Journal of Law, Medicine & Ethics (2026), **54**, 2, 259–262
doi:10.1017/jme.2026.10235

CAMBRIDGE UNIVERSITY PRESS

Columns: Currents in Contemporary Bioethics

Remembering Dr. Kenneth C. Edelin

Carmel Shachar[1], Meg Lanthier[1], and Eli Adashi[2]

[1]Harvard Law School, Harvard University, United States and [2]Brown University Warren Alpert Medical School, United States

Abstract

After performing an abortion in 1973, Dr. Kenneth Edelin was indicted and convicted of manslaughter. Dr. Edelin's conviction was reversed 50 years ago. However, the conflict between the medical and legal systems, the use of abortion prosecution to control patients and providers, and the framing of a fetus as a person feel just as relevant to today's abortion landscape.

Keywords: abortion; medical-legal conflicts; reproductive ethics; law

About This Column

The Currents in Contemporary Bioethics column features examinations of recent developments and trends in bioethics. If you would like to submit to this column, please contact JLME editor-in-chief Aaron Kesselheim at akesselheim@bwh.harvard.edu.

Dr. Edelin was an African American obstetrician gynecologist who, in the 1970s, worked at Boston City Hospital's obstetrics and gynecology department, a facility that was serving predominantly low-income women and women of color. After performing an abortion in 1973, in the immediate aftermath of *Roe v. Wade*, Dr. Edelin was indicted and convicted of manslaughter. Throughout the indictment and the subsequent trial, the prosecution insisted that this was not a case about abortion. Instead, the Commonwealth maintained that this was a case in which Dr. Edelin caused the death of an infant that would have been viable.[1]

Dr. Edelin's conviction was reversed 50 years ago by the Massachusetts Supreme Court. However, the conflict between the medical and legal systems, the use of abortion prosecution to control patients and providers, and the framing of a fetus as a person feel just as relevant to today's abortion landscape. Dr. Edelin, a leader in his field, should be remembered for the care he provided countless patients, the mentorship he provided to generations of physicians training at Boston City Hospital and Boston Medical Center, and his advocacy for reproductive care. But Dr. Edelin's case should also be studied as relevant to the challenges facing patients and providers navigating a post-*Dobbs* legal landscape.

Dr. Edelin's Conviction and Acquittal

The abortion at issue in Dr. Edelin's trial began when a seventeen-year-old was brought to Boston City Hospital by her mother to terminate an unwanted pregnancy. Dr. Edelin first attempted to perform the abortion by means of a saline injection, a routine, minimally invasive method for a second trimester abortion. When Dr. Edelin determined that proceeding with this method of abortion would be unsafe, he pivoted to a hysterotomy, a surgical method of abortion. The prosecution alleged that during this procedure, after detaching the placenta, Dr. Edelin remained with his hand inside the patient's uterus for three to five minutes, cutting off the fetus's oxygen supply. The prosecution further alleged that the fetus took a breath during this time, so that Dr. Edelin's action effectively suffocated a fetus that was otherwise born alive.

The social backdrop of the time was marked by tense race relations and racism. Court-ordered desegregation of the Boston schools had just begun,[2] and the city was wrought with redlining and *de facto* segregation. Dr. Edelin himself became Boston City Hospital's first Black chief resident in obstetrics and gynecology the same year he performed the abortion at the heart of this case. In a word, it was a highly charged time for a Black man to be put on trial for abortion in Boston, and the controversial nature of Dr. Edelin's trial was reflected in the jurors' racial epithets and eventual conviction.

Dr. Edelin was eventually acquitted on appeal in 1976. The six judges on the Massachusetts Supreme Court determined that there was insufficient evidence of Dr. Edelin's wanton and reckless failure to provide medical care to the fetus, a requirement for a manslaughter conviction.[3] Dr. Edelin went on to be a fierce advocate for reproductive health, chairing the board of the Planned Parenthood Federation of America for three years and writing a book about his trial. He also chaired the Department of Obstetrics and Gynecology at Boston University for over a decade, was director of Obstetrics and Gynecology at Boston City Hospital, and managing director of the Roxbury Comprehensive Community Health Center, a significant provider of primary health services for Boston's Black community.

