Alireza Bagheri *Editor*

Abortion

Global Positions and Practices, Religious and Legal Perspectives

Abortion

Alireza Bagheri
Editor

Abortion

Global Positions and Practices, Religious and Legal Perspectives

Foreword by Robert M. Veatch

Editor
Alireza Bagheri
School of Medicine, Tehran University of Medical Sciences
Tehran, Iran

ISBN 978-3-030-63022-5 ISBN 978-3-030-63023-2 (eBook)
https://doi.org/10.1007/978-3-030-63023-2

© The Editor(s) (if applicable) and The Author(s), under exclusive license to Springer Nature Switzerland AG 2021
This work is subject to copyright. All rights are reserved by the Publisher, whether the whole or part of the material is concerned, specifically the rights of translation, reprinting, reuse of illustrations, recitation, broadcasting, reproduction on microfilms or in any other physical way, and transmission or information storage and retrieval, electronic adaptation, computer software, or by similar or dissimilar methodology now known or hereafter developed.
The use of general descriptive names, registered names, trademarks, service marks, etc. in this publication does not imply, even in the absence of a specific statement, that such names are exempt from the relevant protective laws and regulations and therefore free for general use.
The publisher, the authors, and the editors are safe to assume that the advice and information in this book are believed to be true and accurate at the date of publication. Neither the publisher nor the authors or the editors give a warranty, expressed or implied, with respect to the material contained herein or for any errors or omissions that may have been made. The publisher remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

This Springer imprint is published by the registered company Springer Nature Switzerland AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

Foreword

Abortion is probably the most contentious issue in bioethics. Twenty-eight courageous authors, including some of the leading scholars in the field, under the editorship of Ali Bagheri provide us with a tour through the complex and controversial territory that is the morass of positions on the moral status of the prenatal human. They describe the philosophical, moral, and legal positions of many of the cultural, religious, and national groups reflecting a huge range of positions on one of the most important and unresolved issues of our times.

The range of views is very great, but the authors, no matter what their personal positions on abortion, are invariably fair. They acknowledge diversity of views even within the tradition in which they stand. In the great abortion debate no one, no matter how liberal, denies that eventually in the development of the human (prenatally or postnatally) he or she attains moral status as a member of the human community. In modern times at least we view the living members the human community as having full and equal moral standing. Having full moral standing is almost always seen as being accompanied with a prohibition on killing, at least killing the innocent, variously referred to as a right not to be killed or a duty not to kill. The question is when that full moral standing begins. At the same time, no one no matter how conservative believes that this full and equal moral status exists for all human tissue including reproductive cells prior to conception.

No one disputes that the embryo and fetus is biologically living human tissue. When several authors in this volume make reference to the fetus gaining the status of a "human," they are surely talking about acquiring this moral status, not merely the genetic markers of humanhood. The controversy is over the moral status or standing of that human tissue. Reading through the chapters assembled here, we can roughly divide the positions into those that identify an instantaneous transition to full moral standing, usually at the moment of conception, and those that can be called "gradualist," that is, those that see moral status gradually accruing until at some point in development full status is obtained. For the gradualists, that critical point may range from very early in fetal development—implantation of the embryo, development of the first contraction of cardiac tissue, the development of brain tissue—to much later points—the formation of the fetus, quickening, viability,

emergence of the capacity for consciousness, or even birth itself. All the positions represented in these rich and varied chapters identify some point for this critical moral status to appear, whether the point is reached instantaneously or only gradually. A remarkable number of the traditions described include more than one position on this critical question.

The discussion is made more complicated by the use of certain ambiguous terms like *human* and *person*. Both these terms contribute to confusion in the abortion debate. Sometimes they are used without moral content. A human is any being sharing the genetic material of the human species, whether given the full moral status shared by members of the human moral community or not. In this sense, sperm and egg cells are human as are bodies after death and isolated organs in transition for transplant as well as embryos, fetuses, and intact post-natal living humans. Any of these may or may not be assigned the full moral status of post-natal living humans. On the other hand, some of the authors of these chapters use the word "human" to refer only to those with full moral status, thus (for the gradualist) claiming that the fetus "does not become human" until some point in fetal development. They can coherently claim that embryos are "not human" or only become human at a certain point. Those who write this way clearly are not denying biological human status; rather they are claiming that prior to achieving full moral standing, the biologically human is not seen as having the moral status of the rest of us.

Similarly, the word "person" is used ambiguously. Most of the authors of the chapters in this volume speak of the point at which a pre-natal human becomes a "person," meaning the point at which full moral standing is achieved. That point may be at conception or some later point. Occasionally in this volume and more often in other philosophical discussions, the term *person* is used nonmorally. For instance, some philosophers define a person as a being who is self-aware. Clearly, embryos are uncontroversially not persons in this sense. The task for the reader is to keep straight when the term *person* is being used to make a moral claim—that the being has the status of one who has a right not to be killed or that we have a duty not to kill it.

In a number of the chapters, the concept of *ensoulment* is introduced implying that that moment is associated with the attainment of full moral standing. We are left attempting to distinguish the moral significance of events such as the fixing of a unique genetic code, acquiring the status of a "human" or a "person," and ensoulment.

Since many cultural and religious traditions described in this volume are gradualist in their view about the accrual of moral standing (or at least include some adherents who are gradualists), the question arises under which circumstances abortion can be tolerated. Almost all the authors claim that at least some of the adherents of the tradition they are presenting will tolerate the tragedy of abortion when necessary to protect the life of the pregnant woman. Since gradualism implies a variable moral status up to the critical point where full standing is reached, many of the traditions describe willingness to accept other reasons for accepting abortion as well, at least at some points during fetal development: the health (physical and perhaps mental) of the pregnant woman, the medical or mental status of the fetus, and, in some cases, whether the pregnancy was the result of rape. One of the chapters even

describes a well-known philosophical example that supports abortion in the case of rape even if, hypothetically, the fetus has full standing. That position is based on the fact that the woman has not consented to the risk of the pregnancy.

There are some additional confusing terms for which the reader needs to be alert. Some authors, in this volume and elsewhere, distinguish "therapeutic" and "nontherapeutic" abortions, where "therapeutic" refers to abortion for the life or health of the pregnant woman. Sometimes therapeutic is contrasted with "elective" abortion as if no woman has any choice when her health or life is at stake and that only abortion for social and economic reasons were elective. In fact, therapeutic and elective are not mutually exclusive opposites. It is possible for a therapeutic abortion to be elective (especially when the pregnant woman's health is at stake and the health risks may be marginal) and, as we see in at least one chapter, there is a possibility that a nontherapeutic abortion could be coerced or compulsory rather than "elective."

Occasionally, terms appear in the volume qualifying abortion as "artificial." The reader needs to be alert to what these terms mean. Artificial, for example, may be contrasted with "spontaneous" or perhaps "nontherapeutic."

