

Article

A Pro-Choice Response to New York's Reproductive Health Act

Bertha Alvarez Manninen

School of Humanities, Arts, and Cultural Studies, Arizona State University, Glendale, AZ 85306, USA;
bertha.manninen@asu.edu

Abstract: On 22 January 2019, New York state passed the Reproductive Health Act (RHA), which specifies three circumstances under which a healthcare provider may perform an abortion in New York: (1) the patient is within twenty-four weeks of pregnancy, (2) the fetus is non-viable, or (3) the abortion is necessary to protect the patient's life or health. The first one, that of abortion being accessible within the first twenty-four weeks of pregnancy, is not unique to New York, as many other states allow medical professionals to provide abortions during this time. The latter two have caused significant controversy because they detail certain circumstances in which abortions would be accessible after twenty-four weeks. This paper will focus on these latter two circumstances. I will first argue that any debate or discussion about (2) must go beyond the conventional debate about the ethics of abortion and incorporate, more appropriately, a discussion on euthanasia and the ethics of end-of-life care for nascent human life. In particular, it requires us to consider the morality of non-voluntary active euthanasia for non-viable fetuses, rather than just a discussion of the ethics of late term abortions. When it comes to (3), I will argue that assessing its moral permissibility actually raises some legitimate moral concerns, even from a reproductive rights perspective. On certain readings, it seems as if condition (3) would allow for the termination of a healthy fetus for reasons not related to the mother's physical health or life. If this is the case, I argue, the right to an abortion would be construed as a right to fetal termination, rather than just fetal evacuation. However, I will argue that there are good reasons that pro-choice advocates should interpret the right to an abortion as a right to fetal evacuation instead of termination, and if this is the case, a woman should not be able to demand the death of a healthy fetus if ending the pregnancy safely via fetal evacuation would suffice.

Keywords: abortion; rights; euthanasia



Citation: Manninen, B.A.

A Pro-Choice Response to New York's Reproductive Health Act.

Philosophies **2021**, *6*, 15.

<https://doi.org/10.3390/philosophies6010015>

philosophies6010015

Received: 13 January 2021

Accepted: 10 February 2021

Published: 16 February 2021

Publisher's Note: MDPI stays neutral with regard to jurisdictional claims in published maps and institutional affiliations.



Copyright: © 2021 by the author. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (<https://creativecommons.org/licenses/by/4.0/>).

1. Introduction

On 22 January 2019, on the 46th anniversary of *Roe v. Wade*, New York state passed the Reproductive Health Act (RHA). The law removes abortion from the state's criminal code and renders it a public health issue, thereby protecting any medical professional who performs abortions from prosecution. It also reaffirms abortion, as well as contraception, as a "fundamental component of a woman's health, privacy and equality" [1]. The RHA specifies three circumstances under which a healthcare provider may perform an abortion.

"A healthcare practitioner licensed, certified, or authorized under title eight of the education law, acting within his or her lawful scope of practice, may perform an abortion when, according to the practitioner's reasonable and good faith professional judgement based on the facts of the patient's case: (1) the patient is within twenty-four weeks of pregnancy, (2) there is an absence of fetal viability, or (3) the abortion is necessary to protect the patient's life or health." [1]

The first circumstance, where a healthcare provider may perform an abortion within the first twenty-four weeks of pregnancy, is not unique to New York; many other states, in accordance with *Roe v. Wade* (1973), allow abortions during this time as well. Moreover, *Planned Parenthood v. Casey* (1992), while overturning the trimester framework of *Roe*,

maintained that states may only limit abortions after the onset of fetal viability, i.e., when the fetus has the capacity to survive outside the womb.¹

The latter two have caused significant controversy because they detail certain circumstances under which abortions would be accessible after twenty-four weeks (referred to here as “later abortions”). This paper will focus on these latter two circumstances. I will first argue that any debate or discussion concerning condition (2) must go beyond the conventional debate about the ethics of abortion and incorporate, more appropriately, a discussion on euthanasia and the ethics of end-of-life care for nascent human life.

The third circumstance is more ethically complex. Under the Supreme Court case *Doe v. Bolton*, what counts as protecting a woman’s health is so broad that some have voiced concerns that (3) may allow for the termination of a viable and healthy fetus for reasons unrelated to the life or physical health of the pregnant woman. If so, this is morally problematic, even from a pro-choice perspective. One of the best arguments in favor of abortion rights, one whose main strength comes from grounding the right to an abortion regardless of whether the fetus is considered a person, is Judith Jarvis Thomson’s “A Defense of Abortion”. In her essay, she argues that no one’s right to life entails that another person is required to use their body to sustain that life, so that even if a fetus were considered a person with full rights, it does not automatically follow that women can be compelled to remain pregnant in order to sustain fetal life. However, she also argues that the right to an abortion is a right to have the fetus evacuated from the womb, not to terminate the fetus were it possible to preserve its life while in the process of ending the pregnancy. That is, a woman has a right to obtain an abortion because she is not required to sustain anyone’s life through the unwilling use of her body. She does not, however, have any further claim to the fetus’ life when it no longer needs her body for survival. Given this, as I will further explain below, if (3) indeed allows for the termination of a healthy viable fetus for reasons unrelated to saving a woman’s life or preserving her physical health, Thomson’s argument may entail that this exercise of abortion rights is morally problematic.

Before going on to these arguments, it is important to keep in mind the practical realities of what is now permitted in New York given the RHA. According to the Center for Disease Control, the incidence of abortion in the United States has been on the decline for the past ten years. The vast majority of abortions, 91.1%, are performed within the first trimester, and 7.6% of abortions take place between 14 and 20 weeks of gestation. This means that 98.7% of abortions would be covered by (1) of the RHA [3]. Out of the 1.3% of women who do procure later abortions, most of them would be covered by (2), since they involve heartbreaking cases of terminal fetal abnormalities, as we shall see below. As I will argue, these instances of abortion are more akin to euthanasia. However, if concern persists that (3) would allow some women to abort a healthy fetus after 24 weeks, then perhaps we should examine why some women, a very low percentage, take this route. The Guttmacher Institute notes that “women seeking later abortions typically experience more logistical delays—including difficulties finding a provider, raising funds for the procedure and travel, finding a facility and securing insurance coverage—than women who receive a first-trimester abortion” [4]. Over half of the women surveyed who obtained a late abortion for non-therapeutic reasons (reasons unrelated to maternal or fetal health) “wish(ed) that they could have obtained their abortion earlier”. Perhaps, then, the “answer” to later abortion incidences is not to oppose the RHA or any law that allow for easier access to therapeutic abortions, but to, instead, make early abortions far more accessible and affordable.

