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IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

CASE NO: _____

In the matter between:

THE VOICE OF THE UNBORN BABY NPC Applicant

and

MINISTER OF HOME AFFAIRS First respondent

MINISTER OF HEALTH Second respondent

AFFIDAVIT

1

I the undersigned,

DANIËL JOHANNES BOTHA

state under oath as follows:

1. I am an adult male gynaecologist and obstetrician with a subspecialisation in reproductive medicine.

2. The facts contained herein are within my personal knowledge unless otherwise apparent from the context and are true and correct.

3. I worked as a general medical practitioner for seven years (1991–1997) before returning to university to pursue a specialisation in gynaecology and obstetrics in 1998. After successfully completing my specialisation, I started a private gynaecology and obstetrics practice in Port Elizabeth in 2001. I am currently still actively involved in this private practice.

4. In 2005 I started with training on a part-time basis (one week per month) towards subspecialisation in reproductive medicine. After successfully completing this subspecialisation in 2009, I took over as

gynaecologist and reproductive specialist at the Fertility Unit at St George's Hospital in Port Elizabeth, (also called the 'Fembryo Clinic'), which I do in parallel with my existing private practice.

5. I am a co-author of the third (2007), fourth (2010), and fifth (2014 – the most recent) editions of the textbook *Clinical Gynaecology*, published by Juta.

6. In 2011, I was elected by my peers in the Southern African Society of Reproductive Medicine and Gynaecological Endoscopy (SASREG) to SASREG's governing council. I still serve on this council.

7. Given that both my specialist training in gynaecology and obstetrics, and later my subspecialist training in reproductive medicine, involved long hours of working in public hospitals, I have experience of the practice of gynaecology and obstetrics in both the public and private sectors.

8. For more than fifteen years, I have interacted on a regular basis with expecting parents from all walks of life who experience pregnancy loss.

9. Given all the above, I am qualified to provide an expert opinion regarding the questions posed to me in this matter referred to in paragraph 11 below.

10. I state from the onset that some of the questions listed in paragraph 11 below relate to the state of mind of expecting parents who experience pregnancy loss. I am not a psychologist; however, as a treating physician I have over the past fifteen years interacted closely with countless expecting parents who experienced pregnancy loss, and am accordingly in a position to assist the Court through my experience by simply stating my observations of the emotional state of mind of such persons.

11. I was requested by the legal representatives of the applicant to provide an expert opinion on the following questions:

    11.1. How do expecting parents perceive the fetus and does viability play a role in such perception?

    11.2. In the event of spontaneous loss of pregnancy, how do expecting parents experience the event and does viability play a role?

11.3. How do the attending health care staff deal with spontaneous loss of pregnancy?

11.4. What is the procedure that precedes termination of pregnancy for medical reasons?

11.5. In the event of termination of pregnancy for medical reasons, how do expecting parents experience the event?

12. In the following I first define the relevant terminology that I employ in this affidavit, after which I address the above questions in sequence and conclude with a summary.

Terminology

13. The product of the union of a male and female gamete is referred to as an 'embryo'. Once an embryo reaches the stage of development where is has recognisable human features, it is referred to as a 'fetus'. This would typically happen at about nine weeks of gestation.

14. In contemporary medical literature, the term 'pregnancy loss' is gaining traction as the preferred term to refer to all types of embryonic or fetal death in an expecting mother's womb. This term may be perceived as a euphemism, but is accurate and recognises the reality of both the pregnancy and the loss thereof. Accordingly, I use this term in this affidavit.

15. Pregnancy loss is firstly categorised into 'spontaneous pregnancy loss' and 'induced pregnancy loss':

15.1. 'Spontaneous pregnancy loss' refers to the natural death of an embryo or fetus in a woman's womb.

15.2. 'Induced pregnancy loss' refers to the death of an embryo or fetus in a woman's womb that is caused by human intervention. This is commonly referred to as 'termination of pregnancy' or (usually more pejoratively) 'abortion'. In line with contemporary medical practice in South Africa, in this affidavit I employ the term 'termination of pregnancy' to denote induced pregnancy loss.