Corresponding author: Carmel Shachar; Email: cshachar@law.harvard.edu

Cite this article: C. Shachar, M. Lanthier, & E. Adashi. "Remembering Dr. Kenneth C. Edelin," *Journal of Law, Medicine & Ethics*, **54**, 2 (2026): 259–262. https://doi.org/10.1017/jme.2026.10235

© The Author(s), 2026. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics.

https://doi.org/10.1017/jme.2026.10235 Published online by Cambridge University Press

Fetal Personhood

Throughout Dr. Edelin's trial, the potential life of a non-viable fetus was consistently placed in the spotlight. The prosecution referred to the fetus as "baby boy" throughout the trial, ignoring the fact that the defense's expert witnesses drew into question the fetus's viability. This focus also omitted the autonomy of the young pregnant woman who sought an abortion. Dr. Edelin's alleged duty to the life of this fetus was the impetus for his indictment and conviction, as the prosecution and jury weighed this duty to a potential life over Dr. Edelin's duty to the pregnant patient coming to him for care.

Today, a similar emphasis on the potential life of a fetus — still ignoring the actual life of the pregnant person carrying that fetus — is growing, as the concept of fetal personhood is steadily gaining momentum in abortion-restrictive states.[4] In 2024, the Supreme Court of Alabama held that a frozen embryo is a person under Alabama's Wrongful Death of a Minor Act, giving embryos and fetuses legal status as persons, regardless of their location in or out of a uterus.[5] Justice Parker's concurrence took this conclusion even further, advancing the theory that Alabama's "Sanctity of Unborn Life" amendment to their state constitution creates not only legal personhood for fetuses, but a personhood that carries all the Christian religious connotations associated with "sanctity" and Christian beliefs that surround when life begins.[6]

Other examples in the last year have directly placed the potential lives of fetuses over the dignity of the pregnant people carrying them. In March of 2025, a Georgia woman was charged with concealing the death of a person and abandoning a dead body after miscarrying at nineteen weeks.[7] Although these charges were dropped, the arrest of a woman suffering a miscarriage places the legal rights of a non-viable fetus over the dignity and privacy of the woman experiencing that miscarriage. State laws advancing fetal personhood concepts also call into question pregnant people's right to die with dignity. Georgia's Living Infants Fairness and Equality (LIFE) Act, which gives fetuses rights as persons, has been interpreted by a hospital to require them to keep a brain-dead pregnant woman on life support until the unborn fetus is viable and can be delivered. The patient, Adrianna Smith, was only nine weeks pregnant when she was determined to be brain dead in February 2025.[8] This recent interpretation of Georgia's law places the rights of a fetus above those of the pregnant woman in both life and in death. At every stage of a pregnant person's life, fetal personhood laws have the capability of depriving them of their dignity, autonomy, and privacy.

The rise of fetal personhood language in judicial decisions and state statutes has steadily increased since the *Dobbs* decision in 2022. As of May 2025, 17 states have granted fetuses legal status as persons and 24 states have enshrined fetal personhood language such as "unborn human being" in their abortion laws and regulations.[9] The broad wording of these fetal personhood laws can lead to increased civil and criminal liability for both pregnant people and clinicians, reduced access to contraceptives, limited availability of infertility treatments such as IVF, and intensify scrutiny of both pregnant people and providers facing emergent situations related to pregnancy.[10] These statutes pose a greater risk to pregnant people of color, particularly Black pregnant people, as they face heightened surveillance, scrutiny, and criminalization during pregnancy.[11] The elevation of a fetus' life far above that of the pregnant person carrying it was central to Dr. Edelin's conviction, and continues to be central to statutes and legal decisions defining the bounds of fetal rights and pregnant people's autonomy today.

Abortion Prosecution as a Tool of Control

Dr. Edelin's trial was also an expression of state control over the medical profession, highlighting where state leaders felt uneasy with medical practices, and their discomfort with a Black physician providing abortion care to a Black patient. Dr. Edelin understood this, remarking in 2007 to the *Boston Globe* that "It was the right place and the right time for those who wanted to make a statement. It was the wrong place and wrong time for me."[12] Fifty years later, abortion prosecutions continue to be a tool of control, both to prevent physicians from offering necessary medical care and to police pregnant people of color.

Some of this "wrong place and wrong time" problem for Dr. Edelin was due to the religious politics of the day in Boston. Although Massachusetts is often seen as a leader in advancing access to abortion and reproductive care, its heavily Catholic population in the 1970s led to a staunch opposition to abortion during that time. The prosecutor who brought the case, Assistant Suffolk District Attorney Newman Flanagan, was a devout Catholic who was deeply uncomfortable with the recently decided *Roe v. Wade* and received significant praise for "pursuing a case that might tighten restrictions and intimidate doctors who performed abortions."[13] Flanagan shaped a jury that was 75% male; ten out of the twelve were Catholic, and all were white.[14] This helped Flanagan secure a conviction, despite the legality of abortion in Massachusetts at the time Dr. Edelin performed the hysterotomy, and the substantial expert testimony supporting Dr. Edelin's surgical technique.