¹ The viability criterion is complicated by the fact that fetuses are increasingly able to survive outside the womb earlier in pregnancy given medical advancements. While viability may not have taken place until the third trimester when *Roe* was decided, now, fetuses are more routinely able to survive outside the womb if born later in the second trimester. Recently, for example, a baby born at 23 weeks and weighing only 8.6 ounces survived and was sent home after weeks in neonatal intensive care [2]. However, this is not the norm, and her survival has been described as “extremely rare”. So, should we now say that viability can take place at 23 weeks, well within the second trimester, because this baby survived? Or, instead, should viability be placed during a time that a fetus is more likely to survive? Moreover, as technology advances, it may be possible that embryos could be fully gestated outside the womb (a process known as ectogenesis), rendering even early embryos viable. As medical technology advances, the law will be required to revisit the notion of fetal viability and its impact on abortion rights.

2. Cases of Problematic Pregnancies

In May 2016, Erika Christensen obtained an abortion at 32 weeks of gestation after it was discovered that her fetus was suffering from an affliction that resulted in an inability to swallow in the womb and, consequently, an inability to breathe once born. The condition was deemed “incompatible with life”; the baby would either die during birth, or “would live for only a short time before choking to death” (Christensen also suffered from a medical condition that made delivering a baby dangerous). Christensen and her husband opted for termination, “knowing immediately it was the most humane possible conclusion to this pregnancy”. Because abortion after 24 weeks was still illegal in New York during this time, Christensen traveled to Colorado to obtain the abortion, at a price of over USD 10,000 [5].

In 2015, Jennifer Gorman discovered at her 21-week ultrasound that her fetus had severe spina bifida “in the cervical region of the spine. Her spinal cord was completely exposed just below her skull”. Had the fetus survived birth, she would have been permanently quadriplegic and attached to a colostomy bag and feeding tube and would have been severely cognitively disabled. Gorman and her husband agreed to a termination, where the baby’s heart would be painlessly stopped in the womb and her body delivered the next day. Gorman writes that “every last tear I cried came from a place of grief. Not one of those tears ever came from a place of guilt. I made the only decision I could. I made the only decision that was right for me, right for my family, and right for my daughter. It is my belief, if she did have a soul, the only kind and merciful thing to do was to release her from a body that would never, ever work” [6].

Desiring, approving of, or causing the death of a person is not necessarily incompatible with loving them. In the case of a pregnancy that is discovered to be non-viable, there was likely already a bond established between the fetus and its would-be parents, often via the repeated exposure to the fetus via ultrasound imaging. Studies have shown that would-be parents often have a loving, empathetic, and protective response to ultrasound imagery. This means that, often, if abortion is chosen as a response to a non-viable pregnancy, it is likely that there were already feelings of love and care present for the fetus [7].

Emily Rapp writes about her experiences parenting her now deceased son Ronan, who succumbed to Tay–Sachs disease at 3 years old in 2013: “Ronan died when he was nearly 3 and he weighed 11 pounds. He was so emaciated that we had to be careful when we moved him that we did not dislocate his shoulders or hips. His eyes were fixed, every bone on his face visible. He died in the middle of the darkest, coldest night of mid-winter” [8]. Rapp unapologetically admits that:

“If I had known Ronan had Tay–Sachs . . . I would have found out what the disease meant for my then unborn child; I would have talked to parents who are raising (and burying) children with this disease, and then I would have had an abortion. Without question and without regret, although this would have been a different kind of loss to mourn and would by no means have been a cavalier or uncomplicated, heartless decision. I’m so grateful that Ronan is my child. I also wish he’d never been born; no person should suffer in this way—daily seizures, blindness, lack of movement, inability to swallow, a devastated brain—with no hope for a cure. Both of these statements are categorically true; neither one is mutually exclusive.” [9]

Gary Comstock echoes a similar sentiment after his newborn son, Sam, suffocated to death in his arms. Sam was born with trisomy 18, and his brain was unable to regulate his lungs, leaving him with an inability to breathe on his own. Comstock and his wife chose not to abort the pregnancy. Once Sam was born, they decided to remove all life-sustaining treatment and allow their baby to die in their arms. After watching his infant son struggle to breathe, his chest convulsing and his body turning limp, for twenty minutes, Comstock writes about how he and his wife rocked Sam’s body for hours after he died. In hindsight,

Comstock writes that he now believes that “you should not have let your baby die. You should have killed him” [10].²

3. Some Traditional Arguments against Abortion

Many of the traditional arguments against the permissibility of abortion do not apply in these cases, nor in any case where a pregnancy is deemed “non-viable”, i.e., when a fetus is suffering from a terminal affliction where it would not survive outside the womb. For example, Don Marquis argues that what renders abortion generally morally impermissible, alongside most instances of killing, is that it deprives a “standard” fetus of its valuable future [15]. The property that makes killing a child or an adult morally wrong, the deprivation of a valuable future, applies equally to “standard” fetuses, so that killing them is, also, morally wrong. One of the advantages of this account of the wrongness of killing, according to Marquis, is that, contrary to sanctity of life theories³, it allows for the permissibility of some forms of euthanasia—namely, when the patient is terminal, experiencing immense suffering, and wants to die:

“Persons who are severely and incurably ill, who face a future of pain and despair, and who wish to die will not have suffered a loss if they are killed. It is, strictly speaking, the value of a human’s future which makes killing wrong in this theory. This being so, killing does not necessarily wrong some persons who are sick and dying.” [15] (p. 91)

