Abortion policies at the bedside: a response

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ABSTRACT

Alicia Hersey, Jai-Me Potter-Rutledge and Benjamin Brown have outlined a proposed ethical framework for assessing abortion policies that locates the effect of government legislation between the provider and the patient, emphasising its influence on interactions between them. They claim that their framework offers an alternative to the personal moral claims that lie behind legislation restricting abortion access. However, they fail to observe that their own understanding of reproductive justice and the principles of medical ethics are similarly predicated on their individual moral beliefs. Consequently, the conclusions obtained from their framework are also derived from their individual beliefs, and have no claim to being objective.

INTRODUCTION

Alicia Hersey, Jai-Me Potter-Rutledge and Benjamin Brown have outlined a proposed ethical framework for assessing abortion policies based on the ‘shared, normative framework of clinical medical ethics’.[1] Their framework locates the effect of government legislation between the provider and the patient, emphasising its influence on the interactions between them. These interactions are examined with a view to the impact of legislation on the reproductive needs of patients — whether it assists or interferes with ethical patient care. A major claimed benefit of their model is that it is ‘an alternative to the individual moral claims that frequently underpin abortion restrictions’.[1] Instead, they claim it observes ‘normative

principles of medical ethics' and 'reproductive justice' — the right of a patient to make their own decisions regarding abortion. [1]

APPLYING THE FRAMEWORK

Hersey *et al'*s ethical framework seems to be a useful way to depict the relationship between healthcare providers, patients and legislation, where legislation can assist or interfere with patient care. It could be used to analyse any legislation that impacts healthcare.

To demonstrate its use, Hersey *et al* apply their framework to several instances of abortion legislation in the United States, as well as examining its global implications. The first example is the Rhode Island Reproductive Privacy Act of 2019 (RPA), which legalised abortion at the state level.[2] Hersey *et al* explain how the RPA 'advances reproductive justice' by protecting patient autonomy on abortion choice, and preventing restricting the healthcare provider's values of beneficence and non-maleficence.[1] In terms of interference with patient care, they identify the shortcomings of the RPA in terms of abortion funding, and how this affects those on low incomes and other historically excluded individuals.

Hersey *et al* then consider legislation that further restricts abortion access: Texas SB 8, which prohibits abortions once a fetal heartbeat has been detected (with some exceptions).[3] In their view, SB 8 restricts patient autonomy, and prevents providers from acting according to the values of beneficence and non-maleficence. As a result, Hersey *et al* believe that SB 8 'reinforces reproductive oppression and injustice'.[1]

Finally, Hersey *et al* consider the application of their ethical framework to abortion laws in the United Kingdom and France. The United Kingdom requires two physicians to agree that the criteria in the Abortion Act 1967 are met, while in France abortion is only without restriction until 14 weeks of pregnancy. They argue that gestational age restrictions and other barriers result in ethical harms to patients.

PERSONAL BELIEFS

The common pattern evident in Hersey *et al*'s analysis is their view that any legislation that interferes with the patient's ability to access abortion services is considered to be unethical, and a barrier to reproductive justice. This view dictates the outcomes of applying their framework to abortion legislation.

However, as I noted in the introduction, Hersey *et al* criticise abortion legislation as being based on the personal moral values of legislators. They seem to believe that their framework is free from personal values and based on a 'shared, normative framework of clinical medical ethics'.[1] Unfortunately, they seem oblivious to the influence their own personal moral values exert on the use of their framework. These personal moral values ground their understanding of the principles of medical ethics and reproductive justice that they use in their assessments, as I explain below.

First, although medical ethicists and healthcare providers agree on the importance of the values of beneficence, non-maleficence and autonomy, when these values are closely examined, it is clear that our understanding of them and how they are applied is highly dependent on our personal beliefs. An important concept that grounds these values is the nature of harm. As

Blackshaw and Rodger point out, the nature of harm is contentious, and our personal beliefs influence its meaning.[4] Further, as they explain, our approach to ethical decision-making itself is similarly dependent on our personal beliefs, even if we share a common understanding of harm.

Second, our understanding of reproductive justice is almost entirely dependent on the value we place on the fetus. It is clear that Hersey *et al* do not believe the fetus has sufficient moral status or possesses the rights to merit consideration with respect to reproductive justice. Their views of the moral status of the fetus and its implications for abortion provision are controversial personal beliefs that are by no means universally accepted, and they clearly have a major influence on the conclusions produced by their framework. For example, let us consider the impact of granting the fetus equivalent moral status to that of adult human beings, as prolife ethicists commonly believe. In this scenario, the principle of maleficence must consider harm done to the fetus as well as the mother, implying that patients cannot be permitted to end their pregnancies without restriction. Similarly, if the fetus is considered to be a valuable human being, reproductive justice cannot mean endorsing the right to choose its death. More generally, the fetus must also be considered to be a patient, and so healthcare providers will have similar ethical obligations towards it as they do towards its mother.

CONCLUSION

Clearly, our understanding of the principles of medical ethics such as beneficence, non-maleficence and autonomy are predicated on our personal beliefs, as is our understanding of reproductive justice. Hersey *et al's* ethical framework, although clearly a useful approach to evaluating legislation that affects matters of healthcare, does not offer an objective model

unencumbered by individual moral claims. The conclusions derived by applying their framework to abortion legislation are influenced by their own personal beliefs regarding abortion just as much as the legislation that they are evaluating is influenced by the personal beliefs of the legislators.

REFERENCES

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[2] Rhode island reproductive privacy act, 2019. § 23-4.13.

[3] The Texas heartbeat act. tx SB8 2021.

[4] Blackshaw BP, Rodger D. Questionable benefits and unavoidable personal beliefs: defending conscientious objection for abortion. *Journal of Medical Ethics* 2020;46:178-182.