The reader is headed in this volume for a rich introduction to many of the most important religious and cultural traditions as well as their complex views on abortion. There are some cutting-edge issues in the abortion debate that do not arise. For example, should opponents of abortion from the moment of conception have objection to emptying the womb of a brain-dead fetus if they accept brain-based death pronouncement? Should a defender of a higher-brain definition of death oppose termination of a pregnancy diagnosed prenatally as being anencephalic? If the fixing of a unique genetic code is the critical reason why most opponents of abortion from the moment of conception take the position they take, what should be implied if state-of-the-art embryology suggests that sometimes genetic codes are not permanently fixed until several days after conception, when, for example, the primitive streak appears? Are some contraceptives that block implantation of a fertilized egg actually killing a pre-embryo and, if so, should they be opposed morally as early abortifacients? Are there ever cases in which societal interest justifies overriding the choice of the pregnant woman (or she and her male partner) about whether to terminate a pregnancy?

These chapters will take the reader on an extensive tour of many traditions revealing not only a range of views on the ethics of abortion, but also a diversity within traditions about one of the crucial, unresolved moral issues of the day.

Robert M. Veatch
Professor of Medical Ethics
Emeritus The Kennedy Institute of Ethics
Georgetown University
Washington, DC, USA

Preface

The “Problem of Abortion”: A Continuing Global Challenge

The divisive and politicized issue of abortion is neither a new nor an easily resolvable problem. Apart from critical moral issues, there are medical, philosophical, socio-cultural, and legal questions pertinent to the problem. None of these can be addressed in a vacuum.

From 2010 to 2014, each year, 55.7 million abortions occurred worldwide. It is estimated that in the same period, 25.1 million abortions each year were unsafe, with 97% of these in developing countries.[1] This unresolved moral issue has become a continuing global challenge which also contributes to the detrimental consequences faced by women all over the world.

The abortion debate cannot be reduced merely to the issues of when human life begins or women’s rights and self-determination. It involves multiple values and interests often in conflict with each other. No one denies the importance of protecting human life and respecting human rights, including individual autonomy and self-determination. However, disagreement arises at the level of interpretation and implementation of these moral norms. As a result, simplistic single-value and one-dimensional solutions to this complex problem have failed to gain a general acceptance even among individuals within the same family, religion, or society, let alone globally. In his landmark book *Abortion: law, choice and morality*, in 1970, Daniel Callahan[2] observed that there is no country, whether with restrictive or permissive legislation on abortion, where everyone agrees that a perfect practical solution is in place. He also argued that “If one’s ultimate desire is to find a final, lasting, wholly satisfactory solution to the problem of abortion, the answer seems to be no.” That observation, however, is still valid after almost half a century.

---

[1] Ganatra B., Gerdts C. and Rossier C., 2017. “Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model.” *The Lancet.* 390: 2372–81.

[2] Callahan D. *Abortion: law, choice and morality.* McMillan. 1970. New York.

In fact, the very diversity of values in secular and pluralistic societies, as well as different interpretations of divine laws in religious societies, makes it difficult to come to a unified response to the moral question of abortion. These disparate perspectives make it very hard, if not impossible, to create laws and policies which would satisfy society as a whole.

Rather than providing one global solution to the problem of abortion—to abort or not to abort—this volume sheds light on different but equally critical moral, philosophical, socio-cultural, psychological, and legal dimensions. It also provides descriptions of different abortion practices based on divergent religious and non-religious perspectives. The aim is to elaborate on distinct value systems and policies in order to empower individuals to morally reflect on the diverse perspectives so that well-informed decisions concerning abortion can be made.

At the individual level, a pregnant woman making an abortion decision has only two options: to abort or not to abort. There is no third option. However, at the public policy level, there are multiple policy options: absolute prohibition, permitting abortion on social grounds, and permitting abortion under certain medical conditions. For practical reasons, as in other areas of public health, the necessity of implementing an abortion policy is inevitable. Yet no policy regarding abortion can be free of gray zones. It is partly because it is difficult, if not impossible, to reconcile all the relevant values at stake. However, what is apparent is that no policy, restrictive or permissive, can ignore the complex and interrelated moral questions pertinent to abortion.

The 21 chapters of this volume are written by distinguished authoritative scholars in each of the religious and non-religious schools of thought. They discuss the differing moral reasoning, religious positions, and socio-legal consequences of abortion, as well as possible alternatives from current global perspectives and practices. The authors in the first part elaborate on different religious perspectives from the Abrahamic religions of Judaism, Christianity, and Islam, and their denominations or schools of thought. The authors in the following chapters present perspectives and practices in Buddhism, Shintoism, Confucianism, and Hinduism. In the last three chapters, the authors discuss the hotly debated perspectives of pro-choice and pro-life in the USA; the role of abortion as a birth control program in China; and, finally, abortion from a feminist point of view. The religious as well as non-religious perspectives, legislative approaches, public policies, and current practices presented in this volume re-affirm the diversity of opinions on abortion decisions that could be, moral or immoral depending on the view one embraces.

By elucidating the moral reasoning behind each position on abortion, these authors raise awareness about different perspectives and practices in favor of or against abortion. The content of this book provides a foundation for better understanding, meaningful dialogue, and tolerance on a complex issue which has divided individuals, philosophers, theologians, policy makers, and legislators within and across societies for centuries.

This book will be suited to academics, healthcare providers, researchers, religious scholars, health policy makers, as well as individuals who face abortion decision.

I would like to thank my colleagues for their scholarly contributions to this book. They have successfully presented a global, comprehensive, and clear picture of abortion debates in their own religious or non-religious perspectives. My thanks also to the anonymous reviewers; their constructive comments helped to improve the quality of the discussion in each chapter. My special thank is due to Robert Veatch for his invaluable foreword to this book.

Alireza Bagheri
Toronto, Canada
January 1, 2020

Contents

A Brief Introduction to Medical Practice and Public Policy in Abortion 1
Alireza Bagheri

Conservative Judaism on Abortion and Related Issues 9
Elliot N. Dorff

Abortion from the Perspective of Orthodox Judaism 23
Noam Stadlan

Abortion in Reform Judaism 37
Jonathan K. Crane

Fearfully and Wonderfully Made: The Catholic Church's Position on Abortion 51
Laura Wolk and O. Carter Snead

Church of England (Anglican) Perspectives on Abortion 63
Robin Gill

Abortion from the Perspective of the Russian and Greek Orthodox Churches 73
Galina Mikirtichan, Sergey Filimonov, Olga Ochkur, and Olga Jarman

The Moral Evaluation of Abortion Within the Wesleyan Methodist Movement 91
James Thobaben

Abortion in the Reformed Christian Tradition 111
David VanDrunen

Abortion in *Hanafī* Law 127
Muhammed V. Stodolsky and Aasim I. Padela

***Maliki* Perspectives on Abortion** 137
Thomas Eich

Abortion: *Shafi'i* Perspective 147
Mohammad Ali Al-Bar

Abortion in the *Hanbali* School of Jurisprudence: A Systematic Ethical Approach 155
Mu'taz Al-Khatib