Although Marquis does not specifically address the moral permissibility of aborting non-viable fetuses, the above reasoning applies in these cases. Fetuses who are suffering from some terminal affliction, and who will experience pain and suffering if they survive birth only to die shortly thereafter, have no future of value of which abortion deprives them.⁴

Arguments that rely on a fetus’ potential personhood in order to ground a current right to life, also, may not be applicable in these cases. Jim Stone, for example, argues that “a strong fetal claim to protection rises or falls with the appeal to the fetus’ potentiality, for nothing else justifies it” [16] (p. 815). John Noonan argues that what makes a fetus fully human, and therefore a bearer of a right to life that abortion violates, is that it has “an 80 percent chance of developing further into a baby outside the womb who, in time, would reason” [17]. It is important to draw a distinction between Stone’s potentiality argument and Noonan’s potentiality argument. Noonan’s argument rests on probabilities—a fetus should be granted a right to life because it is highly probable, 80%, that it will become a person if it is successfully gestated, birthed, and grown up. According to this understanding of potential, non-viable fetuses have no potential to become persons—probability is not on their side in these cases, because they have a terminal illness, and so Noonan’s argument fails to apply.

Stone’s appeal to the potentiality of the fetus is less about probability and more about the teleology of the fetus: “What the fetus is finally, is something that makes itself self-

² Some philosophers would argue that in cases such as these, it would be morally problematic to continue such pregnancies and, as such, there may exist a moral obligation to abort. This is because the fact that a child’s life would be fraught with misery, pain, and suffering counts as a reason against creating such a child (as such pregnancy would be conceptualized as part of the creation process), while the fact that a child’s life would be full of happiness does not count as a reason in favor of creating the child. That is, we have a moral obligation not to bring miserable people into existence and, therefore, the harms suffered later by the infant should count in favor of abortion, but we do not have a moral obligation to bring happy people into existence, lest we have a general moral obligation to create as many happy people as possible, which we do not. In the literature, this is called “procreative asymmetry” [11–14].

³ I have thus far overlooked sanctity of life arguments—the position that all human life is sacred and that any act of violence against human life is morally wrong. Sanctity of life arguments would equally oppose abortion in most cases (except to save the pregnant woman’s life) and all kinds of euthanasia, even the euthanasia of a terminally ill human being who is suffering. Because my purpose here is to put the ethics of later abortions in conversation with the ethics of euthanasia, sanctity of life arguments do not offer much by way of advancing this conversation, other than to affirm that both of these actions are morally wrong.

⁴ It is important to note here that we are not talking about fetuses born with some disability, but able to go on to live happy and fruitful lives. So, for example, (2) of the RHA could not justify aborting a fetus with Down Syndrome, since these kinds of pregnancies and fetuses are not non-viable. Though abortion (and infanticide) has been used for eugenic purposes, this is not an aim of the RHA.

aware; that good is the fetus's good—this is its nature" [16] (p. 82). That is, it is in the fetus' innate nature to develop and grow into a person. It may be possible to contend that even non-viable fetuses possess this kind of potentiality—their illness does not change their innate nature, or their teleology, it may be argued. One can respond, however, that while the illness may not change the fetus' nature, it does interfere with its teleology; the illness prohibits the fetus' teleology from manifesting itself.

Arguments that are critical or in defense of Marquis', Noonan's, and Stone's respective arguments against the moral permissibility of abortion abound in the literature. My goal here is not to evaluate each individual argument, but simply to note that, even if these arguments are successful in their criticism of typical abortions, they do not apply in the cases I am concerned with in this paper. Fetuses from non-viable pregnancies have no futures of value of which abortion deprives them. The probability that such fetuses will become persons is not 80%, as Noonan says is the case with a typical fetus, but rather 0% in cases where a pregnancy is non-viable. And while perhaps someone like Stone may argue that an illness does not change the innate teleology of a fetus, it does prevent the fruits of that teleology from realizing itself. The upshot here is to note that some of the most influential arguments against the moral permissibility of abortion do not apply to the kinds of pregnancies that are of concern in this paper.

4. Abortion as Non-Voluntary Active Euthanasia

Adequately exploring the ethical dimensions of these instances of abortion requires us to move beyond the arguments either for or against the moral permissibility of abortion and into the ethical dimensions of euthanasia and end-of-life care. What is essentially legalized in New York is non-voluntary active euthanasia for fetuses older than 24 weeks of gestation.⁵ It is "non-voluntary" because fetuses are incapable of consenting to being euthanized, and their respective parents are, essentially, acting as their proxy.⁶ It is "active" because the fetuses are not just passively dying in the womb; instead, their deaths are being actively hastened, typically by stopping their hearts, before they are born.

In this sense, New York's law has some things in common with the Netherlands' implementation of the Groningen Protocol in 2004 by Eduard Verhagen, medical director of pediatrics at the University Medical Center Groningen. The protocol legalized non-voluntary active euthanasia for suffering and terminally ill newborns so long as five criteria are met:

- The diagnosis and prognosis must be certain.
- Hopeless and unbearable suffering must be present.
- The diagnosis, prognosis, and unbearable suffering must be confirmed by at least one independent doctor.
- Both parents must give informed consent.
- The procedure must be performed in accordance with the accepted medical standard [18].

In the United States, voluntary and non-voluntary passive euthanasia is legal—that is, patients can request that life-sustaining treatment be withdrawn or not initiated, and for patients who cannot give consent, their proxies are allowed to decide for them. Physician-assisted suicide, where a doctor can prescribe a lethal dose of a medication that the patient then self-administers, is legal in California, Colorado, Hawaii, Montana, Oregon, Vermont,

⁵ It is important to distinguish this from involuntary euthanasia, where someone is "euthanized" against their wishes, rather than in absence of their wishes.

