Essay

Abortion and public health: Time for another look

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Four decades after Roe v. Wade, abortion remains highly contentious, pitting a woman's right to choose against a fetal claim to life. Public health implications are staggering: the US annual total of more than one million induced abortions equals nearly half the number of registered deaths from all causes. Sentiment regarding abortion is roughly evenly split among the general public, yet fundamental debate about abortion is largely absent in the public health community, which is predominantly supportive of its wide availability. Absence of substantive debate on abortion separates the public health community from the public we serve, jeopardizing the trust placed in us. Traditional public health values—support for vulnerable groups and opposition to the politicization of science—together with the principle of reciprocity weigh against abortion. Were aborted lives counted as are other human lives, induced abortion would be acknowledged as the largest single preventable cause of loss of human life.

Lay Summary: *Four decades after Roe v. Wade, abortion remains highly divisive. Public sentiment regarding abortion is roughly evenly split, yet fundamental debate is largely absent in the public health community, which supports abortion's wide availability. Absence of substantive debate separates the public health community from the public it serves. Traditional public health values—support for vulnerable populations and opposition to politicization of science—and the principle of reciprocity (“the Golden Rule”) weigh against abortion. Were aborted lives counted as are other human lives, induced abortion would be acknowledged as the largest single preventable cause of loss of human life.*

Keywords: Abortion, Eugenics, Reciprocity, Human rights, Hierarchy of values

INTRODUCTION

More than four decades have passed since the Supreme Court's 1973 *Roe v. Wade* decision legalizing most induced abortions in the United States of America (US) (U.S. Supreme Court 1973). In the wake of this and companion decisions, the US has one of the world's most liberal abortion regimes, allowing early abortion for any reason and extending to viable fetuses throughout pregnancy for reasons related to the mother's

physical or mental health. Far from settling the issue, there has been continuous and fractious debate in society at large over persistent ethical and legal issues (Kaposy 2012; Marquis 1989; Nathanson 1979; Thomson 1971). Polling data, despite their limitations, have consistently shown the general population to be roughly evenly split between “pro-choice” and “pro-life” positions, i.e., between support and opposition, respectively, regarding legalized abortion (Gallup Poll 2015). Yet within the public health

community, discussion about fundamental ethical aspects of abortion has been largely absent, and there is broad and vocal support for its wide availability ([APHA 2003](#)).

REFLECTIONS

The absence of substantive debate in the public health community represents a danger to our profession and society, because we thereby distance ourselves from the communities we serve, jeopardizing our credibility and the trust placed in us. At this juncture one often hears that opposition to abortion is based on sectarian religious beliefs that have no place in setting public policy in a secular society. This is an arguable point because our social and legal systems have religious roots impossible to disentangle fully from the secular, and I will not address that topic here. Rather, I hold that the application of reason, in the context of our shared secular ethical values as considered below, militates against abortion.

Our shared values: We stand with the vulnerable and marginalized

Our public health community has a proud history of championing the rights of marginalized and voiceless groups, such as immigrants, the poor, and others, often to angry opposition from society's powerful. Yet we must also acknowledge our historical complicity with decidedly illiberal forces. In the previous century members of the public health community were important proponents of the eugenics movement, which argued for forced sterilization, denial of citizenship, and other sanctions against groups considered undesirable ([Pernick 1997](#)).

African-Americans in particular have suffered greatly from these historical injustices and continue to do so. The Tuskegee study, in which the public health establishment stood by to observe the course of syphilis as a “natural experiment” among poor African-Americans rather than intervene with available treatment, occurred within living memory and to this day troubles relations between the African-American and scientific communities ([Reverby 2009](#)). Planned Parenthood, the US abortion industry's largest provider, was founded by Margaret Sanger, an outspoken racist and eugenicist who believed that artificial contraception was necessary for controlling the populations of non-White races. Today, African-Americans are 3.7-fold more likely than Whites to have an abortion, and over one-third of all recognized pregnancies among African-Americans end in abortion ([Pazol et al. 2014](#)). Let us take justifiable pride in our history, but not be blind to its cautionary tales. They are invitations to humility, to question our assumptions, and above all to honest debate.