Abortion: *Shi'ite* Perspective 169
Alireza Bagheri

Buddhism and Abortion 179
Soraj Hongladarom

Abortion: Shinto Perspective 191
Atsushi Asai, Hiroko Ishimoto, Sakiko Masaki, and Yasuhiro Kadooka

The Ambivalence and Complexities in Hinduism in Portrayal of Abortion and Fertility 203
Minakshi Bhardwaj

Confucianism and Abortion 217
Ivo Kwon

A Survey of the United States Supreme Court's Abortion Jurisprudence 229
Michael P. Moreland

Abortion and China's State Birth Control Program: A Socio-Ethical Inquiry 241
Jing-Bao Nie

Feminist Accounts of Abortion 257
Angela Ballantyne

Index 273

About the Editor and Contributors

Editor

Alireza Bagheri-chimeh MD, PhD, is assistant professor of medicine and medical ethics in the School of Medicine, Tehran University of Medical Sciences (Iran), and a research affiliate in the Centre for Health Care Ethics, Lakehead University (Canada). He is an elected fellow of The Hastings Center (USA).

Dr. Bagheri served as a member of the UNESCO International Bioethics Committee (2010–2018) and on the board of directors of the International Association of Bioethics (2009–2014). He serves as the book series editor of *Intercultural Dialogue in Bioethics b*y the Imperial College Press. In 2010, Dr. Bagheri received the Rhazes Medical Research Award for his work on medical futility, and in 2018, he received the Bioethics Leadership Award in recognition of his contribution to the discipline of bioethics scholarship at the international level.

Dr. Bagheri was a clinical ethics fellow at the Joint Center for Bioethics, University of Toronto, Canada (2006–7); Erasmus Mundus visiting professor at Leuven University, Belgium (2007–8); Edmund Pellegrino Fellow (2007); visiting scholar in the Center for Clinical Bioethics at Georgetown University, USA (2007–09). His published books include *Medical Futility* (2013), *Biomedical Ethics in Iran* (2014), *Global Bioethics* (2015), *Islamic Bioethics* (2017), and Indigenous Health Ethics (2020).

As a palliative care physician and a clinical ethicist, he advocates close attention to both clinical realities as well as socio-cultural context in healthcare decision-making.

Contributors

Mohammad Ali Al-Bar is the Director of Medical Ethics Center in the International Medical Center in Jeddah, Saudi Arabia. He is a Counselor to The International Islamic Fiqh Academy as well as the Islamic Fiqh Council.

Mu'taz Al-Khatib is Assistant Professor of Methodology and Ethics at Center for Islamic Legislation and Ethics in Hamad Bin Khalifa University, Qatar.

Atsushi Asai is Professor of Bioethics in the Department of Medical Ethics, Tohoku University Graduate School of Medicine, Sendai, Japan.

Alireza Bagheri is Assistant Professor of Medicine and Medical Ethics, Tehran University of Medical Sciences. He is an Elected Fellow of The Hastings Center, New York. Dr. Bagheri was the Vice-chairman of the UNESCO International Bioethics Committee (2010–2014).

Angela Ballantyne is Senior Lecturer in Bioethics in Department of Primary Health Care and General Practice, University of Otago Wellington, New Zealand.

Minakshi Bhardwaj is Research Associate and Programme Officer based at the Liverpool School of Tropical Medicine. Her expertise lies in international public health exploring issues related to maternal health, gender and equity, health systems strengthening in LMICs.

Jonathan K. Crane is professor of Bioethics and Jewish Thought at Emory University's Center for Ethics, USA. He is the founder and co-editor-in-chief of the Journal of Jewish Ethics.

Elliot N. Dorff Rabbi, is Rector and Distinguished Service Professor of Philosophy at American Jewish University. He is Chair of the Conservative Movement's Committee on Jewish Law and Standards.

Thomas Eich is Professor of Islamic Studies at Hamburg University. He currently directs a research project entitled, Contemporary Bioethics and the history of the Unborn in Islam.

Sergey Filimonov is a Professor of otolaryngology and Bioethics, Department of Humanities and Bioethics Department of Saint-Petersburg State Pediatric Medical University, Russia. He is the editor-in- chief of the journal "Church and Medicine."

Robin Gill is Emeritus Professor of Applied Theology, University of Kent, UK. He was the first holder of both the Michael Ramsey Chair at Kent and the William Leech Research Chair at Newcastle.

Soraj Hongladarom is a Professor of Philosophy, Department of Philosophy and Center for Ethics of Science and Technology, Faculty of Arts, Chulalongkorn University, Thaliland.

Hiroko Ishimoto is PhD. candidate at the Department of Bioethics, Graduate School of Medical Science, Kumamoto University, Kumamoto, Japan.

Olga Jarman is a Senior Lecturer in the Department of Humanities and Bioethics in Saint-Petersburg State Pediatric Medical University, Russia. She is also a practicing TB-specialist in Radiology.

Yasuhiro Kadooka is medical doctor and research fellow in the Department of Bioethics, Kumamoto University Graduate School of Medicine, Kumamoto, Japan.

Ivo Kwon is Professor of Bioethics in the Department of Medical Education, Ewha College of Medicine, Ewha Womans University, Seoul, South Korea.

Sakiko Masaki is PhD. candidate at the Department of Bioethics, Graduate School of Medical Science, Kumamoto University, Kumamoto, Japan.

Galina Mikirtichan is the Head of the Department of Humanities and Bioethics in Saint-Petersburg State Pediatric Medical University, Russia. She is the founder of the first Bioethics course in Russian universities.

Michael P. Moreland is Professor of Law and Religion and Director of Eleanor H. McCullen Center for Law, Religion and Public Policy, Villanova University Charles Widger School of Law, Pennsylvania, USA.

Jing-Bao Nie is Professor of bioethics in the Bioethics Centre, University of Otago, New Zealand. He is also an adjunct prof. in The Institute of the Medical Humanities, Peking University, China. He is the author of *Behind the Silence: Chinese Voices on Abortion*.

Olga Ochkur is palliative care physician and a lecturer in the Department of Humanities and Bioethics in Saint-Petersburg State Pediatric Medical University, Russia.

Aasim I. Padela is Assistant Professor of Medicine, Department of Medicine and the Director of Initiative on Islam and Medicine, Program on Medicine and Religion, The University of Chicago, USA.

O. Carter Snead is Professor of Law and the William P. and Hazel B. White Director, Notre Dame Center for Ethics and Culture, University of Notre Dame.

Noam Stadlan is Assistant Professor of Neurosurgery in Pritzker School of Medicine, University of Chicago. He writes and lectures on neurosurgical topics and bioethics with a concentration in *Halakhic* medical ethics.

Muhammed V. Stodolsky is the Chair of the Department of Islamic Law, Darul Qasim, Glendale Heights, IL, USA.