⁶ It should be noted here that this marks a difference between aborting a non-viable fetus and the kind of euthanasia that Marquis argues is permissible according to his argument; Marquis is talking about the permissibility of voluntary euthanasia, not non-voluntary. While this is a valid distinction, it is important to note that proxies, typically the next of kin, routinely make medical decisions on behalf of non-conscious patients. Passive euthanasia decisions, when a person is taken off life support, for example, are often made by medical proxies when the patient cannot consent, and so may be considered a kind of non-voluntary euthanasia. When deciding whether a non-viable fetus should be aborted, looking towards Marquis' argument is helpful. A fetus in such a circumstance not only does not have a valuable future, but often whatever future it does have is fraught with pain and suffering, as the above examples illustrate.

Washington, and the District of Columbia. Neither voluntary nor non-voluntary active euthanasia is currently legal for any extrauterine human being. The RHA changes this for terminally ill intrauterine humans past the point of the second trimester in New York, as does any other state—for example, Colorado—which allows late abortions for non-viable pregnancies.

Therefore, to adequately morally assess condition (2) of the RHA, we need to expand our general discussions about the permissibility of euthanasia, particularly in its non-voluntary form, to include non-viable fetuses. The literature here is vast and varied. Some bioethicists—for example, Stephen Potts—argue that no instance of active euthanasia is permissible [19]. Dan Brock argues that while voluntary active euthanasia is permissible, non-voluntary active euthanasia is a “potential unwanted side effect of permitting voluntary euthanasia” [20] (p. 11) because the respect for personal autonomy that underlies a defense of voluntary euthanasia is absent when patients are incapable of consent. On the other hand, Verhagen and Pieter Sauer argue that policies such as the Groningen Protocol are permissible because “when both the parents and the physicians are convinced that there is an extremely poor prognosis, they may concur that death would be more humane than continued life” [21] (p. 960). This is a perspective echoed by the abovementioned parents who either opted for a later abortion for their terminally ill fetuses or wished they had once their child was born and suffered until their death. On the other hand, others have argued that euthanizing severely ill infants involves quality of life judgements that are hard to quantify and therefore may, sometimes, be in error. Alan Jotkowitz and Shimon Glick bring up the following concerns:

“... there is a serious question about the quality of the informed consent of parents. The parents who agree to the decision are relying on experts to predict the future for them without having experienced it ... There is also the clear potential for bias in the parents’ decision making because of the emotional, physical, and financial hardships they face in the long term care of a severely disabled child. This bias also extends to the state, which in addition to being charged with protecting the weak in society, is also in most instances financially responsible for the infant’s care. It is also impossible to separate the attending physician’s personal ethical perspective and burden in caring for a chronically ill infant from the decision to actively terminate the child’s life.” [22] (p. 157)

While a detailed analysis of the arguments both for and against infant euthanasia is beyond the scope of this paper,⁷ it is important to acknowledge that this is the discussion that we should be having in reference to (2) of the RHA, rather than insisting that this is simply another incarnation of the abortion issue. While undoubtedly the two are intertwined here—a terminally ill fetus still does live in the body of another human being after all, and whatever choice is made about the fetus’ welfare and life cannot be implemented without the consent of the woman in whom the fetus resides—failing to recognize the commonalities with the euthanasia debate means that we are forgoing an opportunity to discuss an issue that has implications not just for terminally ill fetuses, but potentially, also, for other terminally ill persons. This is because once active euthanasia becomes legal for one subset of terminally ill human beings, it is only a matter of time before the conversation is expanded to include other terminally ill human beings as well.

5. Abortions Due to Women’s Health

The Reproductive Health Act allows for late abortions when it is “is necessary to protect the patient’s life or health”. This third circumstance appears to be separate from the others and makes no mention of fetal health. Given this, it appears possible that, on some readings, a viable and otherwise healthy fetus may be permissibly aborted when it

⁷ It is important to note that Jotkowitz and Glick’s concerns do not apply here. In the cases that concern this paper, we are not talking about the long-term care of disabled infants, and whether the difficulties of that care warrant euthanasia in some instances. Rather, what we are talking about are fetuses and infants whose death is inevitable, if they even survive the birthing process, and who stand to suffer until they die.

is necessary in order to protect the patient's life or health, the latter of which is broadly defined. In *Doe v. Bolton* (1973), the Supreme Court ruled that preserving the health of a pregnant woman can amount to many things:

“medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the wellbeing of the patient. All these factors may relate to health.” [23]

While it is understandable to opt for a broad definition of what can encompass “health” in order to account for as many diverse situations as possible, the worry is that the criteria are so broad that virtually any reason given by a woman may be deemed sufficient grounds for aborting a viable and healthy fetus after 24 weeks.

Before we begin this discussion, an important point must be made. While it should go without saying, women do not gestate a fetus for two thirds of a pregnancy and then wantonly decide to obtain an abortion. The idea that women can just saunter into a medical establishment and demand that an almost-born healthy fetus be aborted for any trivial reason smacks of misogyny, as it portrays women as callous, uncaring, morally irresponsible people who have no problems “ripping” their babies from their wombs, as Donald Trump has routinely repeated [24]. Such accusations and falsities betray a deep ignorance of the realities and phenomenology facing women who opt for later abortions. A responsible and morally sensitive conversation on the ethics of later abortions has to take place from this lens; otherwise, what we are dealing with is a deeply confused and harmful strawman.

Given all this, it is still the case that there may be some aspects of (3) that are legitimately concerning. Suppose that a woman desires a third-trimester abortion for reasons that do not include an immediate threat to her physical health (as in, she is not in danger of dying or experiencing severe medical repercussions) but that do fall into the other circumstances detailed in *Doe v. Bolton*—perhaps there would be negative emotional, psychological, or familial repercussions for continuing the pregnancy. These are not wanton or trivial reasons to want to terminate a pregnancy, and a woman in these tenuous life circumstances deserves our sympathy and care. However, suppose that the pregnancy has progressed to the point that the fetus is viable and otherwise healthy; were it to be delivered now, the baby would, with perhaps some initial medical intervention, go on to live a perfectly healthy life. It does appear that the RHA would permit the termination of such a fetus. If so, there are good reasons that even reproductive rights activists should repudiate this possible outcome, while staying sensitive to the conditions and needs that influence such a woman to seek a late abortion.

