



## Rethinking Fetal Personhood in Conceptualizing Roe

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To cite this article: Rosemarie Garland-Thomson & Joel Michael Reynolds (2022) Rethinking Fetal Personhood in Conceptualizing Roe, *The American Journal of Bioethics*, 22:8, 64-68, DOI: [10.1080/15265161.2022.2089485](https://doi.org/10.1080/15265161.2022.2089485)

To link to this article: <https://doi.org/10.1080/15265161.2022.2089485>



Published online: 02 Aug 2022.



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research and patient care against the potential costs of lawsuits, licensure loss, and even prosecution, and many will leave states where those threats are too great. All pregnancy-capable individuals benefit from the tremendous advances in fetal and pregnancy care that have resulted from the past decades of research, and anyone who learns that their wanted pregnancy is affected by a treatable condition benefits from the increasing availability of surgical and other prenatal interventions. But since any medical intervention entails some risk, however small, and many currently available in utero interventions are still classed as innovative care or research, these leading-edge interventions are likely to become less accessible or inaccessible in states with blanket abortion bans—leaving parents with difficult or even insurmountable barriers to healthy outcomes for a deeply desired pregnancy. In a post-Roe world, state and local abortion bans will harm pregnant people and their future children, along with everyone else, by deterring research and innovative care in many of the places that need them most.

## FUNDING

Funding associated with this work: National Human Genome Research Institute grant no. R01HG011480.

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THE AMERICAN JOURNAL OF BIOETHICS  
2022, VOL. 22, NO. 8, 64–68  
<https://doi.org/10.1080/15265161.2022.2089485>

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# Rethinking Fetal Personhood in Conceptualizing Roe

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We concur with the target articles' fundamental claim that abortion is an exercise of liberty crucial to patient autonomy and a right to bodily integrity, self-determination, and self-ownership (Paltrow et al. 2022; Watson 2022; Ziegler 2022). These justifications for equal access

to abortion as a health care service are long-standing precedents in law and bioethical practice. Our commentary concerns the concept of *fetal personhood* that underpins the ethical and legal conflicts Roe presents. We contend that medical, legal, and social

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understandings of fetal personhood need to be reconsidered. The increasing quantity and quality of information about the fetal person now available in current reproductive ethics, practice, and imagination has changed considerably since Roe went into effect in 1973. We briefly outline here how twenty-first century reproductive information-gathering technologies present a much more distinctive fetal person than the pre-Roe fetal person. This informational profile of distinctive human individuality available to pregnant women can create a strong sense of the fetus's present and future potential for personhood. Because this informational profile yields a fetus recognizable in its human individuality, the denial of its personhood becomes increasingly difficult and can heighten women's distress in reproductive decision-making (Garland Thomson 2022; Werner-Lin et al. 2019). We maintain that this profile of human individuality available through reproductive information technologies presents a case for considering new ways to understand both the fetal and maternal persons as individual human subjects whose rights and futures are dependent upon one another during the gestational period.

Addressing ethical, medical, and regulatory questions about competing liberties and rights requires us to clarify relationships between *persons* as individually bounded embodied agents and *persons* as morally and physically entangled entities. The legal history of personhood in modern liberal orders relies on an understanding of the person as an ontologically bounded individual in which one body equates to one person. Western culture has evolved a Cartesian notion of personhood as a singular individual with the capacity for reason contained by the envelope of embodiment (Thompson 1971). The case of conjoined twins presents a rare exception to this understanding of individual personhood. Because the state of twoness in this type of conjoinment is culturally and medically intolerable, these twins are usually surgically separated (Dreger 2004). In contrast to twin conjoinment, the physiological state of pregnancy is a universal exception to this liberal concept of the individual person. Even though every human being has the gestational experience of being one of two at once bonded and bounded beings, we have not been able to adequately recognize this state of liminality—this ontological *inbetweenness*—fundamental to human development. Instead, a conceptually limited “container model” of human reproduction constrains our appreciation of the interdependent ontology at work in the biology of pregnancy (Finn 2017; Vintiadis 2021). Such a framework is inadequate for adjudicating conflicting

interests between these two beings that are biologically interdependent and conjoined during human gestation.

Our aim here is not to assail medicine and law for this conceptual shortcoming nor are we proposing a personhood threshold for when life or moral personhood might begin during gestational entwinement. Rather, we sketch out a brief history of how the development and use of predictive reproductive information technologies over the fifty years since Roe has changed the literal image of the fetus. The prenatal testing environment now provides a capacious epistemological landscape through which we know, recognize, and anticipate the future child. This fetal medical-scientific knowledge has made the denial of fetal personhood implicit in Roe a less tenable premise upon which to base the legal and ethical position that a fetus has no claim to human personhood. Moreover, this informational image of the developing person has complicated rather than clarified a pregnant woman's exercise of reproductive autonomy that Roe intended to guarantee.