James Thobaben is Professor of Bioethics and Social Ethics, Dean of School of Theology and Formation, Asbury Theological Seminary, Kentucky, USA. He is author of *Healthcare Ethics: A Comprehensive Christian Resource.*

David VanDrunen is Robert B. Strimple Professor of Systematic Theology and Christian Ethics, Westminster Seminary California, USA.

Robert M. Veatch is Senior Research Scholar and Professor of Medical Ethics, Emeritus, at the Kennedy Institute of Ethics at Georgetown University. He received his PhD from Harvard University and formerly served as the Director of the Kennedy Institute.

Laura Wolk graduated Phi Beta Kappa from Swarthmore College in 2009 with a B.A. in Psychology. In 2016 she earned her J.D. summa cum laude from Notre Dame Law School. Currently, Laura serves as a law clerk to Associate Justice Clarence Thomas during the Supreme Court's 2019 term.

A Brief Introduction to Medical Practice and Public Policy in Abortion

Alireza Bagheri

1 A Global Picture of Abortion

Worldwide, there is no society in which abortion has not been discussed as a medical, moral, and socio-cultural problem.

The most reliable global statistics regarding abortion are data published from several studies between 1995, 2003, 2008, and 2014. A study published in 2008 shows that about one in five pregnancies ended in abortion. Accordingly, the global abortion rate was stable, between 2003 and 2008, with rates of 29 and 28 abortions per 1000 women aged 15–44 years, respectively. While compared with 1995, the global data show a period of decline from 35 abortions per 1000 women, the number of unsafe abortions has increased from 44% in 1995 to 49% in 2008 (Sedgh et al. 2007). The most updated data published in The Lancet in 2017 show that 55.7 million abortions occurred worldwide from 2010 to 2014, each year. It has been estimated that in the same period 25.1 million abortions each year were unsafe, with 97% of these in developing countries. When grouped by the legal status of abortion, this study concludes that the proportion of unsafe abortions was significantly higher in countries with highly restrictive abortion laws than in those with less restrictive laws (Ganatra et al. 2017).

Since 1967, the World Health Organization (WHO) has recognized unsafe abortion as a serious public health problem and urges the member states to address the health consequences of abortion especially unsafe abortion. Provision of safe and legal abortion is essential to fulfilling the global commitment to the Sustainable Development Goal of universal access to sexual and reproductive health (target 3.7). To achieve that goal, the WHO provides global technical and policy guidance on

A. Bagheri (✉)
Department of Medical Ethics, Tehran University of Medical Sciences, Tehran, Iran
e-mail: ali.bagherichimeh@utoronto.ca

© The Author(s), under exclusive license to Springer Nature Switzerland AG 2021

A. Bagheri (ed.), *Abortion*, https://doi.org/10.1007/978-3-030-63023-2_1

safe abortion, the use of contraception to prevent unintended pregnancy, and the treatment of complications from unsafe abortion. The most updated WHO guidelines (2012) entitled “Safe abortion: technical and policy guidance for health systems” is an effort to address this problem. The guidelines recommend to the member states that, “laws and policies on abortion should protect women’s health and their human rights” as well as “Regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed”. To achieve this goal, in 2017, several United Nations agencies have jointly launched an open-access Global Abortion Policies Database (2017) to monitor the situation of laws and policies on abortion in countries worldwide.

2 Medical Terminology and Practice

The word *abortion* derives from the Latin *aboriri* means “to miscarry”. Abortion is defined as the spontaneous or induced termination of pregnancy before fetal viability. Viability lies between the lines that separate abortion from preterm birth.

The World Health Organization (WHO) defines abortion as pregnancy termination before 20 weeks’ gestation or with a fetus born weighing less than 500 grams (WHO 2012). In the medical context “miscarriage” and “abortion” are used interchangeably. However, the term abortion is popularly used by laypeople for a deliberate intact pregnancy termination. In the case of spontaneous fetal loss, many prefer to use the term miscarriage (Cunningham et al. 2014). It should be noted that the terminology used to define fetal viability and thus an abortus has tremendous medical, legal, and social implications. Viability as defined by the American College of Obstetricians and Gynecologists (2017) is the; “capacity of the fetus for sustained survival outside the woman’s uterus. Whether or not this capacity exists is a medical determination, may vary with each pregnancy and is a matter for the judgment of the responsible health care provider”.

Technological developments have revolutionized current abortion terminology, making it possible to distinguish between a “chemical” (when the blood test is positive for hCG hormone in early pregnancy) and a “clinical” pregnancy (when there are high levels of the hCG hormone and ultrasound confirms fetal heartbeat). Currently, transvaginal sonography and precise measurement of serum human chorionic gonadotropin (hCG) concentrations are used to identify very early pregnancy as well as those with an intrauterine versus ectopic location. During pregnancy, a woman may lose her fetus due to spontaneous abortion. This includes complete (expulsion of the entire pregnancy), incomplete, and missed abortion (dead products of conception that were retained for sometimes in the uterus). In the abortion debate, controversies are around induced abortion which is defined as “a surgical or medical termination of a live fetus before the time of fetal viability” (Cunningham et al. 2014). However, elective abortion—when a pregnant woman requests abortion with no medical reason—poses the most moral and legal challenges.

In abortion decisions, it is important to find out the fetus's gestational age or menstrual age. This is "the time elapsed since the first day of the last menstrual period, a time that actually precedes conception. This starting time, which is usually about two weeks before ovulation and fertilization and nearly three weeks before blastocyst implantation, has traditionally been used because most women know their last period" (Cunningham et al. 2014).

There are several maternal and fetal medical disorders that are indications for termination of pregnancy. In many countries, these medical conditions have been cited as justified reasons for induced therapeutic abortion to save pregnant women's lives. It should be noted, however, in some countries, these medical conditions are subject to gestational age limitation, and abortion beyond that age limitation is not permitted (Bagheri and Afshar 2011).

The concerns about the negative health consequences due to unsafe abortion have been emphasized by many commentators and activist groups as an ethical justification to push public policies toward more permissive abortion laws. The WHO defines unsafe abortion as "a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards" (WHO 2011). According to WHO "Unsafe abortions are frequently performed by providers lacking qualifications and skills to perform induced abortion, and some abortions are self-induced" (WHO 2018). Unsafe abortions, although preventable, continue to pose undue risks to women's health and lives. As indicated by the WHO the barriers to accessing safe abortion include: restrictive laws; stigma; poor availability of services; high cost; conscientious objection of health-care providers and unnecessary requirements, such as mandatory waiting periods. In developing countries, however, the risk of death following unsafe abortion may be several times higher. The mortality and morbidity risks associated with unsafe induced abortion depend on the facilities and the skill of the abortion provider; the intervention method used; the general health of the woman and the stage of her pregnancy. The mortality rate of pregnant women following safe abortion performed by qualified health providers, using correct techniques and in standard sanitary conditions, is very low. In the United States, legal induced abortion results in only 0.6 deaths per 100,000 procedures. However, worldwide, unsafe abortion accounts for a death rate that is 350 times higher (220 per 100,000), and, in Sub-Saharan Africa, the rate is 800 times higher, at 460 per 100,000 (WHO 2012).