6. Abortion as Fetal Evacuation vs. Abortion as Fetal Termination

Pro-reproductive-rights philosophers and ethicists have long debated what should be the proper understanding of a right to an abortion. Some philosophers argue that fetuses are not persons, so that they do not possess a right to life. Consequently, no abortion kills any being with moral status, nor does it violate any rights [25–27]. Other philosophers argue that any robust reproductive right for women must entail not just a right to terminate a pregnancy but also a right to terminate the fetus itself, at least during the earlier stages of pregnancy [28]. According to these philosophers, the right to an abortion is construed as a right to fetal termination.

Other philosophers disagree, and argue, instead, that the right to an abortion is a right to fetal evacuation, but not necessarily fetal termination. In “A Defense of Abortion”, Judith Jarvis Thomson argues that even if we concede, for the sake of argument, that the fetus is a person with a right to life, this alone does not entail that a woman can be obligated to gestate it, because no one's right to life entails that another person can be compelled to use their body to sustain that life. However, towards the end of her essay, Thomson argues that, were it possible to remove a fetus alive, the woman has no additional right to demand its death. Even though she may suffer emotional and psychological pain at the thought

of her child existing in the world, this alone is not sufficient for justifying the death of the fetus.

“ . . . while I am arguing for the permissibility of abortion in some cases, I am not arguing for the right to secure the death of the unborn child a woman may be utterly devastated by the thought of a child, a bit of herself, put out for adoption and never seen or heard of again. She may therefore want not merely that the child be detached from her, but more, that it die All the same, I agree that the desire for the child’s death is not one which anybody may gratify, should it turn out to be possible to detach the child alive.” [29] (p. 66)

All human beings have a right to deny anyone the use of their body even for life itself. If one human being required a bone marrow transfusion to continue living, for example, and one of his neighbors was a match but refused to donate, the afflicted human being has no right to forcibly intrude his neighbor’s body to take the bone marrow. Even if the neighbor did agree to the transfusion, he is allowed to stop at any time he deems fit—he retains his bodily autonomy throughout. Yet, were it to be the case that somehow the afflicted person survives after all without the need for bone marrow, his neighbor does not have an additional right to kill him. His neighbor has a right to refuse the transfusion, even at the expense of a person’s life, because he has a right to his body, but he has no additional claim to that person’s life. Thomson argues that this distinction applies to pregnancy and abortion as well.

Some may think that such hair-splitting distinctions are practically inconsequential, given that, for most of the pregnancy, termination of the pregnancy necessarily entails fetal death. But once a fetus is viable, and could feasibly survive outside the womb, this distinction becomes vitally important. From a Thomsonian perspective, if (3) of the RHA allows for the termination of a healthy viable fetus in certain circumstances, then this may be an overextension of reproductive rights. Abortion then becomes a right to fetal termination, rather than just fetal evacuation.

7. *Roe v. Wade* and the Consequences of Personhood Amendments

Why should this consequence concern reproductive rights advocates? It is here that we expand our conversation from the moral realm into the legal one, which contributes to our philosophical arguments having real-world ramifications (as ethicist Peter Singer writes “an ethical judgement that is no good in practice must suffer from a theoretical defect as well, for the whole point of ethical judgments is to guide practice”) [27] (p. 2). Let us examine the Supreme Court arguments in *Roe v. Wade*. The Justices explicitly rejected defending abortion rights on the grounds of bodily autonomy: “. . . it is not clear to us that the claim asserted by some *amici* that one has an unlimited right to do with one’s body as one pleases bears a close relationship to the right of privacy previously articulated in the Court’s decisions”. Instead, they write:

“This right of privacy . . . 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.” [30]

In other words, women have a right to an abortion in virtue of their right to privacy because they have an interest in avoiding the negative repercussions of unwanted parenthood. The right to procreative liberty in this respect has been repeatedly referenced in other

cases concerning reproductive freedom.⁸ However, it is not clear, given the arguments expressed in *Roe*, that the right to an abortion is covered by the right to reproductive liberty.

The Justices who decided *Roe* explicitly argued that they had no capacity to decide the issue “of when life begins”; that is, they refused to wade into the murky waters of determining fetal personhood. However, the arguments in *Roe* only successfully secure abortion rights if fetuses are not considered persons with rights of their own. Procreative liberty is best understood as the right to refrain from having children, or to not be interfered with if one chooses to have children. While exercising this right does entail that you can prevent the existence of your child, it does not entail that you can kill your already existing child. If someone were to lose their job, become homeless, have their partner leave, or even learn later in life that their child was actually the product of a previously unknown sexual assault, none of these reasons could ever justify killing a born child. This is because such a child is a person, with rights of her own, and those rights cannot be violated due to these, admittedly very difficult and sensitive, situations. Therefore, if these same situations do justify fetal termination, it can only be because fetuses are not persons after all. For were fetuses considered persons, these difficult social circumstances could not justify their termination any more than it could justify killing born children given those very same circumstances [31].

The reason that this is problematic is a practical one. Although New York and Colorado have worked to secure abortion access in their respective states, far more states have been taking steps for years to codify fetal personhood into law. States like Mississippi, Nebraska, and Florida, amongst others, have all tried to pass Personhood Amendments, which would render fetuses persons from conception onwards and therefore make abortions tantamount to homicide. All 50 states have an active “personhood” movement, “operating through an organization known as Personhood USA” [32]. Although, as of 2021, none of initiatives these have yet to pass, given the current demographics of the Supreme Court, it is not a stretch to say that, were any bill be challenged at their level, it is possible that the majority of the Justices would rule in favor of some version of a fetal personhood law. If this happens, the justification behind *Roe* could very well falter for the abovementioned reasons. Advocates of Personhood Amendments have latched onto this, and some have argued that a successful passage of a Personhood Amendment would be a “silver bullet” to *Roe v. Wade* [33].