In 1973, a pregnant woman could know very little about the individual that her body would produce. She could know the sex or receive a Down syndrome prediction, but neither of those individual traits could have been known without a physician-ordered genetic test based on what standard obstetrical care considered increased risk for medical conditions or social disadvantages. The Down syndrome test was diagnostic and the sex information incidental. The anonymous fetus presented by pregnancy care in 1973 was largely unmarked by human or even developmental particularities. Without the identifying particularities that constitute human individuality as we understand it legally and morally, the fetal person of Roe was an abstract, vague figure stripped of most all identifying human characteristics. Women entering obstetrical care had a *pregnancy* about which to make decisions, not the variously individualized fetal future person reproductive technology now presents to her. The decision Roe made possible for a pregnant woman was whether to end or continue her pregnancy, not to determine what kind of pregnancy would continue or what kind of child the pregnancy might yield.

By contrast, in the first decades of the twenty-first century a prospective parent's imaginative, emotional, and psychological experience of the gestating child is unavoidably shaped by information that multiple forms of testing and information gathering provide. At any stage during gestation— or even before—a pregnant woman must make choices in the present for both the future person and herself simultaneously.

The autonomous decision to continue or terminate a pregnancy must now include her knowledge of a fetus's individuality, the very qualities that make us human and distinct from other persons (Piepmeyer 2013). The viability thresholds now under revision in various state laws turn on a struggle to settle moral thresholds for personhood shaped by distinctive individual knowledge available about fetuses that was unthinkable in 1973.

The fetal person genetic testing and reproductive imaging now presents to a prospective parent is an increasingly individualized profile of a distinctive being that is no longer easily imagined as an undifferentiated part of a woman's body—an anonymous *pregnancy*—but rather is a recognizable developing person with whom a parent can either identify with or differentiate from. The informational profile that describes the fetus is not, however, neutral. The gestational testing economy is a technology of pathological diagnosis. Such medical technologies mark an expanding range of human variations as either pathological or neutrally normal (Davis 2021; Reynolds 2020). The available option of termination based on prenatal predictions of present or future pathology could be understood as a form of what has been cautioned against as “medical dehumanization” (Stern 2021). While disease diagnosis and risk assessment remain the medical justification for prenatal evaluation, testing for characteristics understood as enhancements are increasingly part of the commercial testing market, leading us to ethical dilemmas about terminating based on social rather than medical predictions (Sparrow 2019).

The twenty-first century fetal person under evaluation for health status and future prospects is also under evaluation in terms of parental resemblance. We understand relatedness in part through recognizing resemblances in the way people *look like* other people. Parents expect their biologically related children to resemble them in some way, often both phenotypically and genetically. Fetuses with prenatally diagnosed genetic conditions are often imagined as being unlike their parents even while they are genetically closely related (Solomon 2012). Violations of resemblance expectations can form the basis for wrongful birth cases (Valentine 2020).

In 1973 and several decades after Roe, our expectations for resemblance between parents and the future child were revealed upon birth when parents recognize the individual characteristics, such as sex and other markers of tribal or familial belonging. In the twenty-first century, parents recognize resemblances

and differences in a future child much earlier through the various informational profiles that the reproductive testing economy provides. These risk and health profiles, often understood as genetic inheritances, differ significantly from the kinds of markers of resemblance that had traditionally established psychoemotional relatedness between a newborn and its parents. Perceptible resemblances genetic information expresses are of course unclear until the revelation of birth presents parents with a fully recognizable human child from whom they can draw narratives of resemblance to the wide range of people in the family. So, whereas the recognition of resemblance at birth in 1973 and now are fundamentally similar, the amount of information before birth about the individuality of any future child produces an unclear and abstract, yet simultaneously distinct picture of the actual child that is coming into the family. The difference between then and now is that the pregnant woman can terminate a pregnancy based on information about the genetic resemblance or potential health profile of a future child in a way that the pre-Roe pregnant woman could not. In other words, Roe enabled a woman to choose whether or not to bring a child into her family, whereas in 2022 Roe enables a woman to choose *what kind of* child she will or will not have in her family.