2.1 Psychological Sequels of Abortion

Psychological consequences of abortion have gained the attention of academic authors for more than half a century. The foci of research in this area includes: whether abortion causes harm to women's mental health; the relative risk of mental health problems associated with abortion; and the prevalence of mental health problems among women who have had an abortion. The concern about the

psychological sequels of abortion has been reflected in the related legislations as well. For instance, in North Dakota, a law passed in 2011 requires a pregnant woman who has requested abortion be given information about the possible adverse psychological effects associated with abortion (Hill 2012).

While in a couple's life, having a child is an important event, a woman bears the burden of pregnancy alone. Pregnancy brings several biological changes and it is a serious health issue, bodily as well as psychologically. In a woman's life, pregnancy is also a reason for a change in her socio-cultural role and responsibility as an expectant woman and as a mother-to-be.

Women respond to abortion with a range of different reactions, and at least some women experience negative psychological sequelae to abortion. The case studies on the serious negative aftereffects of abortion suggest that abortion is inevitably traumatic, because it is the negation of a fundamental need of women (Cohen and Roth 1984). According to this study, which evaluated individual differences in coping style in response to an abortion procedure, 55 subjects displayed a wide range of responses, although the average level of distress was fairly high. A longitudinal cohort study from 30 abortion facilities in 21 states throughout the United States looked at mental health and well-being of women 5 years after receiving or being denied an abortion find that, being denied an abortion may be associated with a greater risk of initially experiencing adverse psychological outcomes. In that study, of the 956, at 1 week after seeking an abortion, women who were denied an abortion reported more anxiety symptoms, lower self-esteem, lower life satisfaction, and similar levels of depression (Biggs et al. 2017).

In another study, based on a literature review about the psychological implications of abortion, the American Psychological Association's (APA) Task Force on Mental Health and Abortion reported that "Among adult women who have an unplanned pregnancy the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy" (APA 2008). The report continues: "terminating a wanted pregnancy late in pregnancy due to fetal abnormality appears to be associated with negative psychological reactions equivalent to those experienced by women who miscarry a wanted pregnancy or who experience a stillbirth or death of a newborn, but less than those who deliver a child with life-threatening abnormalities". By emphasizing that the global statements about the psychological impact of abortion on women can be misleading, the report states that "…in general, however, the prevalence of mental health problems observed among women in the United States who had a single, legal, first-trimester abortion for nontherapeutic reasons was consistent with normative rates of comparable mental health problems in the general population of women in the United States". It should be noted that the psychological sequel of abortion in cases with unsafe abortions has not been the focus of those studies which might present a different, more problematic picture. However, psychological sequels following abortion have become a controversial issue. While opponents of abortion have provided results of studies showing negative psychological affect following abortion, proponent groups have presented data showing no psychological sequel due to abortion. Nonetheless, it has been claimed that research intended to refute the analytic

view, much of it inspired by the pro-choice movement, concludes that women suffer no or mild ill effects (Kummer 1963).

Social stigma is another psychological pressure on women who want to terminate their pregnancy. Women who have abortions report significant social stigma. A survey among 627 women in the United States identified worries about judgment, isolation, self-judgment, and community condemnation as four factors of stigma experiencing by women. In this study, women with the strongest religious beliefs experienced more negative self-judgment and greater perception of community condemnation compared to only somewhat religious women (Cockrill et al. 2013).

3 Abortion as a Matter of Public Policy

In his global review on abortion laws, Daniel Callahan observed that "I was unable to discover a single country in which everyone agreed that the perfect solution had been found; every extant legal solution, from the most restrictive to the most permissive, seems to carry with it some undesirable consequences" (Callahan 1970, p, 19). A brief review of the existing literature on abortion confirms the situation remains the same in today's world.

In making a decision on abortion, at the individual level, for a woman there are only two options, to abort or not to abort. There is no third option. However, at the public policy level, there are more policy options: absolute prohibition; permitting abortion on request; permitting abortion on social grounds; and permitting abortion under certain medical conditions.

The conditions under which abortion is legally permitted differ from country to country. In some countries, access is highly restricted; in others, pregnancy termination is available on broad medical and social grounds or upon request. It is worth mentioning that women's authority in terms of healthcare decision-making such as abortion varies in different societies and this also can play an important role in the decision about abortion.

According to a UN report (2007), on world abortion policies, the overwhelming majority of countries, 97%, permit abortion to save the woman's life. In five countries, abortion is not permitted. Abortion laws and policies are significantly more restrictive in the developing world. In developed countries, abortion is permitted for economic or social reasons in 78% of countries and on request in 67% of countries. In contrast, 19% of developing countries permit abortion for economic or social reasons, while in 15% of developing countries abortion is available on request.

Many countries have additional procedural requirements that must be met before an abortion may be legally performed. Additional requirements may relate to the gestational limits, mandatory waiting period, parental or spousal consent, third-party authorization, the types of medical facilities where abortions may be performed, and mandatory counseling. In addition, even when abortion is legally permitted, access to abortion services may be limited.

In the United States, in its landmark 1973 abortion cases, in *Roe v. Wade*, the U.S. Supreme Court held that a woman's right to an abortion is not absolute and that states may restrict or ban abortions after fetal viability, provided that their policies meet certain requirements. For instance, 41states require an abortion to be performed by a licensed physician. Nineteen states require an abortion to be performed in a hospital after a specified point in the pregnancy, and 19 states require the involvement of a second physician after a specified point. Also, 43 states prohibit abortions, generally except when necessary to protect the woman's life or health, after a specified point in pregnancy (Guttmacher Institute 2018).

A study done by Sedgh et al. (2007) suggests that "Restrictive abortion laws are not associated with lower abortion rates". The authors suggest that "measures to reduce the incidence of unintended pregnancy and unsafe abortion, including investments in family planning services and safe abortion care, are crucial steps toward achieving the Millennium Development Goals".

According to an analysis by United Nations Department of Economic and Social Affairs Population Division, the average rate of unsafe abortion is estimated to be more than four times higher in countries with more restrictive abortion laws than in countries with less restrictive laws (UN Report 2014).