Codifying fetal personhood into law does not just affect abortion. Consider the example of Carmen Aldana, a woman from El Salvador, who was sentenced to 30 years in jail for, allegedly, self-administering an abortion when she delivered a stillborn baby. Her sentence was overturned in 2015, but her conviction was a result of Article 1 of El Salvador’s Constitution, which holds that embryos and fetuses are persons with rights from conception [34]. In 2019, Georgia attempted to pass HB 481, which aimed to ban abortion after six weeks of gestation, after a fetal heartbeat can be detected. One consequence of the bill, which has been challenged by the American Civil Liberties Union and the Center for Reproductive Rights, is that a woman who self-administers an abortion could be charged with first-degree murder [35]. Miscarriages found to be the “woman’s fault” can also have legal repercussions. Even if no conviction takes place, fetal personhood means that every woman who loses a pregnancy would be subject to some degree of investigation (as most deaths of persons are investigated). There are other areas of reproductive choice that could be challenged by Personhood Amendments. For example, in vitro fertilization (IVF), where a woman’s egg is fertilized outside the womb and then reinserted for possible implantation, may be affected. IVF embryos are often tested for genetic conditions, with only healthy embryos being implanted while embryos with genetic abnormalities are discarded. If embryos are considered persons, discarding them would be tantamount to homicide. These are just two of the ramifications, in addition to abortion restrictions, that can result if fetuses gained a right to life under Personhood Amendments [36].

⁸ See, for example: *Griswold v. Connecticut* (1965), *Eisenstadt v. Baird* (1972), and *Carey v. Population Services International* (1977).

8. The Advantages of Thomson's Argument

The upshot here is that arguments in favor of reproductive rights must be secured on premises that are not contingent on fetal personhood. Thomson's argument does this.⁹ No human being's right to life is strong enough to warrant making another human being undergo any level of bodily intrusion in order to sustain that life. If human beings cannot be compelled to, say, donate blood, bone marrow, or any other kind of bodily fluid to save another human being's life, then it is difficult to see how a woman can be compelled to undergo a much more severe and burdensome bodily infraction (as pregnancy and childbirth surely are) to sustain fetal life. The onus is on pro-life supporters to give an argument here that fetuses have an additional right—the right to use someone's body without their consent to sustain life—that no other person possesses. This is yet another benefit to Thomsonian-type arguments in favor of abortion rights—although her arguments are meant to be moral arguments, they are easily transferred into the legal realm because they render the right to an abortion sufficiently similar to other cases where the right to bodily autonomy is regarded as more stringent than the right to life.¹⁰ Indeed, this is the basis on which Canada's abortion right is based: “forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus an infringement of security of the person” [39].

But if Thomsonian-type arguments are to be preferred for these reasons, the “bullet” that must be “bitten” is that the right to an abortion needs to be understood as a right to fetal evacuation, not to fetal termination. A woman has a right to deny the fetus' continued use of her body even if it costs the fetus its life (as is the case before viability) but the woman has no right to kill the fetus once it is no longer in need of her body. This means that there is a strong case to be made that, if a woman desires an abortion after fetal viability, then, *prima facie*, the pregnancy must end via early delivery rather than fetal termination.

It is only “*prima facie*”, however, because there may be cases where abortion via fetal termination rather than early delivery is necessary in order to actually save the woman's life. Consider Cecily Kellogg's diagnoses of severe preeclampsia that came at 23 weeks of gestation and after she discovered one of her two twins had died:

“I was in advanced kidney failure. My blood pressure was skyrocketing, and it could not be controlled with medications. My liver was beginning to decline. The horrific headache I was experiencing could no longer be treated with pain medications because they were afraid it would depress my ability to breathe when I began to have the seizures they expected at any moment. I would soon likely suffer a stroke or a heart attack. In other words, I was going to die unless the pregnancy was terminated. Immediately. There was no hope for my surviving son. He was too tiny and too frail to be viable. With my dangerously high blood pressure, a c-section would have likely caused me to bleed to death, and inducing labor would have stressed my system too much. My safest option was the procedure known as an intact dilation and extraction. It would save my life, and preserve my future fertility.” [40]

Had her surviving twin been older, and therefore viable, in the same set of circumstances, Kellogg's decision to opt for termination rather than early delivery is entirely

⁹ Some arguments against Thomson's conclusion here point to other potential sources of obligations that are supposed to make abortions morally wrong. For example, one argument is that a woman has special obligations towards her fetus because the fetus is her child, and we clearly have moral obligations to our children that we do not have to strangers. This obligation, it is argued, may entail that the woman should allow the fetus continued use of her body. For a detailed analysis of some of these arguments, and responses to them, see David Boonin's *A Defense of Abortion* [37].

¹⁰ For example, there is the 1978 Pennsylvania court case *McFall v. Shimp*. Robert McFall was suffering from aplastic anemia and his cousin, David Shimp, was found to be a bone marrow match. However, Shimp refused to submit to the transfusion, and McFall took his cousin to court in the hope that the state would compel Shimp to submit to the blood transfusion. The state refused, arguing that “for a society which respects the rights of *one* individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for *another* member, is revolting to our hard-wrought concepts of jurisprudence” [38]. This echoes Thomson's conclusion: the right to life does not entail the right to use another's body for continued sustenance.

justified. A woman cannot be required undergo a medical procedure that will likely result in her death. Her right to bodily autonomy, and her right to life, means that she alone is in the unique position to decide what to do in such a difficult case. As Laurie Shrage writes, the courts have ruled that “after viability, if two methods [of pregnancy termination] are equally safe for the woman, the state constitutionally can require that the one least hazardous for the fetus be used”, although they have also ruled that “when a fetical method of pregnancy termination is safer for a woman, she or her physician may choose that method, even after viability” [41] (pp. 22–23).

However, barring an immediate threat to her life or physical health, there is a strong case to be made that the best defense of abortion rights, one that is largely impervious to attacks from pro-life advocates who insist on fetal personhood, is one that also entails that women cannot, in general, demand fetal termination to end a pregnancy when fetal evacuation safely suffices. Like all other persons, women have a right to choose whether they want to use their body to sustain someone else’s life. Like all other persons, a woman may choose to not do so even if it costs another person their life. But that also means that, like all other persons, a woman cannot demand the death of another if they are no longer in need of her body for survival. If the third condition of the RHA permits the termination (rather than the evacuation) of a viable fetus when it is not necessary in order to preserve a woman’s life or physical health, then this is morally problematic, even from a reproductive rights perspective.