The use of prosecution to control physicians, especially those providing reproductive health care, is all too familiar in 2025. For example, both Louisiana and Texas have prosecuted Dr. Maggie Carpenter for prescribing medication abortion via telehealth.[15] Similarly, private suits were filed in Texas by anti-abortion activist Johnathan Mitchell against physicians in other states who are facilitating access to telehealth abortion care. Some physicians, such as Dr. Carpenter, may choose, as Dr. Edelin did, to accept legal risks to provide the care their patients need and seek. But for others, the threat of prosecution is chilling. As a result of abortion bans, and of the willingness of state leadership to prosecute physicians (even those providing care under exceptions to the ban for the life or health of the patient), some physicians are leaving certain areas, resulting in health care deserts.[16]

Dr. Edelin's experience is also one in which prosecution of an abortion was used to enforce racial politics and discrimination. Dr. Edelin was Black and his patient was Black, yet the jury was all white at a time when racial tensions were high in Boston. An alternate juror reported after the trial that jurors had used racial slurs to refer to Dr. Edelin "more than once."[17] Dr. Edelin himself reflected, "A lot came together for them in my case. They got a black [sic] physician, they got a woman more than 20 weeks pregnant, and they got a fetus in a mortuary."[18] In 2025, abortion prosecutions continue to be a tool to reinforce health disparities. Latina and Black women report high levels of perceived race-based discrimination in health care, including in family planning.[19] Latina and Black women are more likely than white women to experience contraception failure and unintended pregnancies.[20] They experience structural inequalities, such as poor geographic access to maternal care and lack of social supports to parenting such as family leave, which drive abortion rates (and needs) in these populations.[21] Prosecutors, on the other hand, are more likely to be white and male. A 2013 study demonstrated that in cases in which a woman was arrested or detained due, in part, to her pregnancy, 59%

https://doi.org/10.1017/jme.2026.10235 Published online by Cambridge University Press

of these individuals were Black, Latina, Indigenous, or Asian.[22] While there are not yet studies charting the rates of abortion prosecutions post-*Dobbs* in different populations, there is little reason to think that the outcomes will be different.

Legislating Medical Practice

The impossibility for physicians to navigate the demands of lawmakers and judges while providing quality care to their patients holds true in both the 1970s and now. Dr. Edelin was ultimately spared his conviction by the Massachusetts Supreme Court, which concluded that, since the fetus had never been alive separate from the patient, Dr. Edelin could not have committed manslaughter. But their decision did little to offer guidance to physicians, leaving the door open for substantial scrutiny into the medical decision-making of abortion providers. While all the judges on the Massachusetts Supreme Court agreed that a live birth created a duty to care for an infant, they failed to advance meaningful guidance for determining when a live birth occurs, whether a doctor's pre-birth conduct should be considered in assessing their alleged recklessness, and how to incorporate the quick decision-making required of physicians into a manslaughter analysis.[23]

In many ways, the Massachusetts Supreme Court's decision reflects the tensions that transpire when state actors try to control the practice of medicine.[24] It leads to laws, regulations, and legal judgements that interfere with the patient-physician relationship — the cornerstone of medical decision-making — and prevents physicians from providing care consistent with evidence-based best practices. Instead, physicians are told that they must comply with the judgment of non-medical professionals, lest they risk liability, but without meaningful guidance on how to meet their professional and ethical responsibilities to their patients.

For example, many state abortion restrictions include exceptions for the life or health of the patient. Recently, there were two cases in Texas that sought clarification of the scope of the "life-of-the-patient" exception to the state's abortion ban.[25] In one case, the lower court granted an injunction to allow a patient an abortion because her fetus had multiple lethal congenital anomalies, and the patient experienced multiple complications and emergency department visits. The Texas Supreme Court, however, denied that injunction, arguing that even though the treating physician had a "good faith" reason to believe that the patient's life was endangered, the physician had not met the "reasonable medical judgement" that "meet[s] an objective standard."[26] Similarly, in *Texas v. Zurawski*, 22 patients who were denied obstetrical care brought suit to clarify the scope of Texas's life-of-the-patient exception to its abortion ban.[27] The *Zurawski* plaintiffs argued for a "good faith" standard rather than a "reasonable person" standard, because under a reasonable person standard "it is unlikely that the prosecution could not find a physician willing to testify that the physician [acted un]reasonably."[28] A good faith standard allows physicians to define the scope of medical exceptions to abortion bans, but an objective standard keeps control of abortion care in the hands of state actors.[29] The Texas Supreme Court implied that the physicians treating the *Zurawski* plaintiffs had been wrong to be hesitant to provide risky abortion care, stating:

A physician who tells a patient, "Your life is threatened by a complication that has arisen during your pregnancy, and you may die, or there is a serious risk you will suffer substantial physical impairment unless an abortion is performed," and in the same breath states "but the law won't allow me to provide an abortion in these circumstances" is simply wrong in that legal assessment.[30]

Despite this admonition, however, the Court rejected the good faith standard and required physicians to meet an objective standard to provide an abortion under the life exception. To date, despite the suggestions of the Texas Supreme Court that it do so, the Texas Board of Medicine has declined to provide guidance on when an abortion would meet the objective standard continually required by the courts. Physicians in Texas in 2025 have as little helpful guidance as physicians in Massachusetts did in 1976 after Dr. Edelin was acquitted.

Conclusion

Dr. Edelin should be remembered for his commitment to his patients, even when that commitment led to significant legal consequences. His case also illustrates how little has changed in the 50 years since Dr. Edelin was acquitted. Abortion continues to be the third rail of American politics. It is dismaying to consider that many of the legal, ethical, and social controversies that faced Dr. Edelin and his patient, including an overemphasis on fetal personhood, using prosecution to control physician and patients (especially those of color), and the impossibility of legislating medical practice also face providers and patients now.

Disclosures. The authors have nothing to disclose.

Carmel Shachar, JD, MPH, is Assistant Clinical Professor of Law at Harvard Law School.

Meg Lanthier is a Clinical Student at the Health Law and Policy Clinic of Harvard Law School

Eli Adashi, MD, MS, MA (ad eundem), CPE, FACOG, FRCOG (ad eundem), is Dean Emeritus of Medicine and Biological Sciences and Professor of Medical Science at The Warren Alpert Medical School, Brown University

References

1. *Commonwealth v. Edelin*, 359 N.E.2d 4, 8 (Mass. 1976).
2. Meg Woolhouse, "Boston schools desegregation, then and now: through the eyes of a Black student who survived the 1970s turmoil," *GBH*, June 27, 2024, https://www.wgbh.org/news/education-news/2021-09-30/boston-schools-desegregation-then-and-now-through-the-eyes-of-a-black-student-who-survived-the-1970s-turmoil.
3. *Edelin*, 359 N.E.2d at 5.
4. Carmel Shachar, Lucy Tu, and Bhav Jain, "Fetal Personhood Laws and Their Implications for Health Care," *JAMA* 332, no. 15 (2024): 1231–1232, https://doi.org/10.1001/jama.2024.14739.
5. *LePage v. Ctr. for Reprod. Med., P.C.*, No. SC-2022-0515, 2024 WL 656591 (Ala. Feb. 16, 2024).
6. *LePage v. Ctr. for Reprod. Med., P.C.*, No. SC-2022-0515, 2024 WL 656591 (Ala. Feb. 16, 2024) at *11-13 (Parker, J., concurring).
7. Michelle Del Rey, "Charges Dropped against Georgia Woman Who Miscarried," *Independent* (U.K.), April 4, 2025, https://www.the-independent.com/news/world/americas/crime/charges-dropped-woman-miscarried-b2727773.html.
8. Jess Mador, "Does Georgia's fetal 'personhood' law mean a pregnant woman must stay on life support?," National Public Radio (United States), June 7, 2025, https://www.npr.org/sections/shots-health-news/2025/06/07/nxs1-5425384/georgia-anti-abortion-fetal-personhood-law-pregnant-woman-life-support.
9. "Legal Landscape," Pregnancy Justice, May 28, 2025, https://www.pregnancyjusticeus.org/legal-landscape/.

https://doi.org/10.1017/jme.2026.10235 Published online by Cambridge University Press