In a Position Statement approved by the Executive Board of The American College of Obstetricians and Gynecologists (2017), "The reasons why women attempt to self-induce abortion are varied and include barriers to accessing clinic-based care, including cost, distance to the facility, and lack of knowledge of where and how to access care, as well as a preference for self-care. Due to the growing restrictions on abortion access and the closure of facilities providing this service, self-induced abortion attempts may become more common". The American College of Obstetricians and Gynecologists (ACOG 2017) opposes abortion of the healthy fetus that has attained viability in a healthy woman in their general policy related to abortion and states that: "Induced abortion is an essential component of women's health care and affirms the legal right of a woman to obtain an abortion prior to fetal viability". However, the ACOG opposes the prosecution of a pregnant woman for conduct alleged to have harmed her fetus, including the criminalization of self-induced abortion. By raising the concern that the threat of prosecution of a pregnant woman for abortion may result in negative health outcomes by deterring women from seeking needed care after abortion, the ACOG opposes administrative policies that interfere with the legal and ethical requirement to protect private medical information by mandating obstetrician–gynecologists to report to law enforcement women they suspect have attempted self-induced abortion.

It has been suggested that there are four possible solutions to the legal problem of abortion, from highly restrictive law to highly permissive law and moderate law which specify a wide range of acceptable indications with formal procedures to be followed in applying for an abortion. The fourth option he suggested is to remove all abortion laws leaving the ethics of its medical practice in the hands of physicians individually or professional bodies, free from government interference or supervision (Callahan 1970, p. 486).

4 Conclusion

The global reports have raised concerns about the increasing number of abortions, and especially on mortality and morbidity risks associated with unsafe abortion. Abortion and its psychological sequel has become a subject of research in many countries. Although controversial, opponents of abortion have provided results of studies showing negative psychological affect following abortion. On the other hand, proponent groups have presented data showing no psychological sequel due to abortion.

In response to the worldwide problem of abortion, in terms of public policy, each society has tried to address the issue in its jurisdiction based on moral and socio-cultural background. These policies may range between restrictive laws, moderate or permissive laws to regulate any demand for terminating a pregnancy; even though all members of the society may not be in agreement. Religious jurisdiction and culture influence legal codes on abortion and shape individual attitudes and practice; however, under enormous pressures, a pregnant woman may still seek abortion against her religious inclination and disregards the law if it restricts legal abortion in her case. As a result, there is a substantial gap between theoretical issues in morality as well as law and practical reality regarding abortion in many societies. Despite the progress made in abortion debate and policy, the unsolved problem of abortion remains an open discussion in all societies.

References

American College of Obstetricians and Gynecologists. (2017). *Position statement: Decriminalization of self-induced abortion*. Available at: https://www.acog.org/Clinical-Guidance-and-Publications/Position-Statements-List. Last visited 10 Sept 2019.

APA Task Force on Mental Health and Abortion. (2008). *Report of the APA task force on mental health and abortion.* Washington, DC. Available at: http://www.apa.org/pi/women/programs/abortion/. Last visited 10 Sept 2019.

Bagheri, A., & Afshar, L. (2011). Abortion in different Islamic jurisprudence: Case commentaries. *Asian Bioethics Review, 3*(4), 351–365.

Biggs, M. A., Upadhyay, U. D., McCulloch, C. E., & Foster, D. G. (2017). Women's mental health and well-being 5 years after receiving or being denied an abortion: A prospective, longitudinal cohort study. *JAMA Psychiatry, 74*(2), 169–178. https://doi.org/10.1001/jamapsychiatry.2016.3478.

Callahan, D. (1970). *Abortion: Law, choice and morality*. New York: McMillan.

Cockrill, K., Upadhyay, U. D., et al. (2013). The stigma of having an abortion: Development of a scale and characteristics of women experiencing abortion stigma. *Perspectives on Sexual and Reproductive Health, 45*(2), 79–88. https://doi.org/10.1363/4507913.

Cohen, L., & Roth, S. (1984). Coping with abortion. *Journal of Human Stress, 10*, 140–145.

Cunningham, F. G., Leveno, K. J., et al. (2014). *Williams obstetrics* (24th ed.). New York: McGraw-Hill Education.

Hill, J. B. (2012). Legislative restrictions on abortion. *AMA Journal of Ethics., 4*(2), 133–136.

Global Abortion Policies Database. (2017). Available at: http://srhr.org/abortion-policies/. Last visited 10 Sept 2019.

Ganatra, B., Gerdts, C., & Rossier, C. (2017). Global, regional, and subregional classification of abortions by safety, 2010–14: Estimates from a Bayesian hierarchical model. *The Lancet, 390*, 2372–2381.

Guttmacher Institute. (2018). Available at: https://www.guttmacher.org/state-policy/explore/overview-abortion-laws. Last visited 10 Sept 2019.

Kummer, J. (1963). Post-abortion psychiatric illness-a myth? *The American Journal of Psychiatry, 119*(10), 980–983.

Sedgh, G., Henshaw, S., et al. (2007). Induced abortion: Estimated rates and trends worldwide. *The Lancet, 370*(9595), 1338–1345.

United Nations Report. (2007). World abortion policies 2007. United Nations Population Division. Department of Economic and Social Affairs. Available at; http://www.un.org/esa/population/publications/2007_Abortion_Policies_Chart/2007AbortionPolicies_wallchart.htm. Last accessed on 8 Jan 2018.

United Nations Report. (2014). *Abortion policies and reproductive health around the world*. United Nations Department of Economic and Social Affairs Population Division. New York.

World Health Organization. (2011). *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008* (6th ed.). Geneva: WHO Department of Reproductive Health and Research.

World Health Organization Guidelines. (2012). *Safe abortion: Technical and policy guidance for health systems*. Geneva: World Health Organization. Available at: http://who.int/reproductive-health/publications/unsafe_abortion/9789241548434/en/. Last visited 10 Sept 2019.

World Health Organization. (2012). Facts on Induced Abortion Worldwide. Available at: http://www.who.int/reproductivehealth/publications/unsafe_abortion/induced_abortion_2012.pdf. Last visited 10 Sept 2019. (second edition)

World Health Organization. (2018). *Preventing unsafe abortion*. Available at: http://www.who.int/mediacentre/factsheets/fs388/en/ Last visited 10 Sept 2019.

Conservative Judaism on Abortion and Related Issues

Elliot N. Dorff

1 Introduction: Texts and Methods of Judaism

Judaism, which traces its history back to Abraham c. 1700 B.C.E. (B.C.) his son and grandson, Isaac and Jacob, and their descendants, is based on the Covenant God made with them and specified more clearly during the revelation at Mount Sinai to Moses and the Israelites assembled there (c. 1290 B.C.E.) on the way to the Promised Land, called originally Canaan and then Israel. Judaism's two daughter religions, Christianity and Islam, also trace their roots back to Abraham, and so it is important to indicate that all three of the Western religions are based not only on what each sees as its sacred scripture, but also on how the authorities of each religion defined which books got into the sacred canon and then how they interpreted and applied those books. So Judaism is based on the Bible, but the Rabbis defined which books got into the Bible and how to interpret and apply it, a chain of tradition that extends to our own day, with rabbis in every generation adding to, deleting, and modifying the tradition as they lived it and made it relevant to their own times. Similarly, Christianity is based on the Bible as defined by the Church Fathers, who determined for Christians which books constituted sacred scripture (they included the New Testament and Apocrapha, both of which are absent in the Jewish Bible) and how to interpret them. Finally, Islam is the religion of the Bible as retold in a different way by the prophet Mohammed and then as interpreted and applied by Muslim authorities through the generations. That is, each of the three Western religions is *a tradition* based on a canon of scriptures.