9. Conclusions

This paper has largely defended a pro-choice position with the concession that certain kinds of abortion may be morally problematic. As mentioned in the beginning of this paper, the number of women who may want to abort a viable healthy fetus for reasons unrelated their physical or medical welfare is less than 1.3%; this is the number of women who obtain later abortions, and out of this 1.3%, most of these women abort due to fetal abnormalities that render their pregnancy non-viable. In other words, almost all abortions are covered under (1) and (2) of the RHA. Given these numbers, some may wonder why I have devoted a paper to such a small percentage of abortions, especially since there is a danger that anti-abortion advocates would weaponize the arguments made in this paper.

First, a lot of attention has been cast upon New York with this law. New York State Senator Liz Krueger’s website has a section of frequently asked questions about the RHA; one of those questions is: “I’ve heard that the RHA allows fetuses to be aborted up to the moment of birth. Is that true?” [42]. These are the kinds of reasons that many people oppose the RHA. A paper that goes carefully through the law and explains what does or does not follow from the RHA seems very needed. We can concede that the kinds of abortion that people are worried about occurring, the ones that fall under (3), are indeed morally concerning, but also emphasize that these instances of abortion are extremely rare. Instead, we should redirect our attention to the heartbreaking cases discussed above, where fetuses have a fatal affliction that leads to parents choosing termination, and have a discussion about the ethics of intrauterine euthanasia, which is a conversation in its own right—one that is being largely ignored given all the attention being spent on (3).

Second, we must go where the argument leads us. If in fact Thomsonian-type arguments against later, non-therapeutic abortions lead to the conclusion that a healthy and viable fetus should not be destroyed for reasons unrelated to the pregnant woman’s physical health, then this is a conclusion that we have to concede. It is important for the pro-choice position (and the pro-life one as well) to admit that there may be gray areas when it comes to reproductive choice, and that arguing in favor of reproductive rights while acknowledging those gray areas, rather than ignoring them or insisting that they do not exist, can only serve to make pro-choice arguments stronger. Consider the words of Dr. Jeannie Ludlow, an abortion provider, who, while arguing in favor of the permissibility of certain instances of later abortion, refuses to deny the fetus’ status as a potential person. Rather, she recommends that pro-choice advocates give this response: “Yes. It’s a baby and

yes, it is killed. I want to talk about all the reasons why so many women choose to have abortions even though they know this, and why it is important that women are allowed to make that choice" [43] (p. 42).

All this serves to emphasize what should be the position on abortion from both the pro- and pro-life perspective: the abortion question is hard. Refusing to grapple with difficult cases of abortion choice does not make them go away. This applies both to pro-choice and pro-life advocates, as this paper has highlighted. Pro-choice advocates would be wise to admit that there may be some cases where abortion choice is morally problematic. Admitting to those difficult cases, while still arguing in favor of reproductive rights, can result in a nuanced pro-choice advocacy—one that appreciates the ethical complexity surrounding abortion and does not shy away from the difficult cases. Pro-life advocates, also, would be wise to admit that there are some cases, like the ones highlighted at the beginning of this paper, where the choice to abort may be defensible, especially when the goal is to prevent more suffering for the fetus/infant. Perhaps making such concessions would be a good start to a conversation on abortion rights that reaches across the aisle and has the potential to result in some degree of convergence.

Funding: This research received no internal funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: Not applicable.

Conflicts of Interest: The author declares no conflict of interest.

References

1. State of New York. S. 240 Reproductive Health Act. Available online: <https://legislation.nysenate.gov/pdf/bills/2019/S240> (accessed on 11 January 2021).
2. Alison, A. World's Smallest Baby Leaves Hospital. Available online: <https://www.webmd.com/parenting/baby/news/20190531/worlds-smallest-surviving-baby-leaves-hospital> (accessed on 13 February 2021).
3. Centers for Disease Control and Prevention. CDC's Abortion Surveillance System FAQs. Available online: https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm (accessed on 11 January 2021).
4. Guttmacher Institute. Later Abortions. Available online: <https://www.guttmacher.org/evidence-you-can-use/later-abortion> (accessed on 12 January 2021).
5. Christensen, E. New York Forces Women Like Me to Carry Nonviable Pregnancies to Term. Available online: <https://rewire.news/article/2017/05/23/new-york-forces-women-like-carry-nonviable-pregnancies-term/> (accessed on 12 January 2021).
6. Gorman, J. Here's What I Want Donald Trump and Everyone Else to Know about My 'Late-Term Abortion'. Available online: https://www.huffingtonpost.com/entry/donald-trump-late-term-abortion_us_5c5b02c5e4b09293b20a8263?ncid=fbklnkushpmsg00000037&utm_source=parents_fb&utm_campaign=hp_fb_pages&utm_medium=facebook&utm_source=main_fb&utm_campaign=hp_fb_pages&utm_medium=facebook&ncid=fbklnkushpmsg00000063&fbclid=IwAR3pt-DI1oq4JiAz99E9vrd2XqitBrllFLUjJODppqKeZN_gUXay-MYskuds (accessed on 11 January 2021).
7. Giebel, H. Ultrasound Viewers' Attribution of Moral Status to Fetal Humans: A Case for Presumptive Rationality. *Diametros* **2020**, *17*, 22–35.
8. Rapp, E. An Anti-Abortion Organization Used the Story of My Dying Son. Available online: <http://www.rolereboot.org/culture-and-politics/details/2013-10-an-anti-abortion-organization-used-the-story-of-my-d> (accessed on 11 January 2021).
9. Rapp, E. Rick Santorum, Meet My Son. Available online: <https://slate.com/human-interest/2012/02/rick-santorum-and-prenatal-testing-i-would-have-saved-my-son-from-his-suffering.html> (accessed on 11 January 2021).
10. Comstock, G. You Should Not Have Let Your Baby Die. Available online: <https://www.nytimes.com/2017/07/12/opinion/you-should-not-have-let-your-baby-die.html> (accessed on 11 January 2021).
11. McMahan, J. Asymmetries in the Morality of Causing People to Exist. In *Harming Future Persons: Ethics, Genetics and the Nonidentity Problem*; Roberts, M., Wasserman, D., Eds.; Springer: Berlin/Heidelberg, Germany, 2009; pp. 49–68.
12. Narveson, J. Future People and Us. In *Obligations to Future Generations*; Sikora, R.I., Barry, B., Eds.; Temple University Press: Philadelphia, PA, USA, 1978; pp. 38–60.
13. Rachels, S. Is It Good to Make Happy People? *Bioethics* **1998**, *12*, 93–110. [[CrossRef](#)] [[PubMed](#)]
14. Algander, P. A Defence of the Asymmetry in Population Ethics. *Res. Publica*. **2012**, *18*, 145–157. [[CrossRef](#)]
15. Marquis, D. Why Abortion is Immoral. *J. Philos.* **1989**, *86*, 183–202. [[CrossRef](#)] [[PubMed](#)]
16. Stone, J. Why Potentiality Matters. *Can. J. Philos.* **1987**, *17*, 815–830. [[CrossRef](#)]