10. Carmel Shachar, Lucy Tu, and Bhav Jain, "Fetal Personhood Laws and Their Implications for Health Care," *JAMA* 332, no. 15 (2024): 1231–1232, https://doi.org/10.1001/jama.2024.14739.
11. Shachar, Tu, and Jain, "Fetal Personhood Laws and Their Implications for Health Care."
12. "A 1970s Boston abortion case brought the Roe v. Wade decision into sharp focus," *GBH*, May 9, 2022, https://www.wgbh.org/news/commentary/2022-05-09/a-1970s-boston-abortion-case-brought-the-roe-v-wade-decision-into-sharp-focus.
13. Robert D. McFadden, "Kenneth C. Edelin, Doctor at Center of Landmark Abortion Case, Dies at 74," *New York Times*, December 30, 2013, https://www.nytimes.com/2013/12/31/us/kenneth-c-edelin-physician-at-center-of-landmark-abortion-case-dies-at-74.html.
14. Kenneth Edelin, *Broken Justice: A True Story of Race, Sex and Revenge in a Boston Courtroom* (Pondview Press, 2007).
15. Jessica Valenti and Kylie Cheung, "Republicans Are Attacking Abortion Pills & Blue State Doctors," Abortion, Every Day, Substack, July 30, 2025, https://jessica.substack.com/p/republican-attacks-abortion-pills.
16. Kristen Kolb, "Maternity Care Providers and Trainees Are Leaving States with Abortion Restrictions, Further Widening Gaps in Care," Commonwealth Fund, October 22, 2024. https://www.commonwealthfund.org/blog/2024/maternity-care-providers-and-trainees-are-leaving-states-abortion-restrictions-further
17. McFadden, "Kenneth C. Edelin, Doctor at Center of Landmark Abortion Case, Dies at 74."
18. Ned Stafford, "Kenneth C Edelin," *British Medical Journal*, no. 348 (2014): 411, https://doi.org/10.1136/bmj.g411.
19. Rachel G. Logan et al., "'When Is Health Care Actually Going to Be Care?' The Lived Experience of Family Planning Care Among Young Black Women," *Qualitative Health Research* 31, no. 6 (2021): 1169–1182, https://doi.org/10.1177/1049732321993094.
20. Andrea V. Jackson, Lin-Fan Wang, and Jessica Morse, "Racial and Ethnic Differences in Contraception Use and Obstetric Outcomes: A Review," *Seminars in Perinatology* 41, no. 5 (2017): 273–277, https://doi.org/10.1053/j.semperi.2017.04.003.
21. Liza Fuentes, "Inequity in US Abortion Rights and Access: The End of Roe Is Deepening Existing Divides," *Guttmacher Institute*, January 12, 2023, https://www.guttmacher.org/2023/01/inequity-us-abortion-rights-and-access-end-roe-deepening-existing-divides.
22. Lynn M. Paltrow and Jeanne Flavin, "Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health," *Journal of Health Politics, Policy and Law* 38, no. 2 (2013): 299–343, https://doi.org/10.1215/03616878-1966324.
23. John A. Robertson, "After Edelin: little guidance," *Hastings Center Report* 7, no. 3 (1977): 15–17, 45, https://doi.org/10.2307/3560685.
24. Susannah Baruch, Louise P. King, and Carmel Shachar, "Intrusion in the Practice of Medicine," *JAMA* 333, no. 16 (2025): 1389–1390, https://doi.org/10.1001/jama.2025.1381.
25. Carmel Shachar, Susannah Baruch, and Louise P. King, "Whose Responsibility Is It to Define Exceptions in Abortion Bans?," *JAMA* 331, no. 7 (2024): 559–560, https://doi.org/10.1001/jama.2024.0001.
26. *In re State.*, 682 S.W.3d 890 (Tex. 2023).
27. *Texas v. Zurawski*, 690 S.W.3d 644 (Tex. 2024).
28. Pls.' First Am. Verified Pet. for Declaratory J. & Appl. for Temp. & Permanent Inj. at 67, *Zurawski v. Texas*, No. D-1-GN-23-000968 (Dist. Ct. Travis Cnty. May 22, 2023) (quoting *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 205 (6th Cir. 1997)).
29. Melissa Morgan, "Medical Judgment and Maternal Health Exceptions in the New Era of Abortion Criminalization," *Texas Journal on Civil Liberties & Civil Rights* 30, no. 1 (2024): 1–51. https://racism.org/articles/basic-needs/54-health-and-health-care/85-bioethical-issues/109-reproductive-issues/12621-medical-judgment-and
30. *Zurawski*, 690 S.W.3d at 653.

https://doi.org/10.1017/jme.2026.10235 Published online by Cambridge University Press