic exception can represent a potential avenue to legal abortion. However, Rosa's case clearly showed the risks involved in relying on this route. When access to abortion is situated in the terrain of health, the moral quandaries associated with abortion do not disappear; they are transferred to the medical profession. In a context in which abortion is publicly condemned, it became the duty of doctors to decide between the uncertain risks posed by Rosa's pregnancy and the certainty of the destruction of fetal life. And medical doctors, as this analysis has tried to demonstrate, will not necessarily defy social consensus.

Access to abortion is a subject that requires social discussion, one that starts from the premise that abortion is a reality: women turn to abortion and doctors practice it, and not necessarily for reasons of health. The recent criminalization of therapeutic abortion in Nicaragua shows that there is a real danger that discussion could bring further legal restriction. Nonetheless, it is my impression that in Costa Rica, where the therapeutic route is only serving an average of two women per year and was not even able to solve Rosa's case, there is not much that a discussion of the problem would be putting in danger.

#### Acknowledgements

I would like to thank Rita Maxera, Cori Hayden, Lissette Navas and the two *Developing World Bioethics* reviewers for their valuable comments.