17. Noonan, J. An Almost Absolute Value in History. Available online: <https://spot.colorado.edu/~jheathwoo/Phil160,Fall02/noonan.htm> (accessed on 11 January 2021).
18. Francis, N. Neonatal deaths under Dutch Groningen Protocol very rare despite misinformation contagion. *J. Ass. Dying* **2016**, *1*, 7–19.
19. Potts, S. Objections to the Institution of Euthanasia. *Houst. Law Rev.* **1988**, *25*, 511–545.
20. Brock, D. Voluntary Active Euthanasia. *Hastings Cent. Rep.* **1992**, *22*, 10–22. [CrossRef] [PubMed]
21. Verhagen, E.; Sauer, P.J. The Groningen Protocol—Euthanasia in Severely Ill Newborns. *N. Engl. J. Med.* **2005**, *352*, 959–962. [CrossRef] [PubMed]
22. Jotkowitz, A.B.; Glick, S. The Groningen Protocol: Another perspective. *J. Med. Ethics* **2006**, *32*, 157–158. [CrossRef] [PubMed]
23. United States Supreme Court. Doe v. Bolton. Available online: <https://www.law.cornell.edu/supremecourt/text/410/179> (accessed on 12 January 2021).
24. USA Today. Trump Fact Check: Babies Executed After Failed Abortions. He’s Oversimplifying, AP Finds. Available online: <https://www.usatoday.com/story/news/politics/2019/05/13/trump-executing-babies-after-failed-abortion-fact-check-ap/1186702001/> (accessed on 13 January 2021).
25. Warren, M.A. On the Moral and Legal Status of Abortion. *Monist* **1973**, *57*, 43–61. [CrossRef] [PubMed]
26. Tooley, M. Abortion and Infanticide. *Philos. Public. Aff.* **1972**, *2*, 37–65.
27. Singer, P. *Practical Ethics*, 2nd ed.; Cambridge University Press: New York, NY, USA, 1993.
28. Mackenzie, C. Abortion and Embodiment. *Australas. J. Philos.* **1992**, *70*, 136–155. [CrossRef] [PubMed]
29. Thomson, J.J. A Defense of Abortion. *Philos. Public. Aff.* **1971**, *1*, 47–66.
30. United States Supreme Court. Roe v. Wade. Available online: <https://www.law.cornell.edu/supremecourt/text/410/113> (accessed on 11 January 2021).
31. Manninen, B. *Pro-Life, Pro-Choice: Shared Values in the Abortion Debate*; Vanderbilt University Press: Nashville, TN, USA, 2014.
32. Rewire.com. Personhood Laws. Available online: <https://rewire.news/legislative-tracker/law-topic/personhood/> (accessed on 13 January 2021).
33. Unruh, B. ‘Personhood’ silver bullet to kill Roe v. Wade? Available online: <https://www.wnd.com/2007/09/43769/> (accessed on 11 January 2021).
34. Manninen, B. Have a Miscarriage and Go to Jail? Potential Consequences of Personhood Amendments. Available online: <https://www.thehastingscenter.org/have-a-miscarriage-and-go-to-jail-potential-consequences-of-personhood-amendments/> (accessed on 27 January 2021).
35. Panetta, G. Women could get up to 30 years in prison for having a miscarriage under Georgia’s harsh new abortion law. Available online: <https://www.businessinsider.com/women-30-years-prison-miscarriage-georgia-abortion-2019-5> (accessed on 12 January 2021).
36. Manninen, B. Beyond Abortion: The Implications of Human Life Amendments. *J. Soc. Philos.* **2012**, *43*, 140–160. [CrossRef]
37. Boonin, D. *A Defense of Abortion*; Cambridge University Press: New York, NY, USA, 2003.
38. Leagle. McFall v. Shimp. Available online: <https://www.leagle.com/decision/197810010padampc3d90189> (accessed on 11 January 2021).
39. Supreme Court of Canada R. v. Morgentaler. Available online: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do> (accessed on 13 January 2021).
40. Kellogg, C. How a Late-Term Abortion Saved my Life. Available online: <https://rewire.news/article/2009/07/01/how-a-late-term-abortion-saved-my-life/> (accessed on 13 January 2021).
41. Shrage, L. *Abortion and Social Responsibility: Depolarizing the Debate*; Oxford University Press: New York, NY, USA, 2003.
42. Krueger, L. FAQs about the Reproductive Health Act. Available online: <https://www.nysenate.gov/newsroom/articles/2019/liz-krueger/faqs-about-reproductive-health-act> (accessed on 13 January 2021).
43. Ludlow, J. Sometimes it’s a Child and a Choice: Toward an Embodied Abortion Praxis. *Fem. Form.* **2008**, *20*, 26–50.