16. In practice, the differentiation between these two kinds of pregnancy loss is usually clear and apparent. Instances can be contemplated where the differentiation would be difficult to make, such as when a pregnant woman uses illegal drugs that causes – perhaps unintentionally – the loss of pregnancy. However, for present purposes the simple definitions in 15.1 and 15.2 above will suffice.

17. Spontaneous pregnancy loss is further sub-categorised into 'early spontaneous pregnancy loss' and 'late spontaneous pregnancy loss'. The differentiating factor is whether the fetus would hypothetically have been able to survive outside the womb or not, referred to as the 'viability' of the fetus. (I exclude an embryo, as an embryo would not be able to survive outside the womb, given our current technology.)

17.1. 'Early spontaneous pregnancy loss' refers to the natural death of an embryo or fetus in a woman's womb prior to viability. This is commonly referred to as 'miscarriage', although older medical texts used the terminology 'spontaneous abortion' or simply 'abortion'. The evolution of medical terminology regarding early pregnancy loss is described by Moscrop (2013) in his recent article in the journal *Medical Humanities*. I attach hereto marked **'DB1'** a copy of this article. In line with the conclusion of Moscrop's article, and in line with contemporary medical practice

in South Africa, in this affidavit I employ the term 'miscarriage' to denote early spontaneous pregnancy loss.

17.2. 'Late spontaneous pregnancy loss' refers to the natural death of a viable fetus in a woman's womb. This is commonly referred to as 'stillbirth'. In line with contemporary medical practice in South Africa, in this affidavit I employ the term 'stillbirth' to denote late spontaneous pregnancy loss.

18. In the context of pregnancy loss, viability is legally set at 26 weeks gestational age in South Africa, given that the Births and Deaths Registration Act, Act 51 of 1992, requires at least 26 weeks gestational age for pregnancy loss to qualify as stillbirth.

19. The context of pregnancy loss should, with respect, be differentiated from the context of life premature birth. In the latter context, the determination of viability – and accordingly whether to initiate active lifesaving treatment on the premature baby or not – is typically determined by a variety of factors that goes beyond gestational age alone: given that the gestational age of the baby is often unknown – especially in public hospitals – the baby's weight and the mother's medical condition are examples of factors that are typically considered.

20. Also, the availability of the required resources to provide active lifesaving treatment to a premature baby, such as equipment available at neonatal units and effective transport protocols to tertiary institutions, inevitably influences the decision whether to initiate active lifesaving treatment or not, and as such contributes to the practical viability of an individual premature baby.

21. I attach hereto marked '**DB2**' a copy of an article by Mullan and Horton (2011) in the journal *The Lancet*. The effect of the availability of resources is reflected in the following statement by these authors (p1291):

> The definition of stillbirth is a delicate task. Although use of the definition recommended by WHO [the World Health Organisation] for international comparison—a baby born with no signs of life at or after 28 weeks' gestation—is sensible, since few babies born before this age are likely to survive in low-income countries, some survive after as few as 22 weeks in high-income countries.

22. It should, with respect, be clear that viability – irrespective of the context being pregnancy loss or premature birth – is as much a social as a biological construct; moreover, in the context of pregnancy loss,

where viability is legally defined according to gestational age, viability is simply a convenient generalisation.

How do expecting parents perceive the fetus; does viability play a role in such perception?

23. The words 'embryo' and 'fetus' are medical terms that are almost never used by expecting parents or by health care practitioners during consultation with expecting parents. There is a clear difference between practitioner–patient parlance and medical parlance. In my experience, it is common practice in South Africa that health care practitioners who are involved in antenatal health care would refer to the embryo or fetus as the 'baby' during a consultation with expecting parents.

24. Modern technology offers expecting parents various procedures during a pregnancy to ascertain the health and proper development of the embryo or fetus in the womb. One such procedure that stands out in terms of how it makes the fetus – that was previously hidden in the expecting mother's womb – visible and in a sense more real to the expecting parents, is a structural anomaly scan using 3D or 4D ultrasound: This scan is usually done at 18–22 weeks gestational age

with the medical purpose of looking at every part of the fetus to detect possible abnormalities.