Both then and now, Roe permits a woman to decide whether to bring a particular fetus into the world and into their family as a full moral and legal person. The political, ethical, and social commitment to autonomy and the protection of bodily integrity and self-determination that structured the logic of Roe in 1973 has been countered by the difficulty of denying fetal personhood to a being increasingly knowable in its individual human particularity. The threshold of birth for personhood status is a pragmatic boundary that allows us to differentiate between termination and infanticide. That birth threshold enables women to carry out Roe's version of reproductive liberty. Several recent studies suggest that this abundance of predictive information, risk profiles, and genetic variants of uncertain significance amounts to evaluation rather than neutral information. The reproductive testing environment that has evolved since the mid-nineteen sixties now presents a pregnant woman with a predictive overload of medical information that describes the fetus. As this largely pathological information profile increases with the development and commercial marketing of more testing, a woman's picture of her future child continuously moves further away from a description of a recognizable actual child

carrying out a lived life. Such a gap between the medical profile of the fetus and an imagined child confuses rather than clarifies reproductive decision-making regarding continued testing, fetal evaluation, and termination options (Beisecker 2019; Reynolds 2020; Werner-Lin et al. 2019).

Fifty years after Roe, the information about the individuality of a fetus presents us with a legal and moral dilemma that bioethics needs to consider more deeply. Much of the information about fetal particularity available to prospective parents is framed through narratives of pathology that provide a medicalized description as a risk profile for ‘disability and disease’ upon which a parent can base decisions to terminate the pregnancy. Such a disability justification for termination creates the potential for interpreting selective termination based on disability risk information as a form of disability discrimination. This moral clash of personhood interests has been recognized in some sectors of the disability rights and advocacy organizations, bioethics, and in some sectors of genetic counseling (Garland Thomson 2022; Stoll 2012). Several emerging and contested *reason ban laws* that prohibit abortion based on a disability diagnosis or reasons of sex or race are now moving through several legal systems. Perhaps most significant is the 2019 concurring opinion from Justice Clarence Thomas in *Box v. Planned Parenthood of Indiana and Kentucky, Inc.* (2019). Thomas’s account of eugenic thought and practice suggests that selective termination based on risk profiles for disability, or what Thomas calls “eugenic abortion,” might be interpreted as a form of discrimination against people with disabilities prohibited by the Americans with Disabilities Act (McGough 2019). This intensely controversial approach realigns what we have generally understood as positions supported by the left and positions supported by the right. Whatever legal outcome such interpretation yields, this ethical and legal dilemma will give bioethicists an opportunity to engage in a more capacious analysis of reproductive ethics that works toward both reproductive justice and disability justice.

## FUNDING

The author(s) reported there is no funding associated with the work featured in this article.

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THE AMERICAN JOURNAL OF BIOETHICS  
2022, VOL. 22, NO. 8, 68–69  
<https://doi.org/10.1080/15265161.2022.2089284>



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## More than Semantics: Abortion Access and Equity

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Watson begins with two questions: “Should the need for abortion care be considered a health disparity? and, “If yes, would framing it this way increase the ability of poor women and women of color to get the medical care they need?” (Watson 2022). Our answers are yes, and no. According to the CDC, health disparities are “... preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations” (CDC 2020). Based on this definition, the inequitable distribution of access to reproductive health services encompasses a health disparity. By extension, we agree with Watson that inequitable access to abortion among marginalized populations is a health disparity. But we disagree that framing abortion access as a health disparity helps lead to an increase in access to abortion services. We argue that the language of health disparities, while a vital descriptive tool, does not provide a robust analytic framework for taking action. Moreover, no matter what conceptual framing we use in our scholarship, bioethicists can (1) elevate reproductive narratives and (2) advance political and practical strategies to help secure abortion access for those who most lack it.

Watson rightly underscores that disparities in abortion access, the current “clinical and social realities” that persist in the U.S., ought to be central to our ethics analysis in order to emphasize the experiences of women (Watson 2022). However, it is unclear how an acknowledgement of uneven abortion access, inarguably a disparity along socioeconomic, racial, ethnic,

and even geographic lines, meaningfully centers pregnant people more than other frameworks. Indeed, other approaches can uplift and highlight the diverse experiences among those seeking abortion. For example, Powers et al.’s (2006) social justice framework for public health and health policy requires that we aim to not further disadvantage populations that are already disadvantaged when weighing health policy options. This framework involves not only the description of health disparities (among other social determinants of health) but provides an analytic component that takes us beyond description. Applying this social justice lens to abortion highlights how women who are poor, living in rural areas, and/or who are Black, Latinx, or Indigenous are underserved and have borne the burden of reproductive injustices, such as forced sterilization (Ross 1992). Centering the narratives of women and their lack of access to reproductive health care including abortion is not a strength unique to the health disparities framework. Instead, we have at our disposal a range of rhetorical approaches to draw upon when working against abortion exceptionalism in our scholarship.

Beyond a useful theoretical reframing, Watson speculates that adopting the health disparities lens may pose our best chance at convincing medical and policy leaders to acknowledge lack of access to abortion as a lack of access to health care because many of them know and accept the health disparities framework. While we cannot prove or refute this claim from an empirical perspective, this move is not particularly convincing given that the awareness of health

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