Our shared values: We cherish truth and guard against the politicization of science

The previous US administration raised concern to high levels over attempts to deny, distort, and suppress fact and opinion interfering with cherished political goals ([Union of Concerned Scientists 2004](#)). We in public health must avoid falling into the same trap. With respect to abortion, the inconvenient truth that is often ignored or obfuscated is the biologic status of the human embryo or fetus. There is often failure to distinguish between biologic fact—the embryo or

fetus as a unique human life—and philosophical construct—the embryo or fetus as a “person” deserving of protections that normally pertain to that status. The very term “human being” is disputed, with one group using it in the factual biologic sense denoting species and the other reserving it for those with advanced cognitive abilities, conveniently excluding the embryo and fetus (Marquis 1989, 2008).

The biologic nature of the fetus is in the realm of verifiable scientific fact and admits but one answer: the fetus *is* a unique human life. To argue otherwise is irrational and deeply anti-scientific. The question—is the fetus a *person*?—is, in contrast, a much-debated philosophical matter carrying life-and-death implications. The answer to the question of fetal personhood and associated rights depends on whom, where, and when one asks. Prior to 1973 in the US, the human fetus had certain legal protections for its life; today it does not.

Reciprocity: A universal human value

While some argue that a right to life is based on developmental milestones rather than membership in the human species (Singer 1993), a more universal reading of human values points to the principle of reciprocity, commonly known as “The Golden Rule” (Gensler 2013; Hare 1975). This notion is present in nearly all societies, religious and secular, and expresses the idea that we should treat others as we ourselves would wish to be treated in similar circumstances. (Some groups extend reverence for life to all animals, but the most universally prevalent form, and that to which I refer here, is limited to members of the human species.) Despite obvious individual exceptions such as suicidality accompanying physical or

mental illness, human life universally acts to sustain itself. Because we act to preserve our own lives, reciprocity holds that it is therefore wrong to take the lives of innocent others. In the context of abortion, because we ourselves appreciate living, and therefore not having been aborted, we in turn should not take human life through abortion. Under the principle of reciprocity, the developing human’s stage of development and legal standing as a person—the basis of today’s denial of the fetus’s right to live—are irrelevant. Marquis reaches a similar conclusion in pointing out that the wrong of abortion lies in robbing the fetus of its future, regardless of the fetus’s cognitive capabilities at the moment of abortion (Marquis 1989, 2008).

The “pro-choice” argument

Many who are personally opposed to abortion believe that their personal convictions should not affect social policy and law, and thus they support the availability of legal abortion. This approach elevates non-judgmentalism to the highest possible value, above even life itself. While attractive at first glance, this argument does not survive scrutiny. A century and a half ago in the US, this same logic was used to support slavery. As with abortion today, many tried to stifle debate by arguing that slavery was a matter of settled law based on US Supreme Court decisions (e.g., *Dred Scott v. Sandford*, 1857) and therefore not a matter for further discussion. Prefiguring today’s pro-choice arguments, many who were personally opposed to slavery accepted slaveholder arguments that they had no right to prevent others from exercising the constitutionally guaranteed property right to own slaves. Abolitionists responded that, although

property rights were important, these and other rights must be considered within a hierarchy of values. Thus, one's right to property should not, in a rational and humane society, be held higher than another's right to his or her own life. Where these two values directly and unavoidably conflict, life deserves primacy.

In 1971 Dr. Judith Jarvis Thomson triggered decades of robust debate about abortion with a series of analogies, most famously including one involving an uninited violinist requiring attachment to a host's body for nine months to survive (Finnis 1973; Thomson 1971; Williams 2004). Thomson argued the fetus's right to life was secondary to a woman's right to control her body throughout gestation. In its essence, this argument holds that maternal autonomy may not be constrained by any living thing—neither fetus, nor father, nor family—and neither by society.

Thomson's analogy has been criticized on several grounds, including its failure to take into account limits on autonomy in other contexts and their implications for pregnancy, the direct role of the parents in bringing the new human life into existence (cases of rape and coercion excepted), and the familial relationship. There are deep historical and ethical responsibilities, many codified in law, that we have toward our own flesh and blood. Thomson's analogy takes on a different complexion if the violinist is the host's dependent offspring.