25. However, for most expecting parents, this new technology is an exciting opportunity to look inside the expecting mother's womb, and be able to actually see their 'baby'. The visual quality of the ultrasound images of the fetus in the womb is stunningly real. The expecting parents would typically articulate their observations about the facial features, hands, fingers, feet, and sex of their 'baby' with a sense of wonder and excitement.

26. I attach hereto marked '**DB3**' a copy of an article by Roberts (2012) in the journal *Sociology of Health & Illness*, which explores the interaction between the expecting parents and the sonographer during a 4D ultrasound scan. The article confirms my observations in paragraph 25 above. In particular, Roberts finds that the capacities of 4D ultrasound to image facial features and movements 'inform stories about fetal experience and family resemblances' and 'enables playfully imagined interactions with the fetus' (p299).

27. Name giving, planning of baby rooms, and deciding the colour of clothing are often done while the pregnancy is still in its early stages.

28. Accordingly, in my observation it is common for expecting parents to perceive of the embryo or fetus in the mother's womb as a 'baby'.

29. Viability is a medico-legal concept that is hardly if ever discussed with expecting parents. In my years of experience I cannot say that viability has any impact on the expecting parents' perception of their unborn 'baby' as articulated during consultations with me.

30. I attach hereto marked '**DB4**' a copy of an article by Lovell (2001) published in the journal *Bereavement Care*. In line with my observations above, Lovell observes that the miscarriage–stillbirth dichotomy is socially constructed (p38) and states as follows (p37):

> . . . for parents, it is not necessarily viability that transforms a fetus into a baby and makes real the baby's identity. The ultrasound scan provides the first image of the unborn baby and even the first picture for the family album.

In the event of spontaneous loss of pregnancy, how do expecting parents experience the event; does viability play a role?

31. During my years of working with both fertile and infertile patients, one of the most difficult tasks as a gynaecologist has always been breaking the news to a patient of a possible adverse pregnancy outcome. In my observation, patients losing a wanted pregnancy through miscarriage or stillbirth, or receiving news of fetal anomalies, experience negative emotion to the same degree as patients who are diagnosed with cancer. (I make this observation as a gynaecologist who still diagnose patients with gynaecological malignancies and who has in the past worked as a general medical practitioner in a small rural town, and who had to inform patients of cancer diagnoses.)

32. Delivering a dead fetus is distressing for everyone involved – nursing staff, doctors, and especially the expecting parents. Instead of the joy of the cries of a welcome baby, everyone is confronted with the sadness of the quiet body delivered.

33. In my observation, viability as such has no discernible effect on the grief caused by spontaneous pregnancy loss on expecting parents.

34. For many expecting parents, losing a wanted pregnancy at 24 or 25 weeks – or even earlier – is the same as losing the wanted pregnancy at full term (37–42 weeks). However, this observation cannot be generalised.

35. In this regard, Lovell ('**DB4**') observes as follows (p38):

> It must also be recognised that for some women early pregnancy loss is not a tragedy and dwelling upon the disposal of the remains is inappropriate, while for others, it is the loss of a baby needing to be mourned.

How do the attending health care staff deal with spontaneous loss of pregnancy?

36. In the private hospital where I currently work, as well as at the public hospitals where I used to do my practical training in the past, a dead fetus would, after delivery, be cleaned and wrapped. The bereaved parents would then be asked if they would like to see or hold the 'baby'. This practice has become increasingly common, even in cases where the gestational age of the fetus was less than 26 weeks.

37. An exception to this practice would occur in the event of a grossly abnormal or macerated fetus, where my health care practitioner colleagues and I would usually advise against viewing the fetus.

38. It has also become common practice for attending health care staff in neonatal units of private and public hospitals to offer to make foot and hand prints of the dead fetus for the parents to keep.

39. However, viability has a major consequence on what happens to the fetal remains after spontaneous loss of pregnancy:

39.1. If the fetus was stillborn, the treating physician would issue a certificate of stillbirth, and the hospital would only allow a funeral undertaker on presentation of a relevant burial order to take possession of the stillborn fetus.