This explains why the differences among the three religions are not only based on what each considers to be canonical scripture, but also on how they variously interpret even scriptures that they share. So, for example, all three religions have the

E. N. Dorff (✉)
Department of Philosophy, American Jewish University, Los Angeles, CA, USA
e-mail: edorff@aju.edu

© The Author(s), under exclusive license to Springer Nature Switzerland AG 2021

A. Bagheri (ed.), *Abortion*, https://doi.org/10.1007/978-3-030-63023-2_2

Garden of Eden story in their scriptures, but in Christianity that became the basis for the Christian doctrine of Original sin, a sin that affects every person born since then, while in Judaism we can learn from the temptations and sins of Adam and Eve, but we are not responsible for, or tainted by, them. Similarly, classical Jewish sources and Orthodox and Conservative Judaism in the modern period see all the laws of the Torah (the Five Books of Moses) as legally binding as they are interpreted by the rabbinic tradition and by the customs of the people, while Paul in Romans, chapters 7–11, established the basis for Christianity's view that the biblical laws are no longer binding except for the Decalogue and loving God and one's neighbor. Furthermore, the Jewish tradition sees the Torah, presented as a revelation to 600,000 people standing at Mount Sinai, as more authoritative than any of the other prophetic books of the Bible, for the latter were, assuming you believe them, the product of revelation only to one man. Christianity, however, uses the prophetic sections of the Bible, especially the messianic passages, as most authoritative.

Rabbinic Judaism asserts that the revelation at Mount Sinai took two forms, the Written Torah and the Oral Torah. "Torah" means instruction, from the same Hebrew root used for the word teacher. The Written Torah is the Five Books of Moses. The Oral Torah is understood by Orthodox Jews as simply the rest of what God revealed to Moses at Sinai. Conservative and Reform Jews, who take an historical approach to understand both the Written and Oral Torah, assert that in the ancient world all traditions were originally oral because writing materials were scarce and few people knew how to read. (Even today, with many forms of written communication and a very high percentage of literacy among the population, much of a nation's tradition is communicated orally. So, for example, you learned that you may not drive a car until you were 16 and only after you passed some tests not by reading it in your state's motor vehicle code, but from someone telling you that.). Eventually, in the Conservative and Reform view, some of those oral traditions were written down and then later edited together. These oral traditions consisted of stories, thoughts about God and human beings (what we call "theology" today), history, and laws (what Anglo-American lawyers call "the common law" in the case of Anglo-American oral legal tradition). The Written *Torah* is then the first editing and commission to writing of a small part of this ongoing oral tradition, stretching back at least as far as Abraham. Parts of the rest of the Oral Torah were later edited and written down in the six books of *the Mishnah,* edited c. 200 C.E. by Rabbi Judah, President of the Sanhedrin, and yet more of the oral tradition was written down in the books of *the Talmud (or Gemara),* edited by Ravina and Rav Ashi in the mid-sixth century C.E. While those books focus on Jewish law, a wealth of *midrash aggadah*, or simply *midrash,* commented on and expanded the non-legal sections of the Bible, and the books collecting those comments were edited and written down between the fifth and twelfth centuries, including, for example, *Genesis Rabbah* ("the Great, or Expanded, Genesis"), *Exodus Rabbah*, and the *Yalkut Shimoni.*

This process of commentary on the Bible continued on through the Middle Ages to the modern period and indeed continues to today, when comments on the weekly Torah reading in the synagogue can be found in books of such commentaries and in multiple sites on the internet. In addition, legal rulings by rabbis (*teshuvot*; singular,

teshuvah) have been written from the early Middle Ages to our own time, and rabbis in all three of the major movements – Orthodox, Conservative, and Reform – write such rulings, based on the precedents of the past but often choosing among them or interpreting them in a new way to apply to modern circumstances. Finally, some codes of Jewish law have been written, collecting and restating Jewish law up to the point of their publication. These include most famously, Maimonides' *Mishneh Torah* (completed 1177 C.E., abbreviated M.T. in the notes) and Joseph Karo's *Shulhan Arukh* (completed 1565, abbreviated S.A. in the notes), with glosses by Moses Isserles to reflect Northern European (Ashkenazic) Jewish practice where it differed from the Mediterranean (Sephardic) Jewish practice that Karo recorded.

In making decisions about moral matters like abortion, Judaism uses Jewish law and the legal techniques embedded in it to help Jews define what exactly is required of them, what are the limits of what is required, and what they may or must do (Dorff 2005). In this way, Judaism is like Islam and unlike Christianity, which shies away from a legal approach to moral issues. Judaism, though, does not use law alone to decide moral issues. Other sources that influence such decisions within Judaism include Jewish stories, history, theology, prayer, familial and communal norms, proverbs, customs, and study (Dorff 2003, 311–344).

2 Conservative (Masorti) Judaism

Like the other two modern movements, Conservative Judaism began in Germany in response to the third generation of German Jews living under Enlightenment conditions – specifically, between 1820 and 1850. The Reformers argued that Judaism should be defined exclusively as ethical monotheism, with few, if any, traditional rituals that would mark them off as a separate people so that Jews could fully engage the modern culture. The Modern Orthodox maintained that although young Jews could attend secular universities (hence "Modern"), whenever what they learned there contradicted traditional Jewish teaching, they must prefer Judaism over secular culture, for the former came from a perfect God and the latter from fallible human beings. The founders of the Conservative movement sought not to reform Judaism but to conserve it (hence the name) while still engaging fully in modern culture. Thus from the very beginning, the objective was to embrace both tradition and modernity and to integrate the two as fully as one could. The movement began when Zacharias Frankel led a group of traditionalists out of the Reform camp in 1845 over the traditionalists' insistence that the bulk of Jewish prayer remain in Hebrew rather than the vernacular that the Reformers endorsed, and that was only one such break with the Reformers, as the very first official statement of Conservative ideology, the Preamble of the Constitution of the United Synagogue of America (1913), made clear (Waxman 1958, 173; Dorff 1996, 273): The purpose of this organization is as follows:

The advancement of the cause of Judaism in America and the maintenance of Jewish tradition in its historical continuity,

To assert and establish loyalty to the Torah and its historical exposition.
To further the observance of the Sabbath and the dietary laws.
To preserve in the service the reference to Israel's past and the hopes for Israel's restoration.
To maintain the traditional character of the liturgy with Hebrew as the language of prayer.
To foster Jewish religious life in the home, as expressed in traditional observances.
To encourage the establishment of Jewish religious schools, in the curricula of which the study of Hebrew language and literature shall be given a prominent place, both as the key to the true understanding of Judaism, and as a bond holding together the scattered communities of Israel throughout the world.
It shall be the aim of the United Synagogue of America, while not endorsing the innovations introduced by any of its constituent bodies, to embrace all elements essentially loyal to traditional Judaism and in sympathy with the purposes outlined above.