I find argument based on reciprocity in the context of a hierarchy of values compelling and relevant to abortion. In our society most agree that a mother's right to control her own life should not outweigh the newborn's right to live. Thus, parents may not kill a newborn because they suddenly realize the unwelcome changes parenthood will bring in their lives. (In a dramatic illustration of the "slippery slope" on which

legalized abortion places us, influential voices in the academic bioethics community have posited a parental right to end the life of even normal infants after birth [Giubilini and Minerva 2012; Singer 1993].)

Support for abortion means that the principle of protection for human life above a parental interest in autonomy does not hold for the days, weeks, and months prior to delivery. Thus, calls for reproductive justice and compassion apply only to the woman with an unintended pregnancy and not to the human life she temporarily shelters. Is there something deficient about that human life prior to birth that upends the rational ordering of values, with life at its head? Arguments center around the early stage of development, lack of faculties such as self-awareness as requisite for personhood, and (temporary) dependence on the specialized environment of the womb (Marquis 1989; Singer 1993). Yet nowhere else do we declare that those in similar states of dependency or reduced function, *even when that state is permanent*, must forfeit their lives based on the opinions and desires of others, be those others family members or not.

The modern face of eugenics

Whereas abortion has traditionally been justified based on developmental abnormalities or social hardship, scientific advances in prenatal diagnosis since *Roe v. Wade* have increasingly opened its use for selection based on parental preference for normal human characteristics. Sex-selective abortion reprises society's and our profession's century-old dalliance with eugenics. Demographers have drawn attention to extreme sex ratios in China, India, and other countries where fetal sex can be inexpensively determined early in

pregnancy and a fetus of the “wrong” sex aborted (Hvistendahl 2011). There are, worldwide, approximately 163 million “missing” girls, victims of sex-selective abortion (Hvistendahl 2011). Societies where this is most prevalent face dire demographic and social consequences, such as trafficking of women and girls, child marriage, and large numbers of single men with little likelihood of establishing families (Hvistendahl 2011). There is evidence that sex-selective abortion occurs in certain demographic groups in the US (Almond and Edlund 2008). Does our public health community have nothing to say about abortion for sex selection, except to affirm it as a right? It is clear which sex bears the brunt of this practice.

CONCLUSION

As heretical as some may view it, core public-health values—concern for the vulnerable and respect for scientific fact—coupled with reciprocity and belief in a rational and humane hierarchical ordering of values support the conclusion that the human life prior to birth has intrinsic worth and deserves protection. Living or dying during a period of temporary dependency should not hinge on whether the fetus is wanted by others.

Public health and clinical medicine are professions endowed with compassion and deep concern for human rights. We must acknowledge that the first human right is to live one's life. The public health implications of this view are staggering: there have been over fifty million abortions in the US since 1973, and the annual total of more than one million abortions (Jones and Jerman 2014) is equal to nearly half of the total number of yearly registered deaths (2.4 million) from all other causes

combined (Xu et al. 2010). We in the health professions teach that tobacco is the leading actual cause of death in the US (Mokdad et al. 2004). Yet if aborted lives were counted as others are, abortion would be acknowledged as by far the largest single preventable cause of loss of human life, far outstripping the 480,000 annual deaths ascribed to tobacco (U.S. Department of Health and Human Services 2014).

We must also consider the public health cost in lives should abortion become legally unavailable. Inevitably some would seek “back-alley” abortions and suffer severe consequences, including death. How many such deaths might occur is uncertain, but that total would be small in comparison to the more than one million fetal lives lost annually to legalized abortion in the US. (In 1972, the last full year before *Roe v. Wade*, the Centers for Disease Control [CDC] reported thirty-nine maternal deaths from illegal abortion [Lawson et al. 1989].) While the number remains indeterminate, the toll would be affected by social and economic factors and thus amenable to social and government action in support of women with an unintended pregnancy.

Any death from abortion is one too many, be it maternal or fetal. Forty-two years after *Roe v. Wade*, it remains a modern tragedy that the energy and resources devoted to abortion are not instead dedicated to supporting both women in crisis and the human lives they bear.

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