39.2. If the fetus was miscarried, the hospital would as a general rule deal with the miscarried fetus as anatomical waste. It is standard practice that such waste should be incinerated. No certificate of stillbirth or death can legally be issued, and hence no burial order can be obtained. Although hospitals may have policies and procedures relating to the release of anatomical

waste to requesting persons, it is exceptional for bereaved parents to request the release of the dead body of the fetus to them. The reasons for the exceptional nature of such requests are, amongst others: a) The health care staff in the neonatal units would advise the bereaved parents that their dead 'baby' will be 'cremated' as 'required by law', without mentioning any alternative to the bereaved parents; and b) in the event that the subject of requesting the body of the dead 'baby' is breached health care staff in neonatal units would generally advise bereaved parents against requesting the fetal remains from the hospital, given the practical reality that parents can in any event not legally bury their dead 'baby' absent a burial order.

40. Accordingly, while expecting parents who experience *late* spontaneous loss of pregnancy – stillbirth – get to bury their 'baby', expecting parents who experience *early* spontaneous loss of pregnancy – miscarriage – do *not* get to bury their 'baby'.

What is the procedure that precedes termination of pregnancy for medical reasons?

41. As soon as a diagnosis of a major or life threatening fetal anomaly is made antenatal or when medical conditions in pregnancy threatens a pregnant patient's health, the patient is informed about the indication, that the suggested treatment is to terminate the pregnancy, the procedures and possible complications of the suggested termination of pregnancy, and the risks involved with continuation of the pregnancy.

42. The chance of future pregnancies being complicated by the same condition is also discussed based on evidence as available in the literature.

43. As I state in paragraph 31 above, in my observation a patient who receives the news of fetal anomaly experiences negative emotion to the same degree as a patient who is diagnosed with cancer. As such, a gynaecologist should attempt to manage the interaction described above in an empathetic fashion. Yet, it is important that the patient must fully comprehend the unfortunate facts and their consequences.

In the event of termination of pregnancy for medical reasons, how do expecting parents experience the event?

44. Losing a wanted pregnancy is generally a stressful and emotionally painful event for the expecting parents. Losing a wanted pregnancy because of termination of pregnancy for medical reasons is, in my observation, certainly no less of a stressful and emotionally painful event for the expecting parents.

45. Moreover, during consultation with patients who have undergone termination of pregnancy for medical reasons, it is not uncommon that such a patient would remark that she feels socially stigmatised and guilty about the termination – even though her decision was based on professional medical advice.

46. I attach hereto marked '**DB5**' a copy of an article by Maguire *et al* (2015) published in the journal *Contraception*. The article reports the results of a qualitative study of grief after second-trimester termination of pregnancy for fetal anomaly. In line with my observations above, the study found that termination of pregnancy for fetal anomaly is experienced as a significant loss similar to other types of pregnancy loss and is also associated with real and perceived stigma.

Conclusion

47. As a general rule in the context of wanted pregnancies, expecting parents perceive the embryo or fetus in the mother's womb as the unborn 'baby'.

48. This perception of the embryo or fetus in the womb as an unborn 'baby' is actively promoted through the attitudes and language used by health care practitioners that work in antenatal health care.

49. As a general rule in the context of wanted pregnancies, pregnancy loss causes grief to expecting parents.

50. Viability has no discernible impact on expecting parents' perception of their unborn 'baby', or on their grief in the unfortunate event of pregnancy loss.

51. Lastly, it is worth noting how modern technology, in particular 4D ultrasound, has impacted on prospective parents' experience of pregnancy: This new technology provides parents with a detailed and realistic image of the 18–22 weeks old fetus in the mother's womb, which clearly strengthens expecting parents' perception of the fetus as

their unborn 'baby', with all the emotional hope and expectation that goes along with it.

DEPONENT

Thus signed and sworn at Port Elizabeth on this 15th day of December 2016 by the deponent who has declared that he has read this affidavit, understands the contents thereof and has no objection to the taking of the prescribed oath, and regards same as binding on his conscience.

RIAN ARNOLD DU TOIT
COMMISSIONER OF OATHS
PRACTISING ATTORNEY R.S.A.
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COMMISSIONER OF OATHS

Ex officio:

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CERTIFY A TRUE COPY OF THE ORIGINAL

RIAN ARNOLD DU TOIT
ATTORNEY / NOTARY / CONVEYANCER