Although fleshed out much more clearly and specifically, the only other official statement of Conservative belief – namely, *Emet Ve-Emunah [Truth and Faith]: Statement of Principles of Conservative Judaism* (1988) – affirms the same principles. Thus the word used for Conservative Judaism in Israel and, in fact, everywhere in the world except the United States and Canada is Masorti, meaning Traditional, the word I suggested in 1980 (Dorff 1980) that we North American Jews adopt as well to describe what we stand for in order to avoid the impression that we are conservative (with a small c) either religiously or politically and also to assert what we do stand for – a traditional form of Judaism which, in order to be traditional, must also integrate modern knowledge and sensitivities, just as our ancestors did.

3 Conservative Judaism: Methodology in Decision-Making

Because this chapter is about abortion, an issue that is treated extensively by Jewish law as well as by other elements of the Jewish tradition, it is important to cite at least part of what *Emet Ve-Emunah* says about Jewish law so that once having understood the general approach of Conservative Judaism to Jewish topics, the reader will be able to understand how it deals with abortion specifically. Here, then, is at least part of what *Emet Ve-Emunah* (1988, 23) asserts about Jewish law:

> We in the Conservative community are committed to carrying on the rabbinic tradition of preserving and enhancing Jewish law (*Halakhah*) by making appropriate changes in it through rabbinic decision. This flows from our conviction that Halakhah is indispensable for each age. As in the past, the nature and number of adjustments of the law will vary with the degree of change in the environment in which Jews live. The rapid technological and social change of our time, as well as new ethical insights and goals, have required new interpretations and applications of Halakhah to keep it vital for our lives; more adjustments

will undoubtedly be necessary in the future. While change is both a traditional and a necessary part of Halakhah, we, like our ancestors, are not committed to change for its own sake. Hence, the thrust of the Jewish tradition and the Conservative community is to maintain the law and practices of the past as much as possible, and the burden of proof rests on the one who wants to alter them.

What this means is that a Conservative (Masorti) discussion of abortion will, as the reader will see, begin with and largely affirm what has been the traditional stance about abortion since the time of the Torah. At the same time, because we now know much more about fetal development than our ancestors did even two or three generations ago, some parts of the Conservative (Masorti) approach to abortion will be tweaked to reflect our new medical knowledge and abilities. In addition, the current social – and especially the demographic – situation of Jews will affect what the Conservative movement says about abortion.

Conservative (Masorti) Judaism follows Jewish historical precedent in its methods for answering questions in Jewish law and ethics. Over the last two thousand years, most questions in Jewish law and morality were answered by the local rabbi (the *mara d'atra*, the teacher of the place). Sometimes he or she (women were first ordained in the Conservative movement in 1985) will contact another rabbi known to have expertise in a particular area for advice, but in the end it is still the local rabbi who decides the matter. The other historical methodology for determining Jewish law and ethics has been regional bodies of rabbis. The Sanhedrin of old was at least in theory the Supreme Court for worldwide Jewry from its inception, which is a matter of historical dispute but certainly by the first century C.E., to its demise in 361 C.E. During the Middle Ages and into the early modern period, regional groups of rabbis met at commercial fairs, did business during the daytime, and discussed legal and moral issues in the evenings. Similarly, Conservative/Masorti has a Committee on Jewish Law and Standards (CJLS), to which rabbis can refer questions that they think the movement as a whole should address. Local rabbis on their own authority are still free to decide for their congregation or educational institution something different from what the CJLS has decided,[1] but Conservative rabbis look to the Committee to set the practice of the movement and so usually follow the decisions of the Committee, either because they respect and agree with the research and reasoning that went into the legal opinion that always accompanies a decision, or because they want to feel that they are part of the movement's mainstream. As a result, in the material below several decisions of the CJLS will be cited as evidence of the position of the Conservative/Movement on abortion and its related issues of birth control and the biblical command to procreate.

[1] The one exception to this is a Standard of Rabbinic Practice, which all Conservative rabbis and synagogues must obey, but there are only three of those as of this writing. For a description of those and a more detailed description of how the CJLS works, see Dorff 1996, 151–162.

4 The Classical Jewish Stance on Abortion

There is a clear bias for life within the Jewish tradition. Indeed, it is considered sacred. Consequently, although abortion is permitted in some circumstances and actually required in others, it is not viewed as a morally neutral matter of individual desire or an acceptable form of *post facto* birth control. Contrary to what many contemporary Jews think, Jewish law restricts the legitimacy of abortion to a narrow range of cases; it does not give blanket permission to abort.

Judaism does not see all abortion as murder, as Catholicism does, because biblical and rabbinic sources understand the process of gestation developmentally. Thus the original Hebrew version of the Torah (Exodus 21:22–25) stipulates that if a woman miscarries due to an assault, the assailant is not held liable for murder but rather must only pay for the lost capital value of the fetus. That early law already indicates that although the mother has the full status of a human being and all its protections, the fetus is not to be viewed as a full-fledged human being but rather as part of one.

Based on this, the Talmud (B. *Yevamot* 69b) determines that within the first forty days after conception – and possibly up to just under two months of gestation – the zygote is "simply water".

Rabbi Immanuel Jakobovits (1959, 1975, 275), the author of the first full-length book on Jewish bioethics and former Chief Rabbi of the United Kingdom, notes that "forty days" in Talmudic terms may mean just under two months in our modern way of calculating gestation due to improved methods of determining the date of conception.

Another talmudic source (B. *Niddah* 17a) distinguishes the first trimester from the remainder of gestation. These marking points are not based on a theory of ensoulment at a particular moment in the uterus; they are rather determined by the physical development of the fetus as the Rabbis witnessed it when women miscarried at various stages of pregnancy. Even in the early stage of pregnancy, whether forty days or three months, the Rabbis have required justification for an abortion in order to preserve the mother's life or health. For until very recently in human history, an abortion was a major threat to the mother's life and more often than not led to her death. It was performed only when both the mother and fetus would otherwise die and so doctors performed an abortion in an attempt at least to save the fetus. The effect of marking off the early stage of pregnancy from the remainder of gestation is to make abortion during the early period permitted for more reasons than during the rest of pregnancy, when the fetus is legally categorized "like the thigh of its mother" (B. *Hullin* 58a and elsewhere). According to B. *Yevamot* 69b, during the first forty days of gestation, the embryo is "simply water", but even then the Rabbis required justification for an abortion based on the mother's life or health. It has been argued that because our bodies are God's property, neither men nor women are permitted to amputate their thigh except to preserve their life or health, and so, *by and large, abortion is forbidden* (Feldman 1968, pp. 265–266 and Chapter 15).